PGY5 Psychotherapy Review Course

PGY5 Academic Day Seminar 2021

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Acknowledgment

I acknowledge with gratitude the Coast Salish Territories and specifically thank the W̱SÁNEĆ people for allowing me to live and work on their traditional land.

Conflict of Interest Disclosures

- No history of remuneration from an institute or company marketing a specific psychotherapy modality
- Associate Program Director for UBC Resident Psychotherapy Training; psychodynamic psychotherapy supervisor
- Additional training completed in psychoanalysis and mindfulness-integrated CBT (MiCBT)
- Mitigating potential bias: Information is consistent with published literature and with current RCPSC/ UBC Psychiatry Postgraduate Education psychotherapy requirements

Disclaimer

- I have endeavoured to ensure that all information in this presentation is accurate at the time of presentation and consistent with general psychiatric and medical standards. However, knowledge and best practice in this field are constantly changing as new research and experience broaden our understanding. Specific situations may require a specific therapeutic response not included in this presentation. Practitioners must always rely on their own experience and knowledge in evaluating the information contained herein. It is the responsibility of practitioners, relying on their own experience and knowledge of their patients, to made diagnoses and determine the best treatment for each patient, and to take all appropriate safety precautions.

- To the fullest extent of the law, neither the author or contributors, assume any liability for any injury and/or damage to persons or property as a matter of products liability, negligence, or otherwise, or from any use or operation of any instructions or ideas in the materials herein.

Session Guidelines

- Please turn video cameras on when speaking if possible
- Please keep microphones muted unless speaking
- To ask questions:
  - Please write them in the chat – I will pause periodically to address them

  OR
  - Please feel free to unmute yourself and ask questions
- Slides and list of Psychotherapy Texts for Additional Learning will be posted on Entrada

Aims and Objectives

Identify foundational principles of psychotherapy

Name common psychotherapy modalities

For each modality:

- Define characteristic features
- Describe key concepts
- Give examples of interventions
- List typical applications
- Outline the empirical research base

RCPSC Psychotherapy Training Requirements

- Proficiency in:
  - Supportive psychotherapy
  - Psychodynamic Psychotherapy
  - Cognitive Behavioural Therapy
  - Either Group or Family Therapy (with working knowledge in the other)
  - Crisis Intervention (expected to be learned and delivered in the ER setting)

- Working knowledge in:
  - Either Group or Family Therapy (with proficiency in the other)
  - Interpersonal Therapy
  - Dialectical Behaviour Therapy
  - Behaviour Therapy

- Introductory knowledge in: Brief Psychodynamic Psychotherapy, Mindfulness Training, Motivational Interviewing, Relaxation

Definitions[1]

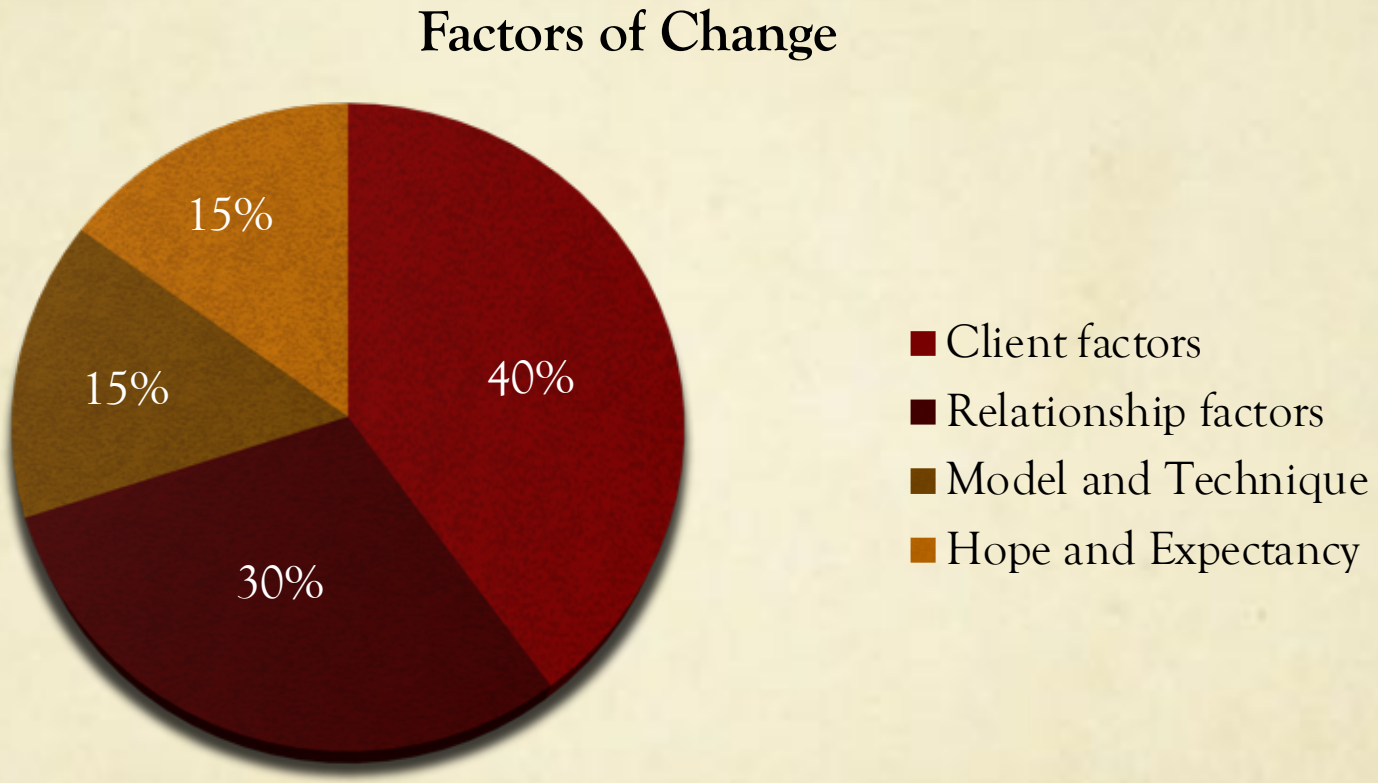
- Proficiency
  - Demonstrates a sound knowledge base with regard to theoretical principles, therapeutic applications, indications & contraindications, and empirical research base
  - Assumes the role of primary therapist under supervision
  - Competence has been assessed by the supervisor
- Working Knowledge
  - Familiar with the theoretical principles, empirical research, and indications & contraindications for the therapy
  - Participation as an observer or co-therapist (does not assume primary responsibility for the delivery of the treatment)
- Introductory Knowledge
  - Familiar with basic theoretical principles & therapeutic applications in psychiatric populations, and the empirical research base that supports the use of the therapy

1. From 'Approaches to Postgraduate Education in Psychiatry in Canada', 2009.
NB: Implementation of the new CBD curriculum in process since 2020.

Overview

Foundations of Psychotherapy

Factors of change in psychotherapy



Duncan and Miller (2004). The Heroic Client

Most important elements of the therapeutic relationship

Demonstrably effective

- Alliance/Cohesion (group)
- Collaboration
- Goal consensus
- Empathy
- Positive regard and affirmation
- Collecting feedback

Probably effective

- Congruence/genuineness
- Real relationship
- Emotional expression
- Cultivating positive expectations
- Promoting treatment credibility
- Managing countertransference
- Repairing alliance ruptures

Norcross & Lambert, 2018 – Task Force commissioned by the APA

In addition, therapist supervision and feedback can improve patient outcomes (Shimokawa 2010, Simon, 2012)

Therapeutic Alliance

Uniform phenomenon across different therapies (Horvath, 2006)

Directly contributes to therapy outcome; predictive of outcome, especially early alliance

Measurement tool: WAI (Working Alliance Inventory)

Bordin (1979) proposed 3 main aspects of working alliance:

- Agreement on **Goals**
- Assignment of **Task(s)**
- Development of **Bonds** (trust and attachment)

"**Enthusiastic collaboration**" is the most consistent indicator of a positive alliance (Hatcher, 1999)

Three Core Therapist Conditions for Therapeutic Efficacy

(Carl Rogers)

Congruence/Genuineness

The therapist is congruent or integrated in the relationship.

Acceptance (unconditional positive regard)

The therapist experiences unconditional positive regard for the client.

Empathy

The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.

Neuroscientific Underpinnings

- Psychotherapy alters **unconscious associative networks** that trigger problematic defensive strategies, emotional reactions and interpersonal patterns (Gabbard & Westen, 2003)
- Psychodynamic psychotherapy neuroimaging studies show normalisation of synaptic or metabolic activity in the prefrontal, limbic and midbrain regions a/w improved clinical outcomes (Abbas et al, 2014)
- CBT and IPT for mood/anxiety alter metabolic activity within (Frewen, 2008):
  - Dorsolateral PFC (executive function)
  - Anterior and posterior cortical midline structures (self-referential processing)
  - Ventrolateral (inferior frontal) cortex, ventral and dorsal ACC, mPFC (regulation of negative affect)
- The volume of the amygdala and the associated perceived stress have been shown to decrease after only 8 weeks of mindfulness meditation (Holzel et al, 2011)
- Mindfulness meditation reduces activity of the ventromedial PFC, which has been related to self-referential processing (Farb et al, 2010)

Neuroanatomical Correlates

- **Limbic system/amygdala**: categorization of experience as pleasant or unpleasant, analysis of potential threats, activation of autonomic nervous system
- **Autonomic nervous system**: fight/flight/freeze response
- **Nucleus accumbens, ventral tegmental area**: positive affect
- **Insular cortex:** processing of interoception
- **Ventrolateral (inferior frontal) cortex, ventral and dorsal ACC, mPFC:** regulation of negative affect
- **Anterior and posterior cortical midline structures (e.g. ventromedial PFC):** self-referential processing
- **Dorsolateral PFC:** executive function

Frewen, 2008; Solms, 2016; Nejad 2013; Cayoun 2019

Supportive psychotherapy

Supportive psychotherapy (1)

- Features:
  - Creation of a therapeutic relationship as a temporary buttress or bridge
  - Etiological emphasis on external rather than intrapsychic events
  - Often includes involvement of family members, other health care providers, institutions

- Indications: Individual in acute crisis, individual with severe and persistent mental illness, cognitive deficits, psychologically disinclined to do more exploratory work
  - Rarely contraindicated as such, but more in-depth approaches may be more suitable for patients who are available for and capable of them

- Goals: Minimize or prevent recurrence of **symptoms**, maintain/improve **functioning** (self-esteem, regulation of affect, reality testing, increased capacity to adapt to problems, live more comfortably with illness)

Supportive Psychotherapy (2)

- Approach and Techniques:
  - create stable, caring atmosphere
  - problem-solving
  - develop pleasurable activities
  - reassurance
  - strengthen adaptive defenses
  - reinforce assets
- Interventions can be conceptualised as being on a continuum from supportive to expressive

Supportive-Expressive Continuum

(Gabbard 2017; Long-term Psychodynamic Psychotherapy)

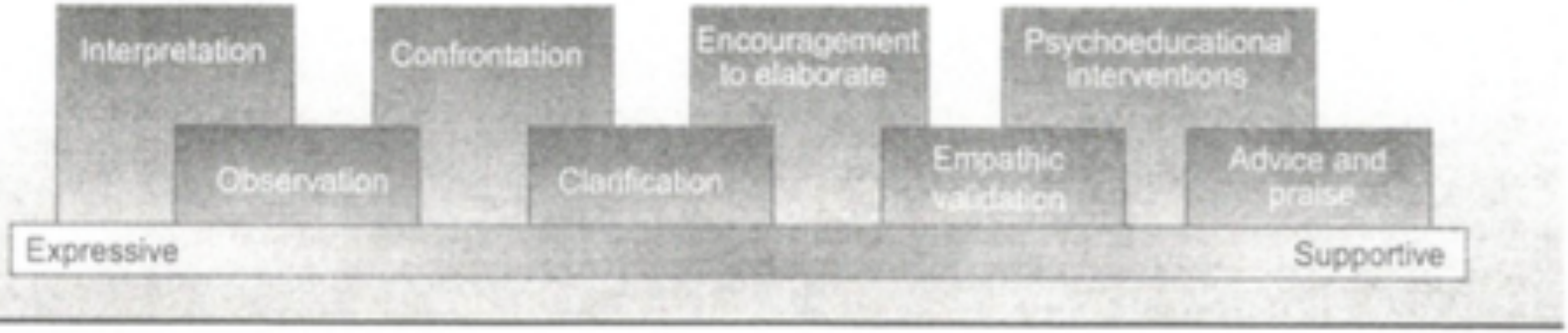


Figure 4–1. An expressive-supportive continuum of interventions.

Therapeutic Interventions

Supportive Psychotherapy Interventions

"It took a lot of courage to ask for help like you did"
(encouragement)

"It sounds like this has been a very difficult time for you"

(empathic validation)

"High emotion can activate your fight/flight/freeze system and make it difficult to respond in the most effective way. Let's work on some strategies you could use when you are feeling really overwhelmed."

(psychoeducational intervention)

MCQ 1

Which of the following is a core therapist condition as described by Carl Rogers:

A. Collaboration

B. Congruence

C. Goals consensus

D. Emotional Expression

E. Collecting Feedback

MCQ 1

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MCQ 2

Which of the following areas plays a key role in mediating awareness of body sensations?

A. Dorsolateral prefrontal cortex

B. Ventromedial prefrontal cortex

C. Posterior parietal cortex

D. Insular cortex

E. Posterior cingulate cortex

MCQ 2

Which of the following areas plays a key role in mediating awareness of body sensations?

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D. Insular cortex ✓

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MCQ 2

Which of the following areas plays a key role in mediating awareness of body sensations?

A. Dorsolateral prefrontal cortex
   - Executive function

B. Ventromedial prefrontal cortex
   - Self-referential processing

C. Posterior parietal cortex
   - Motor planning, spatial reasoning, attention

D. Insular cortex
   - Interoception

E. Posterior cingulate cortex
   - Default mode network (component)

MCQ 3

The following strategy is the most likely to be identified as a strategy in supportive psychotherapy:

A. Reinforcing assets

B. Teaching TIP skills

C. Guiding progressive muscle relaxation

D. Challenging all-or-nothing thinking

E. Developing discrepancy

MCQ 3

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Psychodynamic Psychotherapy

Psychodynamic PT – Characteristics (1)

- Psychodynamic psychotherapy originated from Sigmund Freud's method of psychoanalysis
- Based on the idea that unconscious thoughts and feelings, though they are beyond awareness, still influence how we think, feel, behave and relate with others
- Uncovering more about how their mind works in the context of the relationship with the therapist helps people better understand and change habitual ways of thinking and behaving

Psychodynamic PT characteristics (2)

Seven distinctive features of psychodynamic psychotherapy:

- Exploring the full emotional range
- Examining avoidances
- Identifying recurring patterns
- Discussing past experience
- Focusing on relationships
- Examining the patient/therapist relationship
- Valuing fantasy life

Shedler, 2010

Psychodynamic psychotherapy: Setting

Typically time intensive: multiple sessions per week for several years

"Classic" Psychoanalysis: 4-5 times per week, use of the couch

Psychoanalytic/Psychodynamic psychotherapy: 1-3 times per week, face-to-face

Psychodynamic PT - Indications

- Initially thought to be suitable only for 'neurotic level' disorders, but the patient population has since been expanded to include more severe psychopathology
- **Positive prognostic features (K&S p. 847)**
  - High motivation
  - Ability to form a relationship
  - Psychological mindedness/capacity for insight (curiosity about oneself and capacity for self-reflection)
  - Ego strength (e.g. good impulse control, frustration tolerance, intact judgment, consistent reality testing)

Psychodynamic PT: Key Concepts

- Developmental perspective: patterns of feelings, thoughts and behaviours are laid down in the brain in childhood as a result of the individual's biological predisposition and developmental history.

- In the context of negative childhood experiences, patterns will be developed to avoid the pain and distress associated with the experience (**defense mechanisms**)

- While at one time these patterns may have been appropriate to the individual's childhood view of the world, they can hinder growth in later life and can result in recurrent intrapsychic, interpersonal and behavioural difficulties

- The individual may be aware of a painful or self-defeating pattern, but feel unable to escape it (e.g. choosing abusive partners, self-sabotage when success is imminent). This is thought to reflect the fact that the underlying core conflicts, fears and fantasies remain outside of awareness (i.e. **unconscious**).

Psychodynamic PT: Process (1)

- Interpersonal patterns that occurred with significant figures in the individual's past will be re-experienced in the therapeutic relationship as well (**transference**).
- Patients will use the same patterns derived from childhood to protect themselves from experiencing painful and distressing feelings during the therapy (**defense mechanisms**)

Psychodynamic PT: Process (2)

The therapist also has an emotional response to the patient (**countertransference**).

Can be related to therapist's past relationships

Can be in response to unconscious pressure from patient to feel and behave toward the patient in a way reminiscent of a previous relationship the patient has had in childhood

- Concordant CT[1]: therapist experiences the patient's emotional position (e.g. feels sense of powerlessness and inadequacy when pt describes a demanding and critical parent, or pt may be behaving in a critical and demanding manner)
  - Can be understood as a communication from the patient
- Complementary CT[1]: therapist experiences the emotional position of an important person from the pt's life (e.g. feels frustrated with a pt's passivity, as family members might)
  - Can be used to increase empathy for patientt's difficulty connecting with others

1. Racker, 1957

Transference Reactions vs. Transference Neurosis

- Transference reactions
  - Patients typically manifest a number of transferences over the course of psychotherapy, e.g. the therapist can be experienced at different times as father, mother, sibling, child…
- Transference neurosis
  - The **whole** of the patient's conflicts, defenses and relationship patterns **from childhood** come into focus with the figure of the analyst **in one predominant transference paradigm**
  - Formerly disparate transference reactions are coordinated
- Possible indicators in the therapy setting
  - The experience in the room loses its 'as if' quality ('*you are like my mother*' becomes '*you are my mother*' for the patient)
  - The whole of the neurosis seems to be contained within the transference, whereas the patient's extratransference experiences in day-to-day life appear to be unfolding more smoothly

Freud S, 1914; Laplanche & Pontalis, 1973; Gabbard 2017

Psychodynamic PT: Techniques

- Listen for themes that give clues to unconscious wishes, fears and fantasies. Facilitating techniques:
  - Free association (including attention to Freudian slips/parapraxes)
  - Therapist listens with evenly-suspended attention
  - Exploration of dreams and fantasies
- Observe the process: follow the affect, identify defense mechanisms, hypothesise about transference, monitor countertransference
- These observations are then explored and worked through to better understand unconscious patterns at play and recognise the effects of past experience on present behaviours
- The hope is that through curious inquiry, the patient will gain self-knowledge and understanding, painful feelings will diminish and new behaviours will become possible

Expressive-Supportive Continuum

(Gabbard 2017; Long-term Psychodynamic Psychotherapy)

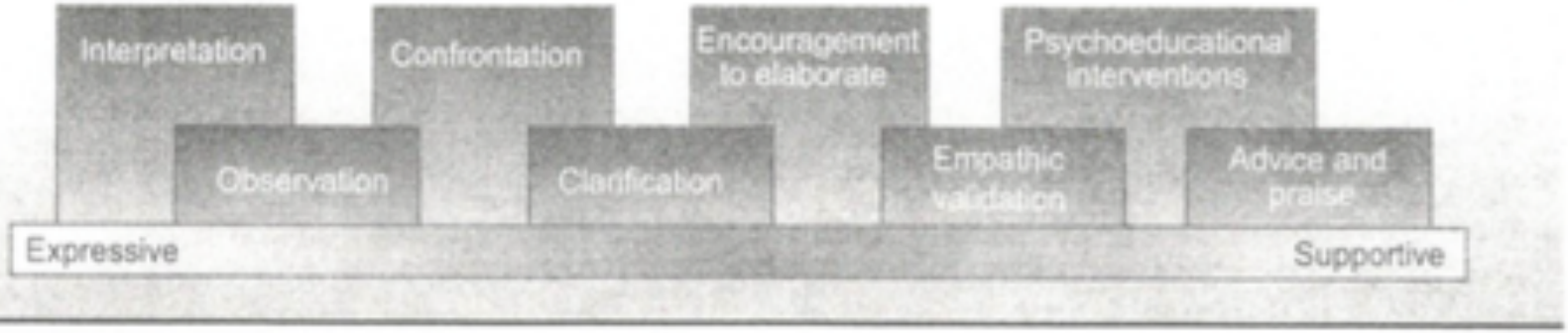

Figure 4–1. An expressive-supportive continuum of interventions.

Therapeutic Interventions

Definitions

Clarification:

Bringing clarity to issues that are vague, diffuse or disconnected. Checking correctness of understanding.

Observation:

Noticing a behaviour, affect or pattern.

Confrontation:

Drawing attention to something that is being avoided.

Interpretation:

Making an explanatory statement that links manifest content to its latent or unconscious meaning. For example, describing a potential link between a here and now experience and past experiences.

Gabbard, G (2017). Long-term Psychodynamic Psychotherapy. A Basic Text. American Psychiatric Association Publishing, Arlington, VA

Expressive Psychodynamic Interventions

"Any sense why that memory might have come to mind just now?"
(invitation for associations)

" I noticed you started telling me about all of the things on your to do list right after I asked how you were managing with your father's death. I wonder if my question might have stirred up some upsetting feelings for you."
(confrontation of defense)

"It seems you expect I will criticize you no matter how hard you try, much like it felt you were never good enough for your parents"
(interpretation)

Empirical Research Base (1)

- Meta-analyses of short-term and long-term psychodynamic psychotherapy studies show effect sizes of 0.69 to 1.46 (Shedler, 2010)
- Consistent trend toward increases at follow up, suggesting that psychodynamic psychotherapy sets in motion processes that continue after termination (Shedler, 2010)
- No significant differences in studies comparing psychodynamic psychotherapy to CBT and other therapies (Anderson & Lambert 1995; Leichsenring et al. 2004; Driessen et al. 2013; Connolly Gibbons et al. 2016)

Meta-analysis Effect Size (ES):
Small: 0.20-0.49; Moderate: 0.50-0.79; Large: ≥ 0.8

Psychodynamic therapy			
Abbass et al. (2006)	Various disorders, general symptom improvement	0.97	12 studies
Leichsenring et al. (2004)	Various disorders, change in target problems	1.17	7 studies
Anderson & Lambert (1995)	Various disorders and outcomes	0.85	9 studies
Abbass et al. (2009)	Somatic disorders, change in general psychiatric symptoms	0.69	8 studies
Messer & Abbass (in press)	Personality disorders, general symptom improvement	0.91	7 studies
Leichsenring & Leibing (2003)	Personality disorders, pretreatment to posttreatment	1.46[c]	14 studies
Leichsenring & Rabung (2008)	Long-term psychodynamic therapy vs. shorter term therapies for complex mental disorders, overall outcome	1.8	7 studies
de Maat et al. (2009)	Long-term psychoanalytic therapy, pretreatment to posttreatment	0.78[c]	10 studies

[a] Median effect size across 18 meta-analyses (from Lipsey & Wilson, 1993, Table 1.1). [b] Median effect size across 23 meta-analyses (from Lipsey & Wilson, 1993, Table 1.2). [c] Pretreatment to posttreatment (within-group) comparison.

Shedler J (2010). The efficacy of psychodynamic psychotherapy. Am Psychol 65: 98-109

Empirical Research Base (2)

- Systematic Reviews of STPP and LTPP (Leichsenring et al. 2015; Fonagy et al. 2015):
  - Substantial evidence for the efficacy of PDT in depressive disorders, anxiety disorders, somatic symptom disorders, eating disorders, substance-related disorders, BPD and heterogeneous PDs
  - Little evidence for OCD, PTSD, bulimia nervosa (conflicting results), cocaine dependence, and psychosis

- For BPD, there is empirical evidence for therapies with strong psychodynamic underpinnings:
  - Mentalisation Based Treatment (Bateman & Fonagy)
  - Transference-focused Psychotherapy (Yeomans, Clarkin & Kernberg)

- CANMAT guidelines for MDD (2016):
  - Long-term PDT: Third-line for acute and maintenance treatment of MDD. May be useful for patients with comorbid personality disorders.
  - STPP: Second-line for acute treatment of MDD

- Anxiety Guidelines (2014): Some evidence of benefit in GAD

MCQ 4

Which of the following would most likely predict a poor response to psychodynamic psychotherapy:

A. Depressive symptoms that have been present for several years

B. Preference to pay out-of-pocket for psychotherapy

C. Comorbid depression and cluster C personality disorder

D. Concurrent treatment with an SNRI

E. External locus of control

MCQ 4

Which of the following would most likely predict a poor response to psychodynamic psychotherapy:

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C. Comorbid depression and cluster C personality disorder

D. Concurrent treatment with an SNRI

E. External locus of control ✓

MCQ 5

Which of the following is NOT an empirically validated psychotherapy for Borderline Personality Disorder (BPD)?

A. Mentalisation-based treatment

B. Schema-focused therapy

C. Motivational Interviewing

D. Dialectical Behaviour Therapy

E. Transference-focused psychotherapy

MCQ 5

Which of the following is NOT an empirically validated psychotherapy for Borderline Personality Disorder (BPD)?

A. Mentalisation-based treatment

B. Schema-focused therapy

C. Motivational Interviewing ✓

D. Dialectical Behaviour Therapy

E. Transference-focused psychotherapy

4 Main Theoretical Models

- **Ego Psychology (Sigmund Freud & Anna Freud)**
  - **Focus on drives and defense mechanisms**
- Object Relations (Fairbairn, Klein, Winnicott)
  - Focus on development of the psyche in relationship to others (object=person)
- Self Psychology (Kohut)
  - Focus on self-esteem, self-cohesion and sense of self-continuity
- Attachment theory (Bowlby, Ainsworth, Main, Mahler)
  - Focus on attachment as a biologically based bond designed to ensure safety and survival

Drive Theory

- Biologically derived model developed by Sigmund Freud
- Individuals seek to gratify instinctual drives, seen as quasi-physiological quantities of energy, with:
  - Source (soma)
  - Aim (discharge/satisfaction)
  - Object (what will allow the drive to achieve its aim)
- Conflict arises when libidinal instincts (which follow the pleasure principle) come up against the reality principle

  → repression

Dual Drive Theory

Later development (historical context: WWI)

There is a fundamental conflict between the life instinct and the death instinct

Death drive comes from the biological need of every organism to return to its original inorganic state (state of zero tension, Nirvana principle)

- Freud considers cell survival/apoptosis as a model

The concept of the death drive remains controversial

Death Drive and Aggression

- The death instincts are to begin with directed inwards and tend towards self-destruction, but they are subsequently turned towards the outside world in the form of the aggressive or destructive instinct.

From: Laplanche J. and Pontalis J.-B. (1973). The Language of Psychoanalysis. WWNorton &Company. New Your; London.

Repetition Compulsion

- Freud considered repetition compulsion to be related to the death drive (however, he does consider control/mastery as a possible aim of recurrent traumatic dreams)
- Contemporary neuroscience: Recurrent patterns related to unconscious associative networks and non-declarative memory systems (Westen & Gabbard 2003; Solms 2019)

Psychosexual Development (S. Freud)

- The organisation of libido occurs in successive stages, with each stage corresponding to a dominant erotogenic zone
- If a child is overfrustrated or overgratified at one of these stages, fixation occurs
- Certain character traits are postulated to reflect each stage of fixation

Psychosexual stages (2)

Phase of fixation	Proposed character trait
Oral phase (0 to 1 ½ years)	Dependent personality
Anal phase (1 ½ to 3)	Obsessive compulsive personality
Phallic/Oedipal phase (3 to 6 years)	Hysterical (Histrionic) personality
Latency phase (6 to puberty)	
Genital (from puberty onwards)	

Erik Erikson

Reformulated Freud's psychosexual stages according to the interpersonal and intrapsychic tasks of each phase

Epigenetic principle: development occurs in sequential stages; each stage must be satisfactorily resolved for development to proceed smoothly

1. **Trust versus Mistrust** (birth to approx. 18 months) - infancy
2. **Autonomy versus Shame** (18 months to 3 years) - toddlerhood
3. **Initiative versus Guilt** (approx. 3-5years) - preschool
4. **Industry versus Inferiority** (approx. 6-12 years) – school age
5. **Identity versus Role Confusion** (approx. 13 to 19) - adolescence
6. **Intimacy versus Isolation** (20s)
7. **Generativity versus Stagnation** (40s)
8. **Integrity versus Despair** (60s)

K&S 11th edition p. 169

For example...

Psychosocial Stage	Associated Virtue	Related Forms of Psychopathology	Positive and Negative Forerunners of Identity Formation	Enduring Aspects of Identity Formation
Trust vs. mistrust (birth—)	Hope	Psychosis Addictions Depression	Mutual recognition vs. autistic isolation	Temporal perspective vs. time confusion

K&S 11th edition p. 169

The Oedipus Complex

- Positive form: desire for the opposite sex parent and rivalry with the same sex parent
  - Resolution: Identification with same sex parent: 'If I'm like dad/mom, I can marry someone like mom/dad'
- Negative form: desire for the same sex parent and rivalry with the opposite sex parent
- Both forms coexist in everyone, based on 'psychic bisexuality'

Formulation of Anxiety – Freud (1)

Signal Anxiety:

- Threat of emergence of unconscious conflict (unacceptable wishes and impulses) produces signal anxiety
- Ego defenses are mobilised to guard against or reduce the excitation
- The anxiety is conscious, the conflict remains unconscious

Formulation of Anxiety – Freud (2)

Hierarchy of Anxiety (linked to developmental stages):

- Disintegration/Annihilation anxiety (fear of loss of self, can be associated with concerns of fusion with the external object) – *early infancy*
- Loss of object/separation anxiety – *later infancy*
- Fear of loss of love (love or approval of the significant other) – *oedipal stage, girls*
- Castration anxiety – *oedipal stage, boys*
- Superego anxiety/Fear of punishment – *post-oedipal*

Freud's topographical model

Unconscious
(unacceptable wishes, impulses, desires)

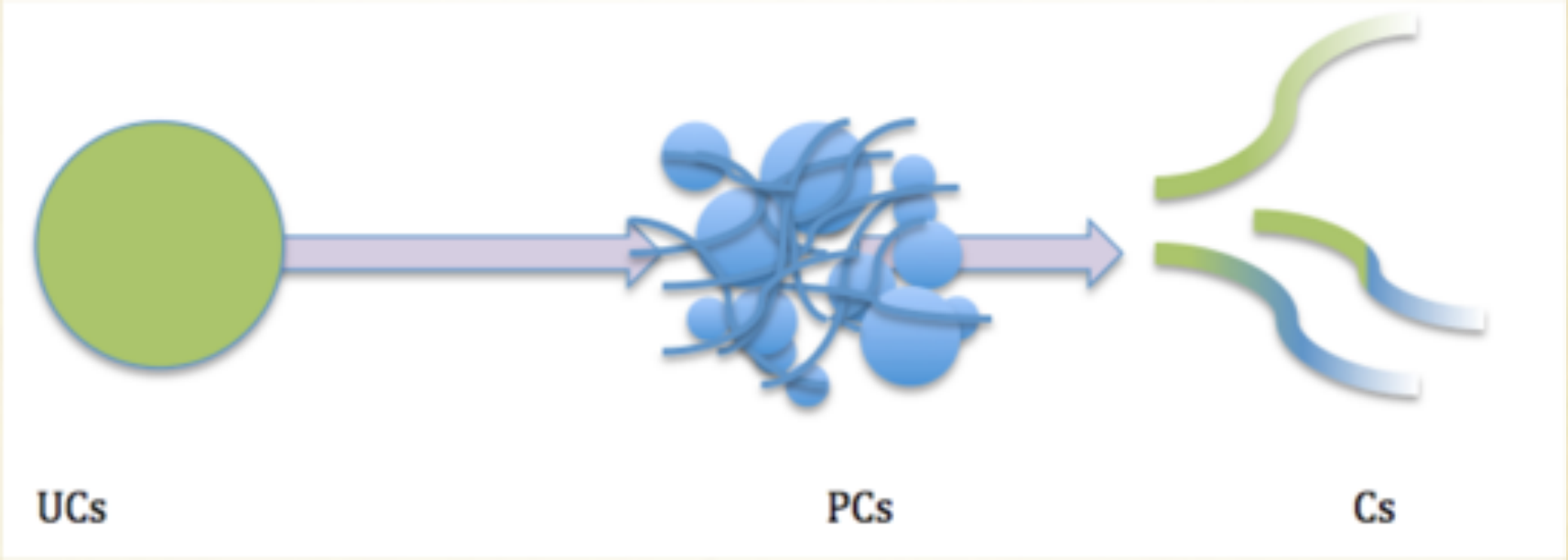
Censorship 1

Preconscious
(more acceptable, capable of becoming conscious)

Censorship 2

Conscious
(acceptable)

Working with the topographical model



Derivatives of the unconscious are retraced to uncover the original conflict

Freud's Dream Interpretation

Dreams are disguised fulfilment of an unconscious wish

The 'censor', acting in the service of the ego, functions to preserve sleep by disguising disturbing thoughts and feelings

- **Condensation** (several unconscious wishes, impulses or attitudes are combined into a singe image)
  - Conversely ,through **diffusion** a single latent wish or impulse is distributed through multiple representation
- **Displacement** (transfer from original object to a substitute)
- **Symbolic representation** (highly charged idea represented by innocent image)

Dream Work

- Unconscious mental operations by which latent dream content is transformed into manifest dream content
  - Manifest content: what is recalled by the dreamer
  - Latent content: unconscious thoughts and wishes that threaten to disturb sleep
- Secondary revision: rearrangement of seemingly incoherent, primitive elements of the dream into a more coherent form
- Anxiety dreams are the result of a failure in the protective function of the dream-work mechanisms

Elements of dream material

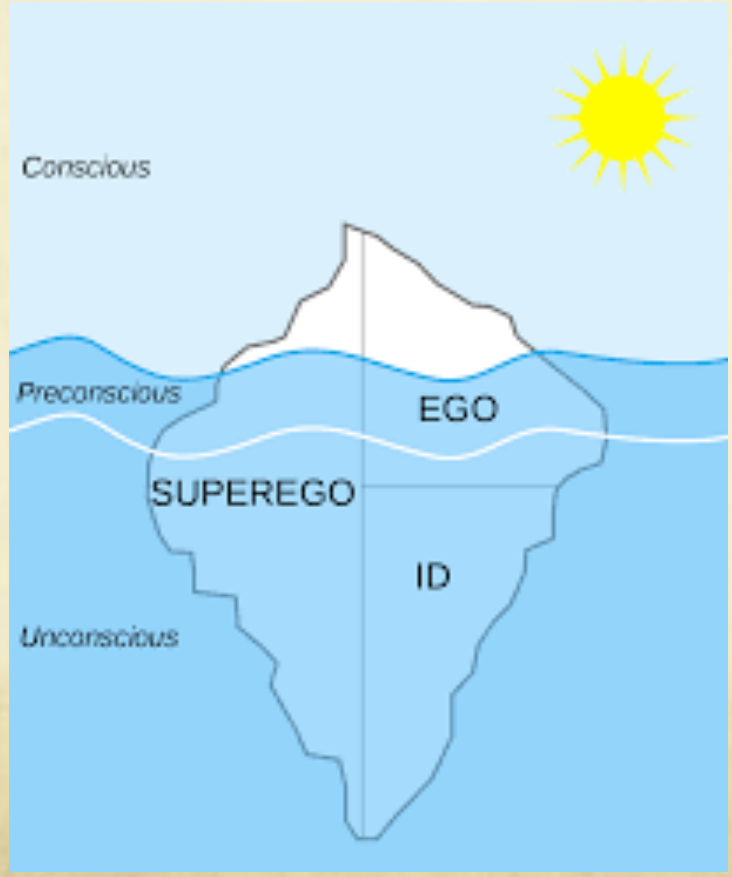
- Nocturnal sensory stimuli (pain, hunger, thirst, urinary urgency)
- Day residue
- Repressed unacceptable impulses

Contemporary Dream Interpretation

- Interpretation broadened beyond wish fulfillment – dreams as a window into unconscious wishes, thoughts, fears, conflicts
- Elements to explore:
  - Dreamer's associations
  - Day residue
  - Affect
  - Self and object representations (figures from the past, figures from the present – including therapist, parts of the self)

Ego Psychology

- Rooted in Freud's **Structural Model:** Id, Ego, Superego
- The Ego mediates amongst Id (primitive drives), the Superego (judges these drives as unacceptable), and External Reality)



The Id

- The part of the mind that contains primitive drives, impulses, wishes, fears and fantasies
- Seeks immediate gratification
  - Operates according to the pleasure principle
  - Primary process thinking: illogical, no sense of time
- Entirely unconscious – inferred from derivatives
- Contemporary neuroscience: cf. limbic system/amygdala

The Ego

Conscious

- Operates according to the reality principle
- Secondary process thinking: mature, reasonable
- Functions of the conscious ego:
  - **Control and regulation of instinctual drives**: the capacity to delay drive discharge (delayed gratification)
  - **Judgment:** the ability to anticipate the consequences of actions
  - **Relation to reality:** mediation between the internal world and external reality (reality testing)
  - **Object relationships:** the capacity to form mutually satisfying relationships; the ability to integrate positive and negative aspects of others and self
  - **Synthetic function** (Herman Nunberg): the capacity to integrate diverse elements into an overall picture
- Contemporary neuroscience: cf. prefrontal cortex

Unconscious

- **Defenses** (Anna Freud's seminal work)

The Superego

- Unconscious
  - Identification with parental superego
  - Freud believed it was formed during the oedipal period; later analysts saw it as originating earlier, in primitive infantile notions of good and bad
    - Negative therapeutic reaction (Freud): paradoxical exacerbation of symptoms following improvement - related to unconscious guilt and belief that one deserves the punishment of suffering
- Conscious
  - Moral conscience

Heinz Hartmann

- Primary autonomous functions of the ego: present at birth and develop independently of intrapsychic conflict
  - Perception, learning, intelligence, intuition, language, thinking, comprehension, motility
  - Will develop normally in an **average expectable environment**
- Secondary autonomous ego functions: arise in the context of intrapsychic conflict in the defense against drives
- Focus on adaptation: defenses originating in the context of intrapsychic conflict could evolve an adaptive capacity (e.g. reaction formation, intellectualisation)
- Neutralisation: over the course of development, the ego strips the drives of their sexual and aggressive qualities

Examples of defense mechanisms (Gabbard 2017, p. 36)

Primitive	Neurotic	Mature
Splitting	Repression	Humour
Projection	Reaction formation	Suppression
Projective Identification	Isolation of affect	Asceticism
Idealisation	Displacement	Altruism
Dissociation	Rationalisation	Anticipation
Acting out	Intellectualisation	Sublimation
Denial	Introjection	
Somatization	Identification	
Regression	Undoing	
Schizoid fantasy	Sexualisation	

Mnemonic for Mature Defenses

SASHA

- **S** uppression
- **A** scetism
- **S** ublimation
- **H** umour
- **A** nticipation

Defenses and Personality Disorders

Case Files: Psychiatry (2012); McWilliams (2011)

- Paranoid: projection
- Schizoid: withdrawal into schizoid fantasy, intellectualisation
- Schizotypal: projection, regression, fantasy
- Antisocial: omnipotent control, projective identification, dissociation, acting out
- Borderline: Splitting, projection, projective identification
- Histrionic: dissociation, repression, regression, sexualisaiton
- Narcissistic: idealisation, devaluing
- Avoidant: isolation, inhibition, repression
- Dependent: idealisation, reaction formation, inhibition, somatisation
- Obsessive-Compulsive: isolation of affect, undoing, rationalisation, intellectualisation, reaction formation, displacement

Other Personality Models (1)

Five Factor Model of Personality (Costa & McRae, 1992)

- Forms the basis of the NEO Personality Inventory
- Mnemonic: **OCEAN**
  - **O**penness
  - **C**onscientiousness
  - **E**xtraversion
  - **A**greeableness
  - **N**euroticism
    - Tendency to experience emotional distress
    - The DSM-5 cites behavioural inhibition, negative affectivity (neuroticism) and harm avoidance as temperamental risk factors for GAD. Neuroticism is also identified as a well-established risk factor for the onset of MDD, and high levels appear to render individuals more likely to develop depressive episodes in response to stressful life events.

Other Personality Models (2)

Psychobiological model of Temperament and Character

(Cloninger et al, 1993)

- Traits postulated to be independently inheritable, with certain neurochemical and neurophysiological substrates

K&S, 11th ed, p. 761

4 Temperament Dimensions

- Novelty Seeking
- Harm Avoidance
- Reward Dependence
- Persistence

3 Character Dimensions

- Self-Directedness
- Cooperativeness
- Self-Transcendence

Cloninger's temperamental traits

- Novelty seeking: heritable bias in the initiation or activation of behaviours such as frequent exploratory activity
- Harm avoidance: heritable bias in the inhibition or cessation of behaviours in response to signals of punishment and non-reward
  - Pessimistic worry, passive avoidant behaviour (fear of uncertainty and shyness of strangers), rapid fatigability
- Reward dependence: heritable bias in the maintenance or continuation of ongoing behaviours in response to cues of social reward
  - Sentimentality, social attachment, dependence on approval of others
- Persistence: maintenance of behaviour despite frustration, fatigue and intermittent reinforcement

Other Personality Models (3)

Alternative DSM5 Model for Personality Disorders

- Disturbances in **self** and **interpersonal** functioning viewed as constituting the core of personality psychopathology
- Elements of self functioning
  - Identity
  - Self-direction
- Elements of interpersonal functioning
  - Empathy
  - Intimacy

MCQ 6

You are seeing a 43-year-old male accountant for assessment, who presents with depressive symptoms following a relationship break-up. As you conduct the interview, he rearranges the pens on the table in a straight line and groups them by colour. He tells you that the interview must end on time because he will fall behind at work and cannot trust his co-workers to cover things properly in his absence. When you ask him about the experience of the break-up, he indicates in a monotone fashion the exact time, location and wording from the last meeting with his ex-girlfriend, and then describes the list of pros and cons he has since established about the relationship.

What defense mechanism is he manifesting?

A. Splitting

B. Projective identification

C. Reaction Formation

D. Isolation of Affect

E. Dissociation

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MCQ 7

Defense mechanisms as examined by Anna Freud are a function of which of the following?

A. The conscious ego

B. The unconscious ego

C. The conscious superego

D. The unconscious superego

E. The id

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MCQ 8

A 4-year-old gets up at the crack of dawn on Mother's Day to make a surprise breakfast in bed for his mom. She hears the noise, enters the kitchen, and exclaims: 'What have you done? It's going to take me hours to clean up this mess!

Which Eriksonian developmental stage could be negatively impacted in this situation?

A. Trust versus mistrust

B. Autonomy versus shame

C. Initiative versus guilt

D. Industry versus inferiority

E. Identity versus role confusion

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Which Freudian psychosexual stage would this correspond to?

A. Oral phase

B. Anal phase

C. Phallic/Oedipal phase

D. Latency phase

E. Genital phase

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C. Anal phase

D. Genital phase

E. Oral Phase

4 main theoretical models

- Ego Psychology (Sigmund Freud & Anna Freud)
  - Focus on drives and defense mechanisms
- **Object Relations (Klein, Fairbairn, Winnicott)**
  - **Focus on development of the psyche in relationship to others (object=person)**
- Self Psychology (Kohut)
  - Focus on self-esteem, self-cohesion and sense of self-continuity
- Attachment theory (Bowlby, Ainsworth, Main, Mahler)
  - Focus on attachment as a biologically based bond designed to ensure safety and survival

Object Relations Main Themes

- Individuals don't seek drive satisfaction as much as they seek relationships (Fairbairn)
- Object=person, typically main caregivers in childhood
- These main objects and the experience of them are internalised
- Internal object relationships are externalised onto new relationships

Object Relations Central Figures

- Melanie Klein
- Ronald Fairbairn
- Donald Winnicott

"However, there are many British psychoanalysts who would claim now that Klein is not truly part of the Object-Relations School." (Hinshelwood, 1991. A Dictionary of Kleinian Thought)

While they derived much inspiration from Klein, members of the 'independent' or middle group of the British Psychoanalytic Society disagreed with Klein's premise of constitutional aggression deriving from the death instinct and placed greater emphasis on the early environment. (Mitchell & Black, 1995)

Melanie Klein

- Oedipus complex placed earlier in life (1st year)
- Splitting and projection
  - Prototype of the good and bad breast (infant cannot integrate good and bad aspects of the object – splits and projects to preserve the good)
- Paranoid-schizoid position (PS)
  - Objects are split, fear of annihilation by bad object, destructive impulses toward it
- Depressive position (D)
  - Object seen as whole, with good and bad aspects. Infant experiences guilt about previous destructive impulses, wish for reparation
- We oscillate between the PS and D positions throughout life

Klein – Envy

- Aggression and envy are seen as constitutional, related to the death drive
- Prototype: The 'good breast', source of gratification and pleasure, arouses intolerable envy in the infant – attacked and spoiled in phantasy
- Negative therapeutic reaction (Klein): Patient longs for help but envies that the therapist would have the capacity to help them –helpful interventions are devalued/dismissed
- Contemporary approaches:
  - Envy is more likely to be seen as secondary, in response to frustration
  - Explore the underlying longing

Projection and Projective Identification

- Klein: Unwanted aspects of the self are attributed to others – through unconscious identification with what is projected, a connection is maintained – the object needs to be carefully watched in an attempt to control (intrapsychic)
- Bion: Introduced the idea of projective identification as a communication. The object of the projection identifies and experiences a pull to behave a certain way (interpersonal)
- Neuroscience: Mirror neuron activation as a mechanism for understanding the actions and intentions of others (Lacoboni, 2009)

Fairbairn

- Individuals don't seek drive satisfaction as much as they seek relationships
- A child bonds to the parents through whatever form of contact the parent provides – this becomes a template for attachment and connection to others
- Provides a different understanding of repetition compulsion
- Therapist becomes a new object with whom new modes of relatedness can develop

Winnicott

- Primary maternal preoccupation
  - There is no such thing as a baby; it is a mother-baby dyad.
- Concept of the ‘good enough’ mother
- Holding environment
- Transitional objects
- True and false self

Some Later Ideas

- Bion:
  - Concept of **'Container/Contained'**: the infant brings the raw experience (beta-elements) to the (m)other, who helps process the experience (alpha-function) and gives it back to the infant in 'digestible' form (alpha elements)
  - When there is failure of maternal containment, the result is the installment of a severe 'ego-destructive' superego
  - Selected fact: "the selected fact is the name for an emotional experience that consists in discovering coherence (Bion, 1962)
- Britton:
  - all internal objects might operate as the superego

Kernberg's Levels of Personality Organisation

- Psychotic Level of Personality Organisation
  - Failure to accomplish the first developmental task of separating what is self from what is other
  - No reliable boundary between internal and external. There is either no relationship or confusing and terrifying merger.
- Borderline Level of Personality Organisation
  - Failure to accomplish the second developmental task of integrating good and bad aspects of self and object.
  - Relationships are polarised. Splitting and other primitive defenses.
- Neurotic Level of Personality Organisation
  - First and second developmental tasks accomplished
  - Ambivalence in relationships. Pathology related to intraspsychic conflict. Higher-level defenses.

Kernberg's BPO

Concept of Borderline Personality Organisation (BPO):

1. Non-specific manifestations of ego weakness
    a. Lack of anxiety tolerance
    b. Lack of impulse control
    c. Lack of developed subliminatory channels
2. Regression toward primary process thinking, psychotic-like states
3. Primitive defenses: splitting, idealisation, projection, projective identification, omnipotence, devaluation, denial
4. Pathological internalized object relations: objects all good or bad, lack of sense of identity; absence of integrated superego functioning (fluctuates)

Mnemonic for BPO

PREP

- **P** rimitive Defenses
- **R** egression toward primary process thinking, psychotic states
- **E** go weakness
- **P** athological internalized object relations

Neurotic versus Borderline Level of Organization

	Neurotic level	Borderline level
Superego	Superego well integrated, but punitive	Superego integration minimal; capacity for concern and guilt fluctuation considerably
Defenses	High-level defenses, including repression, reaction formation, intellectualisation, doing and undoing, displacement	Primitive defenses, including, splitting, projective identification, idealization, devaluation
Identity	Identity reasonably stable and internal object relations characterised by ambivalently regarded whole objects and triangular conflict	Identity diffusion and object relations of a 'partial' rather than 'whole' nature – split into 'all good' and 'all bad' aspects
Ego	Notable ego strengths, including good impulse control, intact judgment, consistent reality resting and capacity for sustained work	Nonspecific ego weaknesses, including impulsivity, impaired judgment, brief compromises in reality testing and difficulty sustaining work
Pathology	Conflict-based pathology	Significant deficits existing alongside conflicts
Reflective function	Intact reflective function	Impaired reflective function

Reference: Gabbard, G (2017). Long-Term Psychodynamic Psychotherapy. A Basic Text.

MCQ 10

According to Object Relations Theory:

A. Individuals seek objects/others to comfort them when they are experiencing increased internal tension

B. Individuals relate to objects/others similarly to how they related to primary caregivers

C. Individuals seek affirmation from objects/others to feel whole

D. Individuals relate to objects/others in order to promote survival

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MCQ 11

Which of the following is NOT a characteristic of Borderline Personality Organisation according to Kernberg?

A. Terror of complete merger with the other

B. Lack of impulse control

C. Pathological internal object relations

D. Frequent use of projective identification

E. Fluctuating superego functioning

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Self Psychology Main Themes

- Orientation toward thinking about people in terms of self-esteem, self-cohesion, sense of self-continuity
- Internalisation of selfobjects helps the individual develop self-esteem and cohesion
- Selfobject: originally the caretaker during childhood who fulfills the function of meeting psychologically essential selfobject needs

Selfobject needs

- Need to be affirmed, valued and validated
  - Need for validation is not phase-based but continues in relationships across the lifespan
- Need to idealize
  - There is a normal need to idealise a healing parent figure, which is then gradually and nontraumatically de-idealised
- Need for a sense of commonality and kinship with another human being

Self Psychology in the Therapy Setting - Transferences (Kohut)

- Mirror transference: patient seeks to be admired with awe and attempts to capture the gleam in the therapist's eye (grandiose self)
- Idealizing transference: patient feels enhanced self-esteem by being in the presence of the exalted figure of the therapist (idealised parent imago)
- Twinship transference: patient perceives the therapist as twin (alter ego)

Self Psychology in the Therapy Setting (2)

Common countertransference responses described in the context of NPD:

- Boredom, impatience, vague irritation
- Feeling insignificant, devalued or overvalued

Deficit Perspective

- If selfobject needs are not met, the individual grows up with a sense of emptiness
- Seeks external validation from outside sources
- In the therapy setting, the patient is seen as attempting to reactivate a disrupted developmental process
- Through manageable frustrations in a supportive setting (***optimal level of frustration***), the patient over time internalizes selfobject functions and develops a cohesive, more resilient sense of of self (***transmuting internalisation***)

Defenses

- Defenses reconceptualised as existing to sustain a consistent, coherent positively valued sense of self
- Underlying central anxiety is ‘disintegration anxiety’ or fear of fragmentation

Heinz Kohut

- Central figure in Self Psychology
- Theories based primarily on work with narcissistically impaired clients
- 'Transmuting internalization' : growth process by which patients are able to internalize the needed selfobject functions and to acquire the missing self-structure
- Emphasizes
  - Empathy
  - Empathic failures
  - Optimal frustration

Related Concepts

- Carl Rogers:
  - Core therapist conditions for therapeutic efficacy include unconditional positive regard, empathy
- Daniel Stern:
  - Used infant observation to develop theories regarding development of the self
  - Emergent self, core self, subjective self, verbal self

Two types of NPD (Gabbard, 1989)

Oblivious Narcissist	Hypervigilant Narcissist
No awareness of reactions of others	Highly sensitive to reactions of others
Arrogant and aggressive	Inhibited, shy, or even self-effacing
Self-absorbed	Directs attention more toward others than toward self
Needs to be the center of attention	Shuns being the center of attention
Has a “sender but no receiver”	Listens to others carefully for evidence of slights or criticisms
Apparently impervious to having feelings hurt by others	Has easily hurt feelings; is prone to feeling ashamed or humiliated

Kohut versus Kernberg on NPD

Kohut	Kernberg
Bases theory on relatively well-functioning people whose self-esteem is vulnerable to slights – all outpatients. (cf. 'hypervigilant narcissist')	Bases theory on a mixture of inpatients and outpatients, most of whom are primitive, aggressive, and arrogant, with haughty grandiosity (cf. 'oblivious narcissist')
Focus on empathizing with patient's feelings	More confrontational For example, focuses on envy and how it prevents the patient from acknowledging and receiving help
Aggression/anger is conceptualized as secondary to narcissistic injury, understandable reaction to empathic failures	Emphasizes aggression and envy Helps patient to see his or her own contributions to problems in relationships
Accepts idealization as normal developmental need	Interprets idealization as a defense against split-off feelings of contempt, envy and rage

MCQ 12

According to the Self Psychology model, the growth process by which patients are able to internalize the needed selfobject functions and to acquire the missing self-structure is called:

A. Introjective identification

B. Twinship transference

C. Transmuting internalisation

D. Concordant development

E. Selective abstraction

MCQ 12

According to the Self Psychology model, the growth process by which patients are able to internalize the needed selfobject functions and to acquire the missing self-structure is called:

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B. Twinship transference

C. Transmuting internalisation ✓

D. Concordant development

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MCQ 13

The following is characteristic of Kohut's approach to narcissistic personality dynamics:

A. Idealisation is understood as a normal developmental need

B. Aggression/anger is conceptualised as constitutional

C. Superego anxiety is hypothesised to be the underlying central anxiety

D. The patient's empathic failures are observed and explored in the middle phase of therapy

E. The patient's envy is confronted

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MCQ 14

Which of the following is a selfobject transference as described by Kohut?

A. Narcissistic transference

B. Alternative ego transference

C. Devaluing transference

D. Transmuting transference

E. Mirror transference

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Attachment Theory Main Themes

- Attachment is a biologically based bond designed to ensure safety and survival
- The child is seeking survival through relationships
- Attachment bonds influence the individual's style of interaction, allowing for an understanding of the trajectory of the patient's development

Attachment Theory Main Themes (cont'd)

- Pattern of attachment is informed by the parent's ability to mentalize and also influences the individual's ability to mentalize in the future
- Parents in reality are often not in tune with children's feelings and needs. What is important is how parents and children repair the relationship after ruptures
- The need for proximity to an attachment figure at times of stress, illness and exhaustion continues lifelong

Attachment Theory: Key Figures

- John Bowlby: concept of secure base, internal working models
- Mary Ainsworth: Strange Situation
- Mary Main: Adult Attachment Interview
- Margaret Mahler: Separation/Individuation

Internal Working Models

(Bowlby, 1969)

- Set of core beliefs and emotions held at conscious and unconscious levels about self, others, world

- Secure:
  - I am good, wanted, worthwhile, lovable
  - Others are appropriately responsive to my needs, sensitive, caring, trustworthy
  - The world is safe, welcoming

- Insecure:
  - I am bad, unwanted, worthless, helpless, unlovable
  - Others are unresponsive to my needs, insensitive, hurtful, untrustworthy
  - The world is unsafe, scary

John Bowlby

- Concept of ‘secure base’, from which the individual can explore the various unhappy and painful aspects of life, past and present
- Stages of response to separation (A Two Year Old Goes to Hospital, 1952)
  - Protest
  - Despair
  - Detachment

Ainsworth's Strange Situation

- Observation of child's response when parent leaves and when parent returns
- 4 types of attachment:
  - Secure: misses parent, seeks the caregiver out upon return, then returns to play
  - Insecure - Avoidant: decreased anxiety during separation, does not acknowledge the caregiver on return
  - Insecure – Ambivalent/Resistant: distress at separation, anger and clinging on return of the caregiver, slow to settle
  - Disorganized/Disoriented (added later): no strategy to cope with separation, may see contradictory approach/withdrawal behaviours (running towards, stopping short, running back), stereotypical behaviours, fear responses, dissociative responses (e.g. freezing)

K&S p. 98 -99, 1092

Mary Main

- Adult Attachment Interview (AAI): Adults describe childhood experiences, how they experience their parents, in particular memories of concrete situations in which parents responded to their distress
- Responses reflect Attachment Representation
- AAI Classifications:
  - Secure/autonomous
  - Dismissing
  - Preoccupied
  - Unresolved or disorganised

Attachment Pairings

- 70% correspondence between parent attachment representation and child's attachment classification (Brisch, 2002)
- Concept of transgenerational transmission

Parent (Main & Goldwyn, 1984)	**Child** (Ainsworth 1978; Main 1986)
Secure/autonomous	Secure
Dismissing	Avoidant
Preoccupied	Anxious/ambivalent
Unresolved	Disorganised

Margaret Mahler

Developmental model: Stages of Separation-Individuation

1. Normal autism: 0-2 months (later discarded)
2. Symbiosis (2-5 months): complete merging
3. Differentiation (5-10 months): awareness of otherness
4. Practicing (10-18 months): increased exploration of the outer world
5. Rapprochement (18-24 months): need for independence alternates with need for closeness. Child moves away then comes back to mother for reassurance
6. Object Constancy (2-5 years): child comprehends and is reassured by the permanence of mother even when not in her presence

K&S p. 1093

Attachment in the Therapy Setting

- The patient's internal working model and attachment style will influence the therapeutic relationship
- Separations in the therapy activate attachment patterns in the transference (vacations, weekends, end of the hour)
- Dynamics of Mahler's separation/individuation stages can play out in the transference
- Individuals can gain more secure attachment representations from later experiences with an important attachment figure or through psychotherapy (Main, 1995)

MCQ 15

The following is NOT an attachment style described in Ainsworth's Strange Situation

A. Secure

B. Ambivalent

C. Dismissing

D. Avoidant

MCQ 15

The following is NOT an attachment style described in Ainsworth's Strange Situation

A. Secure

B. Ambivalent

C. Dismissing ✓

D. Avoidant

MCQ 16

A toddler out for a walk with his dad runs over to a field to pick a flower, then anxiously looks back to make sure his dad is still watching. This is a manifestation of the following developmental stage described by Margaret Mahler:

A. Symbiosis

B. Differentiation

C. Practicing

D. Rapprochement

E. Object constancy

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MCQ 17

A patient relates a memory of being at the playground and falling off the swing when she was about 4 years old. She recalls calling for her mother and searching for her, and then seeing her several feet away texting on her cell phone, unaware of the fall.

Which Attachment Representation will your patient likely describe during an Adult Attachment Interview?

A. Secure/autonomous

B. Preoccupied

C. Unresolved

D. Dismissing

E. Ambivalent

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MCQ 18

A patient relates a memory of being at the playground and falling off the swing when she was about 4 years old. She recalls calling for her mother and searching for her, and seeing her several feet away texting on her cell phone, unaware of the fall.

What attachment style are you most likely to encounter in your patient?

A. Secure

B. Insecure - avoidant

C. Insecure - ambivalent

D. Disorganised

E. Dismissing

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B. Insecure - avoidant ✓

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Carl Jung – Key Concepts

- Collective unconscious: universal, common to mankind, contains the archetypes
- Archetypes: representational images and configurations with universal symbolic meanings (e.g. mother, father, child, hero)
- Personal unconscious: unique to each individual
- Complex: feeling-toned ideas that develop as a result of personal experience
- Animus: woman's undeveloped masculinity
- Anima: man's undeveloped femininity
- Introverts vs. extraverts
- Persona: the face a person presents to the outside world
- Shadow: real person concealed by the persona
- Goals of individuation and fulfilling creative potentialities

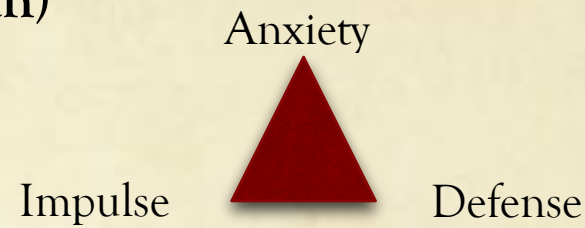
Short-term Psychodynamic Psychotherapy (STPP)

- In research, typically defined as <40 sessions
- Shared characteristics among STPP models:
  - Importance of quickly established therapeutic alliance
  - Identification of a circumscribed central issue
  - Active use of transference
  - Repetitive links between parental and transference issues
  - Early termination

K&S, p. 856 plus supplementary handout

STPP types

- **Brief Focal Psychotherapy (Tavistock-Malan)**
  - Clear cut selection and rejection criteria
  - Use of 'triangle of conflict'



- **Time-Limited Psychotherapy (Boston University - Mann)**
  - Strict adherence to 12 sessions
- **Short-term Dynamic Psychotherapy (McGill -Davanloo)**
  - Predominantly oedipal focus
  - Focus on flexibility, e.g. no specific end-date
- **Short-term Anxiety-Provoking Psychotherapy (Harvard - Sifneos)**
  - Oedipal focus
  - Use of anxiety-provoking questions and confrontations

See supplementary handout for details

Behaviour Therapy

Learning Theory (1)

- Classical Conditioning (Pavlov): A previously neutral stimulus is paired with a biologically or psychologically potent stimulus - aka respondent conditioning
  - Terminology
    - Unconditional stimulus (US): food
    - Conditional stimulus (CS): bell
    - Unconditional response (UR): natural response (salivation)
    - Conditional response (CR): New response to neutral stimulus
  - Response is controlled by the antecedent stimulus
  - Clinical examples: phobias, panic disorder, PTSD, obsessions

Learning Theory (2)

Operant Conditioning (Skinner): A behaviour is linked with a psychologically significant event – aka instrumental conditioning

- Types
  - Positive reinforcement (behaviour is followed by a pleasurable stimulus)
    - Shaping (approximations to the desired behaviour are reinforced)
  - Negative reinforcement (behaviour is followed by removal of a aversive stimulus)
  - Positive punishment (behaviour is followed by an aversive stimulus)
  - Negative punishment (behaviour is followed by removal of a pleasurable stimulus)
  - Extinction (a previously reinforced behaviour is no longer reinforced)
- Response is controlled by the consequence
- Clinical examples: disulfiram (positive punishment); naltrexone (extinction – decreases positive reinforcement); acamprosate (decreases negative reinforcement)

Extinction

The phenomenon of extinction can occur through both classical and operant conditioning

- Classical conditioning:
  - If the conditioned stimulus (bell) is presented repeatedly without the unconditioned stimulus (food), the conditioned response decreases (controlled by the antecedent stimulus)
- Operant conditioning:
  - The reinforcement of the behaviour is eliminated, e.g. pushing the lever no longer results in food pellets (controlled by the consequence)

Schedules of Reinforcement

- Continuous reinforcement: every action is reinforced
- Fixed ratio schedule: every x^{th} action is reinforced
- Variable ratio schedule: reinforcement after a variable number of actions – **most potent (e.g. gambling)**
- Fixed interval schedule: reinforcement after a given amount of time
- Variable interval schedule: reinforcement after varying amounts of time
- Interval schedules tend to generate slower responses than ratio schedules

Behaviour Therapies

- Behavioural interventions based on classical conditioning:
  - Systematic desensitisation (Wolpe)
    - Based on the principle of counterconditioning: anxiety-provoking situation (CS) is paired with relaxed state (US/UR)
    - Reciprocal inhibition: Anxiety is inhibited by the relaxed state
    - Three stages: relaxation training, hierarchy construction, desensitisation
  - Bell and pad for enuresis
- Behavioural interventions based on operant conditioning:
  - Contingency management
  - Token economy (NB: the token itself is a conditioned reinforcer, as it has no intrinsic value) – used in the tx of SCZ (in the 60's and 70's)
  - Time out (negative punishment)
  - Therapies: Biofeedback, Habit Reversal Training, Aversion Therapy

Behavioural Activation in Depression

- Behavioural Model of Depression:
  - Depression is a state of extinction from positive reinforcement (e.g. following loss).
  - Lack of reinforcement decreases frequency of potentially positive behaviours → vicious cycle/metaphor of deconditioning (e.g. muscles)
  - Withdrawal and avoidance help short-term but contribute to perpetuating low mood, low self-esteem
- Goal in BA: Increase positive reinforcement
- Techniques
  - Dispel myth that changes in mood need to occur before changes in behaviour
  - Monitor daily activities, set goals, assessment of pleasure and mastery, graded task assignments
  - May include sleep hygiene, regular exercise, nutrition

MCQ 19

A first-grader ate far too much candy on Halloween and vomited during math class the next day. He now says he can't do math anymore because it makes him feel sick to his stomach. This is an example of:

A. Negative reinforcement

B. Classical conditioning

C. Positive punishment

D. Extinction

MCQ 19

A first-grader ate far too much candy on Halloween and vomited during math class the next day. He now says he can't do math anymore because it makes him feel sick to his stomach. This is an example of:

A. Negative reinforcement

B. Classical conditioning ✓

C. Positive punishment

D. Extinction

MCQ 20

A patient in an anxiety group you are leading describes that - as before every group - she had to check she had locked the door 7 times to settle her anxiety enough to be able to make it to the group. Her checking behaviour is an example of:

A. Negative reinforcement

B. Classical conditioning

C. Positive punishment

D. Extinction

MCQ 20

A patient in an anxiety group you are leading describes that - as before every group - she had to check that she had locked the door 7 times to settle her anxiety enough to be able to make it to the group. Her checking behaviour is an example of:

A. Negative reinforcement ✓

B. Classical conditioning

C. Positive punishment

D. Extinction

Cognitive Behaviour Therapy (CBT)

Piaget' Stages of Cognitive Development

Stage	Characteristics	Developmental Achievement	Possible Manifestations
Sensorimotor (0-2 years)	• Learning through sensory observation • Gaining control of motor functions • 6 substages (KS p.94)	• Object permanence (object has independent existence) • Symbolic thought (incl. use of words)	• Play peek-a-boo • Attainment of object perm. marks transition to next stage
Pre-operational Thought (2-7years)	• Thinking is symbolic but illogical • No sense of cause and effect • Can name but not classify objects • Egocentricity • Immanent justice (punishment inevitable) • Phenomenalistic causality (co-occurrence means causality) • Animistic thinking	• Semiotic function (something can stand for something else, e.g drawing represents the real world)	• Believe they are responsible for events such as divorce or death

Piaget' Stages of Cognitive Development

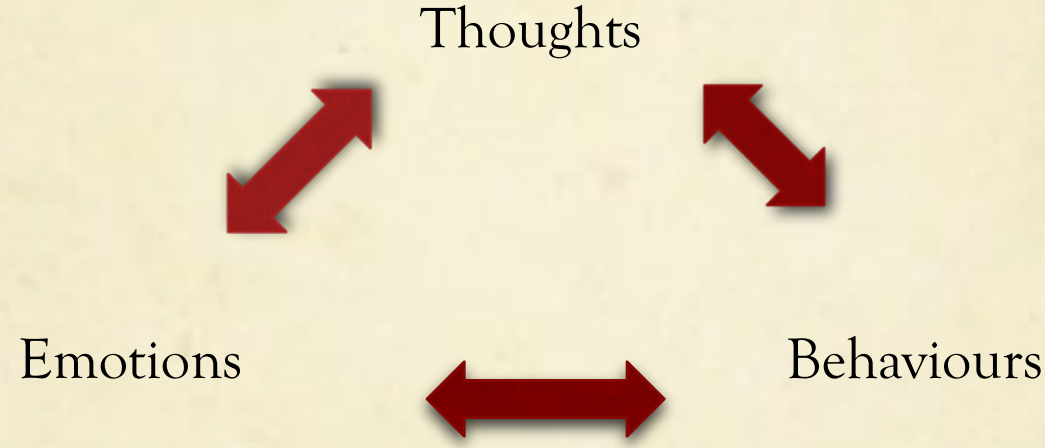
Stage	Characteristics	Achievements	Possible Implications
Concrete Operations (7-11 years)	• Can classify, organise, order • Can see others' perspectives • Syllogistic reasoning (conclusion formed from 2 premises) • Inductive reasoning: from particular to general) • Develop moral sense, follow rules	• Conservation (object the same despite change in shape – plasticine balls, water in different glasses) • Reversibility (one thing can turn into another in back – water to ice)	• Obsessive-compulsive behaviours if overly invested in rules
Formal Operations (11 to end of adolescence)	• Thinking is logical and systematic • Abstract, conceptual thinking	• Hypothetic-deductive reasoning (make a hypothesis and test it against reality – general to particular)	• Thinking about the future and its possibilities

CBT – Characteristics

- Brief and time limited: typically 5-20 sessions
- Structured and directive
- Based on the here and now
- Between session exercises (homework) are an integral part of CBT
- Emphasis on collaborative relationship (collaborative empiricism).
  "You are the expert on your particular problem. My role is to facilitate better understanding of your problem and to work with you to find skills and strategies to manage it. The ultimate goal is for you to become your own therapist".

CBT – Theoretical Underpinnings

- Aaron Beck is often referred to as the 'father' of CBT
- There is a strong relationship between the way we think (our thoughts), the way we feel (our emotions) and what we do (our behaviours)



- Some models also include a physiological domain (eg Barlow 2004, 2006)
- Thoughts and behaviours are more amenable to active change than emotions and are the focus of intervention in CBT.

CBT – Key Concepts

Three levels of cognition (Beck JS, 1995):

- Core beliefs: deep cognitive structures that contain ideas regarded by the person as absolute truths
  - 'I am basically good, capable and worthy' (adaptive)
  - 'I am incompetent' (maladaptive)
- Intermediate beliefs: attitudes, rules and assumptions (often unarticulated) for processing information from the environment
  - 'Even if I try, I won't succeed' (maladaptive)
  - 'No matter what happens, I will manage somehow' (adaptive)
- Automatic thoughts: cognitions that occur rapidly in response to a situation that can be based on erroneous logic

Common Automatic Thoughts
JAMMED SLOP

- Jumping to conclusions
- All or nothing thinking
- Magnifying/Minimising
- Mental filter (tunnel vision)
- Emotional reasoning
- Discounting the positive
- Shoulds
- Labeling
- Overgeneralization
- Personalisation

Other cognitive distortions (KS p. 355, 875):

- Selective Abstraction: focus on negative aspects, ignoring others (cf. mental filtering)
- Arbitrary Inference: drawing a conclusion without sufficient evidence (cf. jumping)

Cognitive Bias in Depression and Anxiety

- Beck's 'cognitive triad' of depression: negative views of the self, world and the future
- Anxiety: automatic thoughts and schemas associated with danger, overestimation of risk, uncontrollability, incapacity to cope
- 'Anxiety formula':

$$\frac{\text{Perceived probability of event} \times \text{Perceived severity of event}}{\text{Perceived ability to cope}}$$

Core Themes of Anxiety

Disorder	Focus of Fear
Panic Disorder	Intolerance of physical feelings/fear of death
Agoraphobia	Intolerance of being unable to escape
Social Anxiety	Fear of negative evaluation
Specific Phobia	Fear of specific objects or situations
GAD	Intolerance of uncertainty
OCD	Fear of harm (to others or self)
PTSD	Fear of re-experiencing

CBT – Cognitive Techniques

- Identifying and modifying automatic thoughts (ATs)
  - Use of Socratic dialogue to evaluate AT (e.g. What is the evidence? Is there an alternative? What would you tell a friend?)
  - Thought Change Records (TCR) - modeled in session and practiced at home
- Identifying and modifying intermediate and core beliefs
  - More difficult to change than ATs, as they are beliefs that are more deeply embedded
  - Identification and evaluation: e.g. through Socratic questioning and downward arrow techniques
  - Techniques for modification (Beck 1995, 2011):
    - Change rules/attitudes to assumption form (ideas, not truths)
    - List advantages and disadvantages
    - Cognitive continuum, extreme contrasts
    - Restructuring early experiences, developing metaphors

CBT – Behavioural Techniques

- Behavioural experiments
  - Establish hierarchy of difficult situations (with SUDS)
  - Graded exposure (in vivo most effective)
  - Practice in session and at home
- Behavioural Activation to reverse helplessness, anhedonia, avoidance in depression
- Other behavioural interventions:
  - Flooding/Implosion: exposure to the feared stimulus without graded hierarchy – has been used in specific phobias, OCD (KS p. 425, 879)
  - Assertiveness training

Cognitive Behavioural Relapse Prevention Therapy in SUD

- Identify triggers (external e.g. pay day; internal e.g. feeling states)
- Identify maladaptive thoughts and beliefs that support substance use (permissive thoughts, positive beliefs about substance use)
- Avoid high risk situations
- Cope with cravings (drug refusal skills, decision delay)
- Identify easily attainable goals to build confidence
- Practice (homework)

CBT applications

- CBT methods have been developed for several conditions, including:
  - Depression
    - CANMAT Depression Guidelines: First-line for acute and maintenance treatment of MDD
  - Bipolar disorder (adjunctive)
    - Second-line for maintenance and for bipolar depression (CANMAT)
  - Anxiety disorders, PTSD, OCD
    - Strong empirical research base - see 2014 Canadian Anxiety Guidelines
  - Psychotic disorders (2017 Canadian SCZ Guidelines)
    - Level A recommendation - strong initial emphasis on therapeutic alliance; useful for medication adherence and to target distress a/w psychotic sx; challenge the evidence for the belief, not the belief itself
  - Eating disorders
  - Substance abuse
  - Personality disorders

- CBT for kids – parent involvement encouraged; use of visual tools - puppets, cartoon bubble; externalise the problem; increased emphasis on behavioural approaches; 'small-medium-large' instead of SUDS

CBT for Anxiety Disorders

- Components include psychoeducation, cognitive strategies, exposure, safety response inhibition, arousal management (relaxation strategies), surrender of safety signals
- Good evidence for both group and individual CBT for most anxiety and related disorders
- Bibliotherapy/self-help books, internet/computer-based programs have also demonstrated significant improvements in anxiety symptoms
- Psychotherapy and pharmacotherapy demonstrate about equivalent efficacy for the treatment of most anxiety and related disorders (CBT favoured over medication in a meta-analysis for panic disorder)
- Current evidence does not support routine combination of psychotherapy and pharmacotherapy – if limited response to one, a trial of the other is recommended
- Benefits often maintained long-term after ending CBT treatment

Canadian Anxiety Guidelines, 2014

Characteristics of CBT for Specific Anxiety Disorders

- In general, exposure is most effective if predictable (planned and structured), grouped close together, prolonged, in vivo, provided in multiple different settings, and with some degree of therapist involvement
- Panic Disorder: **interoceptive** exposure - exposure to physical sensations
- Specific Phobia
  - Applied tension (muscle tension exercises) to prevent fainting for B-I-I
  - Virtual reality exposure for flying, heights, spiders, claustrophobia
- Social Anxiety Disorder: consider including assertiveness training
- GAD:
  - Individuals may worry about worrying (meta-worry) or may have positive beliefs about worry (metacognitions: thoughts about initial thoughts)
  - Progressive Muscle Relaxation techniques may be used
  - Imaginal exposure

Canadian Anxiety Guidelines, 2014

CBT for OCD and PTSD

- OCD
  - Emphasis on exposure: Exposure and Response Prevention (ERP)
  - Emphasis on cognitive elements: Danger Ideation Reduction Therapy (DIRT)
  - Assess for possible family accommodations (family taking part in rituals or avoidance – a/w poorer response to treatment)

- PTSD
  - Evidence does not support the widespread use of early intervention or debriefing
  - Use of both imaginal and in vivo exposure; appear to be equally effective
  - Specific protocols:
    - EMDR
    - Trauma-focused CBT
    - Prolonged Exposure (PE) – e.g. 30-60 minutes
    - Cognitive Processing Therapy (CPT) – includes cognitive therapy and written accounts
    - Stress-management therapy

Canadian Anxiety Guidelines, 2014

Trauma-focused CBT

Mnemonic **PRACTICE** for the 9 components used in TF-CBT for the treatment of PTSD in children and adolescents (Cohen, Mannarino & Deblinger, 2009) – 10-16 treatment sessions:

- **P²** Psychoeducation/Parenting Skills
- **R** elaxation
- **A** ffective Expression and Modulation
- **C** ognitive Coping and Processing
- **T** rauma Narrative
- **I** n Vivo Exposure and Mastery of Trauma
- **C** onjoint Child-Parent Sessions
- **E** nhancing Future Safety

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MCQ 21

Cognitive restructuring would be least likely to be used in the treatment of which of the following?

A. Generalised Anxiety Disorder

B. Panic Disorder

C. Obsessive-Compulsive Disorder

D. Specific Phobia

E. Posttraumatic Stress Disorder

MCQ 21

Cognitive restructuring would be least likely to be used in the treatment of which of the following?

A. Generalised Anxiety Disorder

B. Panic Disorder

C. Obsessive-Compulsive Disorder

D. Specific Phobia ✓

E. Posttraumatic Stress Disorder

MCQ 22

Which of the following mechanisms is the most likely implicated when a patient reports improvement after having practiced an Exposure and Response Prevention task consistently over the past week?

A. Shaping

B. Dissociation

C. Repression

D. Implosion

E. Extinction

MCQ 22

Which of the following mechanisms is the most likely implicated when a patient reports improvement after having practiced an Exposure and Response Prevention task consistently over the past week?

A. Shaping

B. Dissociation

C. Repression

D. Implosion

E. Extinction ✓

Interpersonal Psychotherapy (IPT)

IPT - characteristics

- Developed by Weissman and Klerman
- Premise: There is a strong relationship between social/interpersonal interactions and symptoms
- Short-term, 10-20 sessions
- Four areas of focus:
  - Grief and loss
  - Role transition
  - Interpersonal disputes
  - Interpersonal sensitivity

    (NB: Interpersonal sensitivity has been de-emphasised as an area of focus – conceptualised more as a complicating personality or attachment factor in the context of one of the other problem areas)
- Goal: reduce or eliminate psychiatric symptoms by improving the quality of the patient's current interpersonal relations and social functioning

IPT – Key Concepts

- IPT draws from multiple theoretical underpinnings[1]:
  - Attachment theory
  - Interpersonal theory (H.S. Sullivan) /Communication theory
  - Social theory

- A sufficiently intense interpersonal crisis in the context of insufficient social support leads to interpersonal problems and psychiatric symptoms because attachment needs are unmet and the patient is unable to communicate the need effectively

1. Stuart & Robertson 2003, 2013. Later versions include cultural/spiritual factors and de-emphasise social theory

Interpersonal Psychotherapy (IPT) Formulation

Stuart S, Robertson M (2003). Interpersonal Psychotherapy. A Clinician's Guide. London, UK: Hodder Arnold

Example...

There is a marked family history of depressive disorders, indicating a likely genetic predisposition. Her shy temperament and avoidant attachment style increased her propensity toward relative social isolation, with strong reliance on her partner to meet her attachment needs.

The breakdown of her marriage has amplified her social isolation and precipitated a major depressive episode.

Initial Phase of IPT

- Initial Phase (1-5 sessions)
  - Give formal diagnosis
  - Provide psychoeducation
  - Assign 'sick role' (gives patient permission to recover and responsibility to recover)
  - Interpersonal inventory
  - Illness timeline (identify interpersonal precipitants of episodes of psychiatric symptoms)
  - Identify area of focus

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Intermediate and Termination Phases

- Intermediate Phase (6-15)
  - Implement strategies specific to the identified problem area
  - Encourage and review work on goals
  - Link symptoms and interpersonal events during the week
  - Identify and manage negative or painful affects
  - Link symptoms to interpersonal problem area
- Termination Phase (16-20)
  - Discuss termination explicitly (potential time of grieving)
  - Review progress, consolidate gains
  - Goals and plans for remaining work
  - Identify early warning signs of recurrence

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IPT – Techniques

- IPT focuses on interpersonal relationships as point of intervention. Aims can include:
  - Improve interpersonal relationships
  - Change expectations about interpersonal relationships
  - Improve social support networks
- Techniques used include:
  - Clarification (to facilitate understanding of the patient)
  - Encouragement of affect
  - Communication analysis
  - Role playing
  - Problem solving
  - Awareness of the transference is used and managed without use of the technique of interpretation

IPT Strategies for specific areas

Problem Area	Strategies	Goal
Grief and loss	• Explore relationship with deceased • Explore negative and positive feelings	• Help patient through mourning process • Re-establish interest in new relationships
Role transitions	• Examine **positive and negative** aspects of old and new roles • Explore feelings about what is lost • Explore social support system and develop new skills	• Deal with loss of old role • Affirm aspects of new role • Develop self-esteem and mastery
Interpersonal disputes	• Appraise relationship expectations • Encourage expression of affect • Communication analysis, role playing • Problem solving (decision analysis)	• Move toward resolution or dissolution • Improve communication
Interpersonal sensitivity	• Discuss negative and positive feelings regarding the therapist • Examine parallel interpersonal relations in patient's life	• Enhance quality of interpersonal relationships • Encourage formation of new relationships

IPT Applications

- MDD
  - CANMAT Depression Guidelines: First-line for acute treatment and second-line for maintenance treatment of MDD
- Adjunctive treatment in bipolar disorder (IPSRT: interpersonal and social rhythm therapy – includes regulation of social and sleep rhythms, 24 individual sessions over 9 months)
  - CANMAT Bipolar Guidelines: Third-line for acute depression and maintenance
- Bulimia
- Has also been studied in Dysthymia, Social Anxiety Disorder, (less extensive evidence)
- Has been extended to adolescent, geriatric, postpartum, HIV populations (for depression)
- IPT-A: fifth problem area (single parent family); telephone contact, school/family involvement, limited sick role assignment (encourage to maintain normal social roles)

Comparative Studies

- NIMH Treatment of Depression Collaborative Research Program (Elkin et al, 1989)
- Compared IPT/CBT/imipramine + CM/placebo+CM in MDD
- 16 weeks
- For less severe depression: IPT=CBT=imipramine
- For severe depression with functional impairment:
  - Strong evidence for IMI + CM, some evidence for IPT
  - IMI>>IPT>CBT
- In later meta-analyses:
  - IPT=CBT (Tolin 2010; Braun 2013)
  - Comparable efficacy for CBT and medication (DeRubeis 2005; Weitz 2015)
- **"Since the time course of improvement is typically faster, pharmacotherapy may still be preferred as the initial treatment in severe and high-risk cases"** (CANMAT Depression guidelines, 2016)

MCQ 23

Which of the following is not a commonly used technique in IPT?

A. Assignment of the sick role

B. Assertiveness training

C. Relationship appraisal

D. Role Playing

E. Communication analysis

MCQ 23

Which of the following is not a commonly used technique in IPT?

A. Assignment of the sick role

B. Assertiveness training ✓

C. Relationship appraisal

D. Role Playing

E. Communication analysis

MCQ 24

Which of the following is the least likely to be an area of focus in IPT?

A. Interpersonal dispute

B. Role transition

C. Alternative rebellion

D. Interpersonal sensitivity

E. Grief and Loss

MCQ 24

Which of the following is the least likely to be an area of focus in IPT?

A. Interpersonal dispute

B. Role transition

C. Alternative rebellion ✓

D. Interpersonal sensitivity

E. Grief and Loss

Dialectical Behaviour Therapy (DBT)

DBT: Characteristics

- Developed by Marsha Linehan as a variant of CBT
- Originally designed for the treatment of BPD
- Long-term treatment, typically at least one year
- Intensive treatment that includes
  - Weekly individual session
  - Weekly group therapy (2 ½) hours
  - Phone coaching with therapist
  - Consultation team

DBT – Key Concepts

- Biosocial model: Sensitive individual (with biological predisposition toward emotional sensitivity and impulsivity) transacts with an invalidating (despite most often doing the best they can) and ineffective environment.
- Behaviours are used to regulate emotion and manage tension, e.g. tension between fears of abandonment and fears of intimacy (fear of getting hurt if too close and fear of abandonment if too distant).
- Dialectics: Need to balance opposing forces, e.g. acceptance of current situation and need for change

DBT - Techniques (1)

- Group: 4 DBT skill modules:
  - Mindfulness
  - Interpersonal effectiveness
  - Distress tolerance
  - Emotion regulation
- Individual:
  - Discussion of diary cards
  - Behavioural chain analysis
  - Treatment target hierarchy: 1. Suicidal and self-injurious behaviours. 2. Treatment interfering behaviours 3. Quality of life interfering behaviours 4. Increase skilled behaviour

DBT - Techniques (2)

- **WISE MIND**: Finding the middle path between Reasonable Mind and Emotion Mind
- **Radical Acceptance**: stop fighting reality and accept in your mind, heart and body (even if you don't like it)
- **TIP** skills for distress tolerance:
  - **T** emperature (use cold water/ice)
  - **I** ntense exercise
  - **P** aced breathing
  - **P** aired Muscle relaxation

DBT - Applications

- Extensively studied for Borderline Personality Disorder
- Studies of adaptations of standard DBT and of DBT skills training alone (without individual treatment) have shown effectiveness in[1]:
  - Bulimia Nervosa, Binge Eating Disorder
  - PTSD (including PTSD due to childhood sexual abuse)
  - Substance Use Disorders
  - ADHD, ODD
  - Depression in MDD, bipolar disorder
- Anxiety Guidelines (2014): Precursor to PTSD treatment - reduced self-harm allowing over half of patients to become suitable candidates for PTSD treatment

1. Linehan (2015), DBT Skills Training Manual, 2nd edition

Psychotherapy treatments for BPD

- **DBT** – has the most research support
- **Schema-focused therapy (SF)**
  - Integrative cognitive therapy
  - 4 central schema modes specific to BPD: detached protector, punitive parent, abandoned/abused child, angry/impulsive child
- **Mentalisation-based Treatment (MBT)** – Bateman & Fonagy
  - Psychodynamically based
  - Focuses on developing patients' understanding of the feelings they evoke in others and the feelings evoked in them by others
- **Transference-focused Psychotherapy (TFP)** – Yeomans, Clarkin & Kernberg
  - Psychodynamically based
  - Primary focus is on the dominant, affect laden themes that emerge between the patient and the therapist

Comparative Studies

- DBT, SFT, TFP, MBT all associated with reduction in overall severity of BPD when compared to TAU (treatment as usual) or CTBE (community treatment by experts) – medium effect (meta-analysis by Oud et al, 2018)

- TFP (twice weekly)/DBT (individual, group, telephone)/supportive treatment (once weekly) for 1 year (Clarkin et al, 2007)
  - All treatments improved depression, anxiety, global functioning and social adjustment ($p<0.05$)
  - DBT and TFP improved suicidality ($p=0.01$)
  - TFP and SP improved anger; TFP improved irritability and verbal assault
  - No effect of medication on results

- TFP versus SFT twice weekly for 3 years (Giesen-Bloo, 2006):
  - Both treatments were associated with reductions in BPD symptoms, reductions in general psychopathological dysfunction, increases in quality of life, and changes in SFT/TFP personality concepts
  - SFT>TFP
  - SFT had lower attrition rate

MCQ 25

Which of the following is NOT a module in the group therapy component of DBT?

A. Community Reinforcement

B. Distress Tolerance

C. Interpersonal Effectiveness

D. Mindfulness

E. Emotion Regulation

MCQ 25

Which of the following is NOT a module in the group therapy component of DBT?

A. Community Reinforcement ✓

B. Distress Tolerance

C. Interpersonal Effectiveness

D. Mindfulness

E. Emotion Regulation

Group Therapy

Group therapy - Characteristics

- Uses forces within the group, constructive interactions between members and interventions of a trained facilitator to change maladaptive thoughts, feelings, behaviours. The group functions as a microcosm.
- Modalities: psychoeducational, supportive, behavioural, CBT, IPT, DBT, psychoanalytic/psychodynamic, transactional (emphasis on the here and now interactions among group members)…
- Typically 8-10 participants, once weekly, 1-2 hours
- Can be closed (set number and composition of members) or open (may impact cohesion if high turnover)
- Can be heteregeneious (maximises interaction) or homogeneous (may enhance cohesion)
- Few contraindications
  - Patients with ASPD do poorly (may respond better in a homogeneous group for ASPD)
  - Patients who pose a physical threat should be excluded
- Possible exclusion criteria: severely depressed; actively suicidal, manic or psychotic - may benefit once stabilised on medication

Group Therapy – Therapeutic Factors (1)

- **Universality**: members recognize that others share similar thoughts, feelings, problems (“ I’m not alone”)
- **Altruism**: members gain a boost to self concept through extending help to other group members
- **Instillation of hope:** Member recognizes that other members’ success can be helpful and they develop optimism for their own improvement
- **Imparting information:** Education or advice provided by the therapist or group members
- **Corrective recapitulation of primary family experience:** Opportunity to reenact critical family dynamics with group members in a corrective manner
- **Development of socializing techniques**: The group provides members with an environment that fosters adaptive and effective communication
- **Imitative behaviour**: Members expand their personal knowledge and skills through the observation of Group members’ self-exploration, working through and personal development

Yalom &Lescz (2005. In: AGPA guidelines, 2007

Group Therapy – Therapeutic Factors (2)

- **Cohesiveness**: Feelings of trust, belonging and togetherness experienced by the group members **- believed to be the most important factor related to positive therapeutic effects**
- **Existential factors:** Members accept responsibility for life decisions
- **Catharsis**: Members release of strong feelings about past or present experiences
- **Interpersonal learning- input:** Members gain personal insight about their interpersonal impact through feedback provided from other members (group as microcosm – interpersonal patterns will eventually be displayed in the group)
- **Interpersonal learning- output:** Members provide an environment that allows members to interact in a more adaptive manner
- **Self-understanding:** Members gain insight into psychological motivation underlying behaviour and emotional reactions

Yalom & Lescz, 2005. In: AGPA guidelines, 2007

Other factors cited in the literature

- **Abreaction**: Painful, repressed material is brought back into consciousness. It is recalled and relived, accompanied by the appropriate emotional response, resulting in insight
- **Consensual validation**: by comparing own conceptualisations with those of other members, interpersonal distortions are corrected, reality is confirmed (Harry Stack Sullivan)
- **Contagion**: expression of emotion by one member stimulates the awareness of a similar emotion in another member

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Group Cohesiveness

- Comprised of multiple alliances (member-to-member, member-to-group, and member-to-leader)
- Often regarded as the equivalent of the concept of therapeutic alliance in individual therapy
- Positively correlated with self-disclosure, member-to-member feedback and member-perceived support/caring (Braaten, 1990)
- Cohesion can be enhanced by principles such as (Burlingame, 2002):
  - Effective pre-group preparation
  - Establishing clarity regarding group processes,
  - Balancing intrapersonal (individual) and intragroup (amongst group members) considerations
  - Modeling and guiding effective interpersonal feedback
  - Managing one's own emotional presence
  - Facilitating emotional expression

Group Process (1)

- Bion (1961): Two levels of group functioning:
  - **Work Group**: concerned with accomplishing the primary task of the group
  - **Basic Assumption (BA) group**: reflects tacit undercurrents
    - Dependency: group behaves passively as thought the leader is omnipotent and omniscient
    - Fight-flight: group behaves as if it must fight or run away from someone/something to preserve itself
    - Pairing: Two in the group interact to create the work, the others wait in eager anticipation
- Both levels are always present, but one predominates. If the basic assumptions group is overly activated (e.g. in the context of anxiety resonating among group members), this can interfere with task accomplishment of the work group
- Exploration, interpretation or confrontation of BA dynamics by the leader allows insight and shift of the group more task-oriented behaviours

Group Process (2)

5-stage model of group development proposed by AGPA (2007):

1. **"Forming[1]"/Preaffiliation**: anxiety, ambivalence and uncertainty about the group; high dependency on the group leader
2. **"Storming[1]"/Power and Control**: characterised by conflict, struggles over authority and status
3. **"Norming[1]"/Intimacy**: consensus on the group task and working process; leadership functions become shared by group members
4. **"Performing[1]"/Differentiation**: mature and productive group process, expression of individual differences, open exchange of feedback
5. **"Adjourning[1]"/Termination**: painful affects related to separation, oscillations between conflict and mature work, members' appreciation for each other and the group experience

Terminology coined by Tuckman, 1965

Group Stage and Therapist Task

Stage	Task
Forming	• Educate members about group purpose, norms and roles • Invite trust • Highlight commonalities
Storming	• Promote a safe and successful resolution of conflict • Encourage group cohesion • Facilitate interpersonal learning
Norming	• Promote the working process • Balance between support and confrontation (model and guide feedback)
Performing	• Let the group to 'run itself' • Highlight the individuality of group members
Adjourning/Termination	• Encourage expression of feelings associated with saying goodbye • Facilitate attention to unfinished business

Group therapy – Empirical Research Base

- Meta-analysis of 111 group therapy studies across a wide range of diagnoses, theoretical orientations and settings (Burlingame, 2003):
  - Group Therapy vs. wait list control: ES 0.58
  - Pre- to Post-treatment: ES 0.71
- Group vs. individual therapy for MDD (CANMAT Depression guidelines 2016)
  - Efficacy evidence may slightly favour individual over group therapy
  - Higher dropout rates for group therapy
  - Factors of availability, cost and patient preference are important considerations
- Group versus individual therapy for anxiety (Anxiety guidelines 2014)
  - CBT can be effectively delivered in both individual and group format
  - SAD: some studies favour individual; no significant difference in meta-analyses
  - GAD: Individual and group equally effective, individual a/w earlier improvement
  - OCD: Conflicting results - no difference or favouring individual

MCQ 26

Which of the following is NOT a stage of group development in the model outlined by the American Group Psychotherapy Association?

A. Performing

B. Forming

C. Norming

D. Informing

E. Storming

MCQ 26

Which of the following is NOT a stage of group development in the model outlined by the American Group Psychotherapy Association?

A. Performing

B. Forming

C. Norming

D. Informing ✓

E. Storming

MCQ 27

The sense of working together toward a common goal in a group is referred to as:

A. Universality

B. Cohesiveness

C. Development of socialising techniques

D. Imitative behaviour

E. Corrective recapitulation

MCQ 27

The sense of working together toward a common goal in a group is referred to as:

A. Universality

B. Cohesiveness ✓

C. Development of socialising techniques

D. Imitative behaviour

E. Corrective recapitulation

Family Therapy

K&S, 11th edition, 2015; Wedding & Corsini, 2019

Family Therapy - Characteristics

- Focus on altering the interactions between or among family members and seeking to improve the relational functioning of the family unit, as well as the functioning of individual members
- Broad range of indications - presence of a relational difficulty is key
- Possible contraindications:
  - Key members unavailable or refuse to attend
  - Family member with destructive motives/behaviour, violence or abuse, severe paranoid ideation
- Sessions typically once a week, may require 2 hours

Family Therapy – Key Concepts

- Systemically sensitive therapy
  - Individual issues occur within the relational context of the family
  - Clinical problems involve salient interactional components
  - The 'identified patient' (family member considered to be the problem in the family) is viewed as a symptom bearer, expressing the family's disequilibrium or current dysfunction
- Families typically enter therapy with anxiety, e.g. due to covertly feeling to blame
  - Need to feel that they did the best they could

Types of Family Therapy

- Psychodynamic
- Systemic
- Strategic
- Structural
- Cognitive-Behavioural

Psychodynamic-Experiential Model

(Virginia Satir)

- Emphasis on revealing unconscious patterns in family relationships,

  Which parent does your child remind you of? How might this influence your parenting?

- Focus on subjective experience
- Uncovering of unconscious anxieties, projections, internal object relations rooted in the past
- Uncovering of unexpressed feelings
- Use of therapist's subjective responses
- Use of metaphor, body language, parapraxes
- Use of family sculpting
- Goal: insight into and resolution of family of origin conflicts and losses

Family Systems Model
(Bowen)

- Emphasis on differentiation from the family of origin
  - Ability of the individual to be their true selves in the face of familial pressures
- Two levels of assessment
  - Degree of family enmeshment vs. degree of ability to differentiate
  - Exploration of emotional triangles
    - Two members relating closely through love or repetitive conflict exclude a third. When shifts occur, emotional cross-currents are activated.
    - Therapist role: stabilise or shift the 'hot' triangle producing the presenting symptoms; work with most available family member(s) to achieve sufficient differentiation so that hot triangle does not recur
- Therapist minimises emotional contact with family members to preserve neutrality in the family triangles
- Use of genogram

Structural Model
(Minuchin)

- Families are viewed as single, interrelated systems with subsystems
- Focus is on the structural properties of the family
- Metaphor: building inspector who looks at the stability of a structure and guides renovation
- Exploration of hierarchies, boundaries, alliances & splits among family members, family tolerance for one another
- Exploration of family adaptability
- Uses concurrent individual and family therapy
- Goal: reorganise family structure and increase adaptability to changing internal and external requirements

General Systems Model

- Overlaps with Bowen and structural models
- Based on cybernetics (regulatory systems maintain an equilibrium through feedback loops) and general systems theory
- Families are systems with external boundaries and internal rules
- Every action in a family produces a reaction in one or more of its members
- When a crisis or disruption occurs, family members try to maintain family homeostasis by activating family-learned mechanisms to decrease stress and restore internal balance
- Every member is presumed to play a role (e.g. spokesperson, persecutor, victim, rescuer, nurturer, symptom bearer, scapegoat,)
- Roles are stable - which family member fills each role may change

Strategic Model (Haley)

- Symptoms are maintained by the family's unsuccessful problem solving attempts
- Unworkable 'solutions' to problems become problems themselves
- Goal: design novel strategies for eliminating the undesired behaviour
- Task setting is an important component
- Use of **paradoxical interventions** (therapeutic double bind): therapist directs the family to continue to manifest their presenting symptoms – highlights voluntary control over the symptom
- Use of **reframing/positive connotation:** relabeling of negatively expressed feelings or behaviour by putting it into a more positive perspective, emphasizing good intention
- Systemic family therapy (Selvini-Palazzolo in Milan)
  - Variation of strategic family therapy
  - Use of **circular questioning** to examine belief systems (metaphor of British mystery: therapist questions all suspects, then gathers them all to tell them how the crime took place)

Family Group Therapy

- Multiple family groups
- Families meet and share problems, compare interaction
- Used in the treatment of SCZ

Social Network Therapy

- Social community or network of a patient meets in group sessions with the patient
- Used in the treatment of substance use disorders

Criteria for Termination

- Family members can complete transaction, check, ask
- They can interpret hostility
- They see how others see them
- They can see how they see themselves
- One member can tell others how they manifest themselves
- One member can tell others what is hoped, feared, and expected from them
- They can disagree
- They can make choices
- They can learn through practice
- They can free themselves from the harmful effects of past models
- They can give clear messages – be congruent in their behaviour – with a minimum of difference between feelings and communication, and with a minimum of hidden messages

K&S p. 865 (from Satir, 1967)

Assessment of Family Functioning

- Family Adaptability and Cohesion Evaluation Scale - Most recent version: FACES IV (Olson & Gorall, 2006)
- Based on the Circumplex Model: Three key concepts for understanding family functioning
  - Cohesion: emotional bonding family members have toward one another
  - Flexibility: quality and expression of leadership and organisation, role relationships, and relationships rules and negotiations
  - Communication: positive communication skills utilised in the couple or family system (viewed as a facilitating dimension that helps families alter their levels of cohesion and flexibility)
- Main hypothesis: Balanced levels of cohesion and flexibility are most conducive to healthy family functioning, while unbalanced levels are associated with problematic family functioning (curvilinear hypothesis)

FACES IV Categories

Flexibility categories:

Rigid – somewhat flexible – flexible – very flexible - chaotic

Cohesion categories:

Disengaged – somewhat connected – connected – very connected – enmeshed

Six family types, from most healthy/happy to most problematic:

- Balanced
- Rigidly cohesive
- Midrange
- Flexibly unbalanced
- Chaotically disengaged
- Unbalanced

Couples Therapy

- Designed to modify the interaction of two persons who are in conflict
- Marital counseling: task-oriented to solve a specific problem
- Marital therapy: emphasises restructuring a couple's interaction, exploring underlying psychodynamics
- <u>Goals:</u>
  - Alleviate the disturbance, change maladaptive patterns, improve individual and relational functioning, enable each partner to see the other realistically
  - NB: Need to define appropriate and realistic goals – may involve problem-solving, reconstruction of the relationship or resolution of the relationship

K&S, 11th ed, 2015

Indications and Contraindications

Indications

- Individual therapy has failed to resolve the relationship difficulties
- Onset of distress in one or both partners is clearly a relational problem
- Therapy requested by a couple in conflict
- Conflicts in several areas (e.g. sexual life)
- Difficulties in establishing satisfactory social, economic, parental or emotional roles
- **Problems in communication between partners are a prime indication**

Contraindications

- Expression of vulnerability is not likely to be adaptive or respected (e.g. violence), i.e not safe
- Emotional divorce – one spouse really wants divorce
- One spouse refuses to participate
- Severe psychosis
  - Severe paranoid elements
  - The marriage's homeostatic mechanism is a protection against psychosis

K&S, 11th ed, 2015

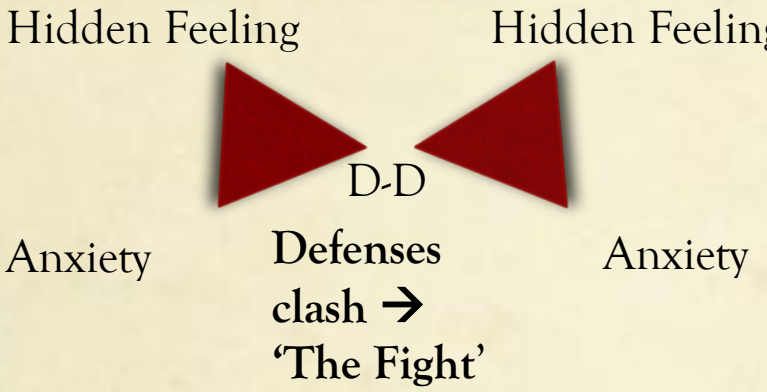
Types of Couples Therapy

- Individual therapy – partners seen individually
- Individual marital therapy:
  - Each partner in therapy
  - Concurrent: same therapist
  - Collaborative: different therapists
- Conjoint therapy
  - Partners seen together
  - One or two therapists
- Four-way session
  - Separate individual therapists with regular joint sessions with all four
- Group: 2-4 couples
- Combined

K&S, 11th ed, p. 866

Couples Therapy Orientations

- Object Relations Couples Therapy (Donovan, 2003)
  - Uses' triangles of conflict'



- Emotion-focused Couples Therapy (Greenberg & Johnson)
  - Uses emotion and attachment theory
  - Relationships are attachment bonds
  - Emotion is the target and agent of change
  - Therapist is 'process consultant'
  - Also an orientation used for family therapy (EFFT)

Family Therapy Applications

- Adjunctive treatment in bipolar disorder (Bipolar Guidelines, 2018)
  - Family-focused Therapy (FFT)
    - Focuses on communication styles
    - Second-line for acute depression and for maintenance (level 2) – typically 21 sessions over 9 months
- Adjunctive treatment in Schizophrenia (Schizophrenia Guidelines, 2017)
  - "Family intervention should be offered to all individuals diagnosed with schizophrenia"
  - Communication skills, problem solving, psychoeducation, addressing issues related to crisis management and relapse prevention
  - Single-family intervention or multi-family intervention
- Anorexia Nervosa in children and youth: Level I recommendation; Level II for BN (APA Eating Disorder guidelines)
- Alcohol use disorder: Marital and family therapy (APA Level I); family therapy for opioid use disorder is Level III recommendation

CANMAT Bipolar Guidelines (2018)

TABLE 10 Strength of evidence and recommendations for adjunctive psychological treatments for bipolar disorder[a]

	Maintenance: Recommendation (Level of Evidence)	Depression: Recommendation (Level of Evidence)
Psychoeducation (PE)	First-line (Level 2)	Insufficient evidence
Cognitive behavioural therapy (CBT)	Second-line (Level 2)	Second-line (Level 2)
Family-focused therapy (FFT)	Second-line (Level 2)	Second-line (Level 2)
Interpersonal and social rhythm therapy (IPSRT)	Third-line (Level 2)	Third-line (Level 2)
Peer support	Third-line (Level 2)	Insufficient evidence
Cognitive and functional remediation	Insufficient evidence	Insufficient evidence
Dialectical behavioural therapy (DBT)	Insufficient evidence	Insufficient evidence
Family/caregiver interventions	Insufficient evidence	Insufficient evidence
Mindfulness-based cognitive therapy (MBCT)	Insufficient evidence	Insufficient evidence
Online interventions	Insufficient evidence	Insufficient evidence

[a]See text for specific definitions of type of therapy and number of sessions needed ("dose of psychosocial intervention") corresponding to this recommendation and evidence.

MCQ 28

In contrast to individual psychodynamic therapy, the following would not be a technique used in a psychodynamic model of family therapy:

A. Use of metaphor

B. Uncovering of unconscious patterns

C. Exploration of projection

D. Focus on subjective experience

E. Encouragement of free association

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MCQ 29

The following is not a key figure associated with a model of family therapy:

A. Bowen (family systems)

B. Haley (strategic)

C. Minuchin (structural)

D. Malan (brief focal)

E. Satir (psychodynamic)

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The following is not a key figure associated with a model of family therapy:

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Motivational Interviewing (MI)

aka

Motivational Enhancement Therapy (MET)

MI - Characteristics

- Developed by Miller & Rollnick
- Originally designed for working with people who are less ready to change
- Stages of Change Model (Prochaska & DiClemente, 1983; Prochaska, DiClemente & Norcross, 1992)
  - **Precontemplation**
  - **Contemplation**
  - Preparation
  - Action
  - Maintenance
  - Relapse (added later by some researchers)
- Acceptance that patient is generally ambivalent about changing behaviour (avoid the 'righting reflex')
- Focus is on increasing the client's intrinsic motivation for change

MI – Key Concepts[1,2]

- **MI spirit – foundational**
- MI processes: Engaging, Focusing, Evoking, Planning
- MI Principles: DEARS or RULE (now less emphasised)
- MI Skills: OARS
- Change talk

1. Miller & Rollnick (2013). Motivational Interviewing Helping People Change. (Third Ed.)
2. Rosengren (2009, 2017). Building Motivational Interviewing Skills. A practitioner workbook

MI Spirit

- Guiding philosophy of MI
- 4 key elements:
  - Partnership/Collaboration
    - Recognising clients' expertise on themselves
  - Acceptance
    - Includes components of absolute worth, autonomy, accurate empathy, affirmation
  - Compassion
  - Evocation
    - Drawing out ideas and solution from within clients

MI Principles

Miller & Rollnick (2002)

- **D** evelop discrepancy
- **E** xpress Empathy
- **A** void Argumentation
- **R** oll with Resistance
- **S** upport Self-efficacy

Miller & Rollnick (2008)

- **R** esist the righting reflex
- **U** nderstand your client's motivation
- **L** isten to your client
- **E** mpower your client

Now emphasised even less – more emphasis on MI spirit

'Resistance' is reconceptualized as 'sustain talk' (opposite of change talk) and 'discord' (disharmony in the collaborative relationship)

MI Skills

OARS

- **O** pen-ended questions
- **A** ffirming
- **R** eflecting
- **S** ummarising

Recognising and Eliciting Change Talk

- Unique to MI
- Evoking specific kinds of speech from clients and reinforcing it when it occurs
- Client makes the argument for change
- Examples of recognising change talk:
  - *"I wish things were different."*
  - *"I know what I have to do – I just need to do it."*
- Examples of eliciting change talk
  - *"If you decided to make a change, how would you like things to be different?"*

MI - Applications

- ES 0.25 to 0.57 in meta-analyses (Burke & Menchola, 2003)
- Has been used in conjunction with CBT, IPT or medications to improve treatment engagement or adherence
- Some evidence that pre-treatment MI as an adjunct to CBT may be helpful in GAD and OCD (Anxiety Guidelines 2014)
- Third-line recommendation for MDD (CANMAT Depression Guidelines 2016)
- Level I recommendation for alcohol use disorder

MCQ 30

The following would be a predominant strategy used in Motivational Interviewing for a patient presenting in the contemplative stage:

A. Application of ice

B. Affirmation

C. Identification of automatic thoughts

D. Reframing

E. Clarification

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MCQ 31

The following is an example of change talk:

A. "I'll have to look out for my friend at the party, just like I used to do with my little brother."

B. "My friend looked away when I said I was going to the party – she must think I'll be a bore."

C. "If people at the party don't laugh at my jokes, I'm a failure."

D. "I told my friend I didn't want to go the party if there was going to be a lot of drinking."

MCQ 31

The following is an example of change talk:

A. "I'll have to look out for my friend at the party, just like I used to do with my little brother."

B. "My friend looked away when I said I was going to the party – she must think I'll be a bore."

C. "If people at the party don't laugh at my jokes, I'm a failure."

D. "I told my friend I didn't want to go the party if there was going to be a lot of drinking." ✓

Mindfulness-based Interventions (MBIs)

MBI – Key concepts

- Rooted in the Vipassana Eastern meditation tradition
- Mindfulness is the purposeful awareness of the present moment in a way that is nonjudgmental and accepting of one's internal and external experience (Hayes 2011; Baer et al 2006; Kabat-Zinn 1994)
- Equanimity: Mind state of balance, calmness and composure in which we feel neither an aversion to unpleasant experiences nor craving for pleasant ones[1]
- Impermanence: the changing nature of all things including our own mental and emotional experiences[1]

1. Cayoun, B. (2015). MiCBT for Well-being and Personal Growth

Mindfulness-Based Interventions

- Meditation practice a component of all MBIs, e.g. mindfulness of breath, body scanning, sitting meditations, walking meditations
- Mindfulness-based Stress Reduction (MBSR) – Kabat –Zinn
  - 8-week group program
  - Includes meditation practice, yoga, group discussions
- Mindfulness-Based Cognitive Therapy (MBCT) – Segal, Williams, Teasdale
  - 8-week group program
  - Integrates meditative practice and cognitive techniques
  - Concept of 'decentering': identifying and disengaging from maladaptive cognitive processes such as self-criticism and rumination
- DBT and Acceptance & Commitment Therapy (ACT) include mindfulness components

MBI - Applications

- MBSR has been applied in both clinical and non-clinical populations
- MBIs have been studied in a wide range of problem areas including anxiety disorders, mood disorders, substance use disorders, chronic pain, ADHD, insomnia, fibromyalgia, cancer, heart disease and stroke
- 2010 meta-analysis showed effect sizes of 0.63 for anxiety symptoms and 0.59 for mood symptoms (Hofmann, 2010)
- MBCT first-line for maintenance and second-line for acute treatment of MDD (CANMAT Depression Guidelines, 2016)
- Anxiety Guidelines (2014):
  - Early results suggest benefit for adjunctive MBCT in panic disorder
  - Adjunctive MBCT and acceptance-based behaviour therapy have demonstrated efficacy in GAD
  - Mindfulness training and ACT may be useful in OCD
  - Mindfulness-based therapy (MBT) a/w improvements in SAD

MCQ 32

Disengaging from negative thoughts that are reactivated with the occurrence of dysphoric moods is called:

A. Reframing

B. Decentering

C. Countering

D. Reappraising

E. Accepting

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E. Accepting

Table 5. Recommendations for Psychological Treatments for Acute and Maintenance Treatment of Major Depressive Disorder.

	Acute Treatment	Maintenance Treatment (Relapse Prevention)
Cognitive-behavioural therapy (CBT)	First line (Level 1)	First line (Level 1)
Interpersonal therapy (IPT)	First line (Level 1)	Second line (Level 2)
Behavioural activation (BA)	First line (Level 1)	Second line (Level 2)
Mindfulness-based cognitive therapy (MBCT)	Second line (Level 2)	First line (Level 1)
Cognitive-behavioural analysis system of psychotherapy (CBASP)	Second line (Level 2)	Second line (Level 2)
Problem-solving therapy (PST)	Second line (Level 2)	Insufficient evidence
Short-term psychodynamic psychotherapy (STPP)	Second line (Level 2)	Insufficient evidence
Telephone-delivered CBT and IPT	Second line (Level 2)	Insufficient evidence
Internet- and computer-assisted therapy	Second line (Level 2)	Insufficient evidence
Long-term psychodynamic psychotherapy (PDT)	Third line (Level 3)	Third line (Level 3)
Acceptance and commitment therapy (ACT)	Third line (Level 3)	Insufficient evidence
Videoconferenced psychotherapy	Third line (Level 3)	Insufficient evidence
Motivational interviewing (MI)	Third line (Level 4)	Insufficient evidence

Crisis Intervention

Crisis Intervention - Definitions

- Definition of crisis: an individual perceives a change event as insurmountable and pre-existing coping responses fail to contain a catastrophic reaction[1]

- Two categories of stressors that contribute to onset[2]:
  - Situational crises, e.g. role and status change, rape, physical illness
  - Lifecycle stressors, e.g. parenthood, retirement

- Four groups of stressors[2]:
  - Loss
  - Change
  - Interpersonal conflict
  - Decisional conflict

1. From: 'Approaches to Postgraduate Education in Psychiatry in Canada', 2009

Crisis Intervention - Characteristics

- Delivery of specific integrated skills in a defined context within a supportive relationship
- Primary goal:
  - Reduce acute distress
  - Facilitate more adaptive coping skills
  - Return patient to a normal level of functioning
- Six-stage process[2] :
  - Explicit transferring of responsibility
  - Organise takeover of tasks
  - Remove patient from stressful environment
  - Lower arousal and distress
  - Reinforce appropriate communication
  - Show concern, warmth and encourage hope

2. Lindemann E, Crisis Intervention. In: Bloch. An Introduction to the psychotherapies, 2006

Meta-analysis of CI Studies

(Roberts, 2006)

- Types of crisis intervention:
  - Family preservation (in-home intensive family crisis intervention) – 8 -72h over 3 months
  - Multisession crisis intervention (4-12 sessions)
  - Multicomponent critical incident stress management (CISM) – group crisis intervention - minimum of 3 sessions, including
    - Pre-crisis training (stress inoculation)
    - Individual or group crisis intervention after the traumatic event
    - Postevent crisis counseling one month later
  - Single –session individual or group crisis debriefing (20 minutes to 2 hours)
- Family preservation studies showed largest ESs
- CISM better than single session debriefing (Richards, 2001)

Crisis Intervention Six-step model

1. Defining the problem
   - Using active listening, empathy, genuineness, acceptance
2. Ensuring Client Safety
3. Providing Support
4. Examining Alternatives
   - Situational supports
   - Coping mechanisms
   - Positive and constructive thinking patterns
5. Making Plans
6. Obtaining commitment

James, R. (2008). Crisis Intervention Strategies – 6th edition Belmont, CA: Thomson.

Brief Interventions

- Studied mostly in connection with AUD, but has also been found to be effective with cannabis, opioid and nicotine use disorders
- Typically 1-3 sessions
- **A-FRAMES** model
  - **Assessment**
  - Providing objective **Feedback**
  - Emphasising that **Responsibility** for change belongs to the patient
  - Giving **Advice** about the benefits of change
  - Providing a **Menu** of options
  - **Empathic** Listening
  - Emphasising and encouraging **Self-efficacy**

APA SUD Guidelines 2006

Resources for Additional Learning

- Review courses: Ottawa, London, Toronto
- McMaster Psychotherapy Training e-Resources (PTeR)
- Sadock BJ, Sadock VA and Ruiz P (2015). **Kaplan & Sadock's Synopsis of Psychiatry, 11th edition**. Philadelphia: Wolters Kluwer
- American Psychiatric Association (2013) **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition**. Arlington, VA: American Psychiatric Association
- Recommended Reading List (will be posted on Entrada)

Clinical Practice Guidelines

- Katzman et al. (2014). **Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.** BMC Psychiatry. 14(Suppl 1): S1
- Yatham et al. (2018). **CANMAT and ISBD 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disorders.** 20: 97-170.
- Parikh SV, Quilty LC, Ravitz P et al. (2016). **CANMAT 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 2. Psychological Treatments**. Can J Psychiatry. 61(9): 524-539
- Norman R, Lecomte F, Addington D & Anderson A (2017). **Canadian Treatment Guidelines on Psychosocial Treatment of Schizophrenia in Adults.** Can J Psychiatry. 62(9): 617-623
- **American Group Psychotherapy Association (AGPA) Practice Guidelines for Group Psychotherapy (2007)**. Available at: https://www.agpa.org/home/practice-resources/practice-guidelines-for-group-psychotherapy
- **APA clinical practice guidelines**. Available at: https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines

Next steps...

ALL THE BEST FOR EXAMS!!!