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LIGHTNING REVIEW OF THE PSYCHO- THERAPIES

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Introduction to Lightning Review of the Psychotherapies

Welcome to the Lightning Review® of the Psychotherapies. In this manuscript I present synopses of several psychotherapies and psychological concepts that show up on Psychiatry board exams.

Organization

Each Review follows a semi-standard format. The following sections are included:

- Synonyms for the Psychotherapy
- Introduction
- Indications
- Contraindications
- Therapy Subtypes
- Key Concepts
- Interventions (the individual treatment activities that comprise the course of therapy)

Psychodynamic Therapy

Synonyms

Insight-Oriented Therapy, Expressive Therapy, Psychoanalytically based Psychotherapy

Introduction

Psychodynamic Therapy encompasses a wide range of techniques and theoretical orientation. The three main schools of thought are: 1. Ego Psychology 2. Object Relations Theory 3. Self Psychology

Indications

- Depressive Disorders
- Anxiety Disorders
- PTSD
- Eating Disorders
- Personality Disorders
- Relationship and intimacy problems
- Lack of life direction and effectiveness

Interventions

Some therapist techniques are common to all psychodynamically oriented therapists as well as to eclectic or client-centered therapists. These fundamental interventions are:

- Clarification

- Challenging
- Interpretation

Ego Psychology

Introduction

- Ego Psychology is based on Sigmund Freud's classical views of the structures of mind. The Topographic Model introduced the concept of the conscious and the unconscious. The Structural Model introduced the concepts of ego, superego, and id. The Structural Model retained the concepts of conscious and unconscious processes and proposed that the ego, superego, and id each had conscious and unconscious components.
- Note that some authors list four schools, separating Freudian Psychology with its focus on drives from its direct descendant, Ego Psychology, with its focus on ego functions and psychological defenses. Here discussion of the two schools is combined since Ego Psychology is often viewed as an elaboration of Freudian Psychology.

Key Concepts

- The unconscious. Each individual is believed to have a reservoir of wishes, desires, instincts, drives and impulses – drives for short – that are not fully open to conscious awareness because they are unacceptable or incompatible with the individual's self-concept. In order to maintain ego integrity, the individual represses these unacceptable drives.
- The unacceptable drives are often believed to be sexual or aggressive in nature.
- The unconscious is believed to be in the causal chain, meaning that these unconscious drives exert influence over the individual's conscious thoughts, feelings, and behaviors.
- Repression refers to the self-censoring from conscious experience that occurs to these unacceptable drives. A further wrinkle is that the self-censoring is itself unconscious. The consequence is that the individual not only has aspects of himself that remain unconscious but also has a repressive mechanism that remains unconscious: "You don't know AND also you don't know that you don't know."

- **Symptom Formation.** Psychiatric symptoms are thought to arise from conflict among the repressed drives, and between them and the individual's conscious self-concept. This unconscious mental tension is transformed into (or expressed as) psychiatric symptoms, especially as anxiety.
- **Given this view of the problem, the solution** is to release these hidden aspects of self into consciousness, where they can be assessed, verbally described, and the emotions associated with them felt. The difficulty is that the unconscious content is difficult to access directly.
- **Access to the Unconscious.** Because of the lack of conscious awareness of these unacceptable drives, indirect approaches are needed. They include:
 - Free Association
 - Analysis of parapraxis: "Slips of the tongue"
 - Dream Analysis
- **Defense Mechanisms.** The essence of Freud's Structural Theory is that aggressive and sexual impulses originating in the id are controlled and directed by the ego that negotiates between the needs of the id and that of external reality. The ego constructs defenses that are meant to minimize pain and to lead to socially acceptable and effective functioning. Although defenses are meant to protect the individual they themselves sometimes lead to psychopathology. Anna Freud focused on further defining and elaborating these psychological defenses. (See Defense Mechanisms below.)
- **Resistance.** In order to maintain the status quo, the ego maneuvers to maintain its repressive function. Thus, in therapy a patient may experience blocking or a defocusing onto unimportant topics.
- **Theoretical Shift:** with the elaboration of defense mechanisms, Ego Psychology shifted from a primary focus on drives to a primary focus onto the defensive actions themselves. This new focus had greater explanatory power for character pathology. Different personality disorders display different styles of defenses.

Interventions

- **Ventilation.** The expression of needs, desires, disappointments, drives, impulses, and especially of experiences that lead to shame or guilt.
- **Understanding.** Recognizing how early experiences have shaped the person they have become. The approach of triangulation is used, in which the client is encouraged to see the relationship between past experiences, current experiences outside the therapy and experiences that occur in therapy.
- **Search for the Meaning of Experiences.** The therapist encourages the patient to assess not only the stressor but also how they interpreted it and how the stressor affected them. The question to ask and ponder is "What were the possibly myriad meanings of that experience for me?"
- **Coming to Terms.** Freud viewed depression as resulting from the discrepancy between reality and the imagined ideal. Accepting the inevitability of failure to attain the ideal can lead to greater peace and decreased depression.
- **Analyzing Defenses.** The client is encouraged to see how it is not so much the experience as it is their reaction to it or their defense against it that leads to the depressive or anxiety symptoms.

Object Relations

Introduction

- **Object Relations** is easier to understand when you substitute "internalized view of 1) aspects of oneself and 2) of important others" for the term "object." Therefore, Object Relations is the study of the relationships an individual has with his internalized representations of important aspects of themselves and of people in his life. For instance, when I interact with you, my behaviors are affected by my internal view of you and by my imagined relationship with you. For instance, I may imagine you as a parental figure and can feel disappointed or even enraged when you don't meet my expectations.
- Often my internal representations are not accurate reflections of your true nature but are colored by my own needs and expectations.
- To complicate things further, as mentioned, object relations extend to the representations

I have of myself, which are multiple and often conflicting. Each of my self-representations can have their own expectations of my relationship with you or, with different aspects of you.

Key Concepts

- **Conflict.** In Object Relations Theory the conflict is thought to arise from the clashing between internal self-representations, object representations of others, and my emotional needs. When the representations are particularly distorted or incomplete, or incompatible to each other, maladaptive emotional and behavioral patterns arise.
- **Defense Mechanisms.** Based on the view of the conflicts between object representations, the following additional Defense Mechanisms are postulated by Object Relations Theory.
 - Splitting
 - Projective Identification
 - Introjection
 - Denial
- **Analysis of the Transference.** Analysis of Transference refers to a therapist intervention in which the therapist interprets the patient's here-and-now use of defenses, clarifies the nature of the patient's interaction with the therapist, and hypothesizes the sources and meanings of the defenses and behaviors.

Interventions

- Therapists who subscribe to Object Relations Theory often use Analysis of Transference techniques. They interpret the patient's use of the defenses listed above in the here-and-now of the therapy session.
- Although effective in many cases to help the patient bring to awareness interpersonal interactional patterns, they can be anxiety-provoking. Imagine how would you react if, when talking to someone, you would have your distortions, denials, and maladaptive interactional patterns continually pointed out to you?
- Many therapists use Analysis of Transference techniques more sparingly and combine them with techniques that grew out of Self-Psychology (described next).

Self Psychology

Introduction

Self Psychology is based on Franz Kohut's writings and focuses on assessing and meeting the patient's relationship needs. It posits deficits in parenting that leave the individual vulnerable to depression, fragile self-esteem, and often recurrently unsatisfying relationships.

Key Concepts

- **Two Types of Transference o Mirroring**
Transference is the client looking for a validating, "gleam in the mother's eye" response from the therapist. Clients who develop a mirroring transference experienced empathic failure from their parents and remain hypersensitive to responses lacking in validation. They may react with rage or withdrawal when confronted with one. Some may brag or perform for the therapist to gain their approval. o **Idealizing Transference**
is the client longing to idealize the therapist in hopes of having a perfect, dependable, and powerful figure comfort and protect them.
- **Double Axis Theory.** Kohut believed that narcissistic needs for validation and protection persist throughout adult life and are not pathological in nature only in degree. The Double Axis theory states that an individual can both have mature, loving relationships while at the same time maintaining relationships with others (self objects) in order to meet their unmet narcissistic needs.

Interventions

- **Corrective Emotional Experience.** Self-psychologists view their treatment as a re-parenting of the client, providing them with the care, attention, and acknowledgement that they did not receive in their childhoods.
- **Optimal Frustration.** The therapist attempts to meet the client's unmet emotional needs. However, since the therapist is not in reality the idealized parent nor does she try to be, the client is inevitably disappointed. The gradual, progressive process of disappointment can lead the client to develop a more realistic view of the therapist and, by extension, others in his life.

- Interpretation. Although self-psychologists make interpretations of the meanings of the patient's behaviors and draw attention to their use of defenses, on the whole they are more cautious and gentle than other therapists. Their interpretations increase gradually in directness and in their power to evoke anxiety or rage. These therapists make interpretations in the context of guiding the patient through this process of optimal frustration.

Treatment Goals:

- Internalization. The aim is for the patient to grow towards being more able to meet his narcissistic needs internally, as if they could then carry a loving, concerned parent inside of them – an internalized self-object. Internalization leads to greater emotional self-sufficiency and stability and to more mature, giving, and loving relationships.

Brief Psychodynamic Therapy

Introduction

- Practitioners of Brief Psychodynamic Therapy may use techniques from each of the Psychodynamic schools. What they have in common is a belief that unlike the minimum 2 years that a patient in long-term Psychodynamic Therapy needs to effect meaningful life changes, change in Brief Psychodynamic Therapy can occur more rapidly.

Key Concepts

- Change does not require the constant involvement of a therapist. A therapist can engage the patient more briefly by helping the patient define the problem and provide a plan for change, and then begin the initial work of change that continues after the therapy ends.
- A central concept of Brief Psychodynamic Therapy is that it should focus on a single main treatment issue rather than, as in the traditional psychoanalytic approach, permitting the patient to free associate and discuss several unrelated issues.
- The main focus of therapy is developed and agreed upon during the initial evaluation process occurring over the first one or two sessions. The patient's core conflict becomes

the main focus and provides structure and a clear goal for the therapy.

- The therapist is active in maintaining a focus on the therapy's main issue.

Interventions

- Interventions are similar to those of traditional forms of Psychodynamic Therapy. They include an interpretation of defenses, which is considered the key intervention. Some therapists maintain a prominent focus on an Analysis of Transference, which is an analysis of the defenses used by the patient in the here-and-now of the therapy session.

Psychological Defense Mechanisms

Mature Defenses

- Humor: appropriate use of humor to reframe viewpoint and decrease catastrophizing
- Sublimation: impulses directed to socially useful projects
- Altruism: vicarious gratification
- Suppression: conscious deferment of painful or unacceptable impulses, emotions, desires, drives or instincts.

Neurotic Defenses

- Isolation: splitting off of unacceptable affects from the thought that accompanies it, e.g., speaking of traumatic events with a neutral affect.
- Displacement: an affect shifted from one object (person) to another, e.g., kicking the dog when you're mad at the boss.
- Reaction formation: transforming an unacceptable impulse into its opposite, e.g., showering a person you hate with kindness.
- Denial: an unconscious repression of unacceptable impulses, emotions, desires, drives or instincts

Immature Defenses

- Regression: a return to earlier modes of acting or feeling, e.g., becoming very needy and helpless when under stress
- Somatization: transforming unacknowledged needs (e.g., dependence) into physical symptoms as a way to have needs met without acknowledging them.

- Acting Out: avoiding unacceptable affects or impulses by engaging in a flurry of diversionary activity.
- Blocking: a temporary stopping of thoughts or feelings as a protection against them.

Narcissistic Defenses

- Projection: shifting unacceptable impulses into outside persons, institutions, etc., e.g., projecting rage at others and feeling threatened by the projected affect.
- Projective Identification: Unacceptable feelings or impulses are projected unto another person who is then “made” to feel that they are his own, e.g., a patient treats the psychiatrist as incompetent. The psychiatrist accordingly begins to feel and act incompetently.
- Splitting (Primitive idealization and denigration): an inability to see people or situations in shades of gray. People or situations are seen as all good or all bad.
- Distortion: reality is distorted to meet the person’s emotional needs.

Mentalization Therapy

What is Mentalization?

- Anthony Bateman & Peter Fonagy, the developers of Mentalization Therapy, define mentalization as “the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons).”
- What this means is that we have the capacity for understanding our actions as meaningful and predictable. We understand that the way we feel, think, and act is motivated by those internal mental states that Bateman & Fonagy mention, such as our desires, feelings, beliefs and reasons.
- We are further able to extend our understanding of our own mind to that of other people. We are aware that others have minds that work in ways similar to ours, that their behaviors are equally meaningful from their point of view. In addition, we are aware that the other person has a similar understanding of our mind.

- Mentalization thus implies that we have the capacity to take an other centric point of view. Recall that Piaget spoke of the child’s growing capacity for “decentration” during the latter half of the Preoperational Stage of Cognitive Development, in which the child is able to recognize other’s point of view.
- Thus, the capacity to mentalizing forms the basis of human communication and emotional-relatedness.

When and How Does Mentalization Develop?

- The mentalization capacity develops during childhood within the context of an attachment relationship. It is suggested that the borderline patient shows a reduced capacity to mentalize and that this has resulted from disruption of the attachment relationship because of adverse interaction between biological and environmental factors.

What Disorders is Mentalization Therapy Used For?

- It was developed specifically for use with patients with Borderline PD. (Mentalization Therapy is based on the “theory of mind” that is used in training children with Pervasive Developmental Disorders, who suffer from deficits in “theory of mind.”)
- Adults without Borderline pathology have the capacity to continue to mentalize while in highly emotionally charged states. The thinking goes that patient’s with BPD, lose their mentalizing capacity when emotionally charged attachment relationships are stimulated.
- This mentalization deficit leads to their misinterpreting the motives of others, difficulty in managing their emotional states, and engaging in self-destructive behavior. These self-destructive actions are seen as attempts by the individual to obtain some sense of stability and to reestablish their mentalizing capacity. Mentalization Therapy is designed to help a patient develop and maintain mentalizing even when in highly negative emotional states.
- In MT the patient is helped to gain the capacity to mentalize during highly aroused states.

MT is a form of psychodynamic therapy. It uses similar techniques and has similar focus. It focuses on:

- intrapsychic processes and conflicts
- the therapist / patient relationship in the here and now
- affective states and their triggers
- unconscious motivations
- processing traumatic experiences within the containment of the therapeutic relationship: mentalizing it: feeling it, re-experiencing it, thinking about it)

How Bateman & Fonagy Describe the Therapeutic Process

- Therapy activates an attachment system which is a pre-requisite for mentalization
- Therapists reconstruct in their own mind the mind of the patient – label feelings, explain cognitions, identify implicit beliefs
- Therapy is a shared attentional process which strengthens interpersonal function and integrative mechanisms
- Content of interventions is mentalistic, irrespective of model
- Dyadic nature of therapy fosters capacity to generate multiple perspectives

Levels of Interventions in Individual Therapy: with sample therapist statements

- **Supportive & empathic**
 - “I can see that you are feeling hurt”
- **Clarification & elaboration**
 - “I can see that you are feeling hurt, I wonder how come?”
- **Basic Mentalizing**
 - “I can see that you are feeling hurt and that must make it hard for you to come and see me/be with me today” (depending on amount affect arousal that you want to allow)
- **Interpretive Mentalizing**
 - Transference tracers: “I can see that you are feeling hurt and that reminds me of how you often react when you feel someone does not do exactly what you want them to do”
- **Mentalizing the Transference**
 - “I can see how you can end up feeling hurt

by what is happening here” (empathy), “and then you are not sure if you want to be here or not” (outcome of feeling -experience near), “In the end I think that the only way you feel you deserve my attention is if you can feel that you are the hurt victim who has a right to treatment (motivation)”

- **Non-mentalizing interpretations (use with care)**
 - Dyadic transference interpretation (Kernberg): “You need to create a relationship in which you feel the victim of someone who is cruel and hurtful to you”
 - Triadic transference (Strachey): “You felt victimized as a child and now with me and with other people you feel compelled to recreate relationships where you are the person who is hurt by those who do not care for you enough”
 - Historical (past blaming, trauma focused): “Your feeling of hurt at the moment is because you have been reminded of how you felt rejected by your mother”

Group Therapy Interventions: The Group Therapist ensures that affects are:

- Identified within the group and by the group
- Verbalized and explored in relation to others within the group
- Recognized as having influenced others in the group
- Recognized as having been induced in oneself by beliefs about others’ reactions and motivations
- Retained in the group and feelings, however intense, do not spill over from the group to other settings in the treatment

Bateman & Fonagy Principle of Therapy

- A therapeutic treatment will be effective to the extent that it is able to enhance the patient’s mentalizing capacities without generating too many iatrogenic effects.
- Iatrogenic effects are reduced if intensity is carefully titrated to patient capacities and if treatment is coherent and flexible.

Format of Therapy

- one individual therapy session a week, lasting 50 minutes
- one group session a week, lasting 1.5 hours

Cognitive-Behavioral Therapy (CBT)

Introduction

- A major aim of CBT is to reduce anxiety, depression and avoidance by analyzing and then changing the cycle of problematic behavior, cognitions, and emotion. Used both with and without medication, CBT is the most popular and commonly used psychotherapy for the treatment of depressive and anxiety disorders. There is evidence that the beneficial effects of CBT last longer than those of medication for people with panic disorder, obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD) and social phobia.
- CBT has 2 main intervention strategies as well as adjunctive techniques. I will discuss each in turn.
 1. Cognitive Restructuring
 2. Exposure Therapy
 3. Adjunctive Techniques

Cognitive Restructuring

Introduction

Cognitive Restructuring is the systematic identification of negative cognitions, assessment of their distorted and illogical nature, their challenging as illogical and the establishment of more positive and logical cognition.

Indications

- OCD
- PTSD
- Depression
- Anxiety
- Panic attacks
- Social phobias

Key Concepts

- Automatic Thoughts have three main aspects.
 - Automatic thoughts are negative, self-defeating, illogical, and distorted. (See list of Cognitive Distortions below).

- Automatic thoughts are preconscious and thus often outside of conscious awareness. Despite this they exert profound effects on mood and behavior.
- Automatic thoughts are habitual, running through well-established patterns
- Cognitions, Mood, and Behavior form reinforcing cycles. One can intervene to change cognitions, mood, or behavior. Cognitive therapists believe that changing cognitions is the most effective approach.
- Cognitive Restructuring comprises two main steps.
 - One. A systematic assessment of the distorted and illogical nature of these preconscious thoughts is undertaken. The client receives homework assignments to notate the nature of the distorted thoughts, the event in which they occurred and their emotional and behavioral consequence.
 - Two. The pattern of the automatic thoughts is changed through challenging the cognitions and replacing them with more accurate and positive alternatives.

Interventions

- Introduce the concept of Automatic Thoughts to the client.
- Teach the client to self-monitor for the occurrence of the Automatic Thoughts
- Have the client challenge the distortions through questioning their logic and through examining the evidence for their accuracy.
- Search for alternate meanings, ones that are more accurate and positive.
- Use Thought Stopping and Distraction as needed.
- Practice the above steps through the systematic application of the Triple Column Technique (example included below).

List of Cognitive Distortions

- **All-Or-Nothing Thinking:** Seeing things in categories of all-good or all-bad. Performance that is less than perfect is interpreted as a complete failure.
- **Overgeneralizing:** Generalizing a single negative event into a larger never-ending pattern of defeat.

- **Negative Mental Filter:** Dwelling on negative details to the exclusion of positive aspects, even when the positive aspects are more prominent.
- **Disqualifying The Positive:** Rejecting positive experiences by insisting they "don't count." For instance, handling an interpersonal challenge effectively and maturely but concluding that it was "just luck."
- **Jumping To Conclusions:** Interpreting events negatively even though there is little evidence to support the negative assessment.
- **Mind Reading:** Believing that others hold a negative view of you without confirming this belief or entertaining alternate explanations. For example, thinking your boss is angry with you because he didn't say "Hi." His behavior in fact may have been unrelated to you, perhaps related to preoccupation with financial problems.
- **The Fortuneteller Error:** Predicting the future in a negative way as if it were preordained to turn out badly.
- **Catastrophizing:** Exaggerating the importance of negative events until they are seen as overwhelming. This increases a person's sense of helplessness and hopelessness.
- **Emotional Reasoning:** Believing that your negative emotions reflect the state of the world. For instance, when depressed, believing that the world is "going to hell in a hand basket."
- **Essentializing:** Seeing setbacks as a reflection of your core self. Rather than thinking, "I made a mistake," you think, "I'm a loser." This distortion also occurs when assessing others. For instance, if someone forgets your name, concluding, "He's such a self-centered and shallow guy."
- **Personalizing:** Believing yourself to be the cause of external negative events, even though it is unlikely you are responsible for them. For instance, when your parents argue, concluding that it's your fault. This distortion is particularly common among people raised or living with an abusive parent or spouse or with a substance abuser.

Triple Column Technique

Situation	Feelings	Thoughts
My boss has been ignoring me. He doesn't even say "Hi" anymore.	I feel sad and worried.	Original: Maybe I'm not doing my job right. I may be fired. What would I do without a job? I really, really need this job. Nothing ever goes right.
		Alternate Thoughts and Actions: When I evaluate the situation, it seems that my boss has been ignoring everyone. He seems preoccupied. Given that he is ignoring everyone, it is unlikely that the problem is with me. If I'm still concerned, however, I will speak with him about my performance and if there are shortcomings in it, I will make the necessary changes to improve.

Exposure Therapy and Exposure Response Prevention

Introduction

- Exposure Therapy consists in exposing the patient to their feared situations, ones the patient avoids or endures with much distress. The goal is to have the patient learn that they are capable of tolerating exposure to feared situations. This makes future exposure much less anxiety-provoking and much less likely to be avoided.
- Exposure Response Prevention is a variation of Exposure Therapy designed for treating OCD

Indications

Treatment for Phobic Avoidance & Compulsions associated with:

- OCD
- PTSD
- Agoraphobia
- Social phobias
- Specific phobias

Key Concepts

- Exposure: There are 2 exposure methods, Systematic Desensitization and Flooding.
- Systematic Desensitization (also known as graded exposure) is a gradual exposure method. It takes a greater time commitment but results in lower levels of anxiety during the therapy and, thus, is more frequently chosen by patients. Systematic desensitization requires that patient and therapist develop a list of progressively more anxiety-provoking stimuli. Then, under conditions of relaxation, the patient is exposed one-by-one to the series of least to most anxiety provoking stimuli. When the patient experiences their capacity to face their feared situations without being overwhelmed by anxiety or escaping from the situation, their anxiety decreases or disappears. The patient learns that their feared situation is not all that frightening.
- Flooding is an exposure method in which the patient's initial exposure is to their most feared and most avoided situation. So rather than gradually and systematically exposing the patient while they maintain a state of relaxation,

in flooding the patient maintains an extended exposure to an extreme fear. The patient's anxiety level is often very high during the initial minutes of exposure but gradually decreases over time. As you can imagine this method is often rejected by all except the most highly motivated patient.

- Imaginal Exposure: In Systematic Desensitization, often the initial exposure is imaginal. The patient is guided to mentally imagine exposure to the feared situation. For example, the patient with a germ obsession and phobic avoidance is guided through visualizing increasingly dirty environments with which the patient imagines coming into contact.
- In Vivo Exposure is the type of exposure that usually concludes the process of Systematic Desensitization. It is usually the most anxiety producing and refers to real, not imagined, exposure in the environment.
- Interoceptive Exposure is exposure to one's own physiological stimuli, such as the beating of the heart or lightheadedness when hyperventilating. Interoceptive Exposure is necessary for patients who fear their normal physiological responses, misinterpreting them as signifying illness or impending death.
- Progressive Muscle Relaxation. As the progressive systematic exposure is occurring, the aim is for the patient to remain in a state of calm through the use of relaxation techniques. When the patient experiences a heightened sense of anxiety or tension, the exposure is suspended and the relaxed state re-established before continuing further exposure steps. A common method of establishing relaxation is through Progressive Muscle Relaxation, an approach in which in turn all the body's major muscle groups are tensed and then relaxed.
- Safety Behaviors. While undergoing exposure to feared situations, patients often resort to the use of "safety behaviors," which are behaviors that decrease the patient's anxiety. Safety behaviors include self-distraction, mental rituals, carrying charms or good luck objects or "safety" equipment such as water bottles, antibacterial creams, alarms, or hidden anxiolytics. Safety behaviors decrease the effectiveness of exposure

by weakening the initial fear the patient feels when in the feared situation. Resort to the use of safety behaviors prevents the generalization of learning to real-life exposures that occur without the 'crutch' of safety behavior. Thus, therapists seek to minimize their use by the patient.

- An offshoot of Exposure Therapy is Exposure Response Prevention (ERP) for treatment of OCD. The obsessions of OCD are highly anxiety-provoking to the patient. In response, the patient engages in compulsive rituals to neutralize the anxiety. ERP consists in 1) exposing the patient to situations that trigger their obsessions and the related anxiety while 2) preventing the patient's habitual maladaptive response, that is, their compulsion. In ERP, the exposure can be done either as systematic desensitization or as flooding. ERP is only effective to the degree that it leads to adequate exposure and to prevention of the maladaptive compulsive response.
- For instance, a patient with a germ obsession may be required to forego showering for increasing lengths of time. In this case, showering in response to the fear of germs and contamination is the maladaptive response that is prevented. Or the patient may be required to clean the toilet. In this case, running away from the task and ritualistically washing himself is the maladaptive response that is prevented.

Adjunctive CBT Techniques

Introduction

Although effective, cognitive restructuring takes discipline and hard work that is driven by the expectation of positive change. Many patients, however, have such degrees of hopelessness and helplessness, and expectations of failure, that the therapist must first take steps to gain the cooperation and active participation of the patient before the formal techniques can begin. In addition, these adjunctive techniques, when used later in the course of treatment, can help extend and maintain therapeutic gains.

Indications

To improve the efficacy of Cognitive Restructuring and Exposure Response Prevention.

Interventions

- Psycho-education about the relationship of thoughts, feelings, and behaviors.
- Relaxation and Guided Visualization exercises to decrease anxiety
- Problem-Solving Training that help patients develop formal methods to analyze problems, break them down into smaller problems, and resolve them.
- Assertive Communication Skills that permit the patient to increase her interpersonal efficacy without resorting to passive or aggressive communications or withdrawal.
- Emotional Acceptance Training teaches patients to recognize their emotions, label them accurately, accept them as part of themselves, act on them in thoughtful considered ways rather than impulsive, angry, or anxious ways, and to tolerate what are at times distressing emotions.
- Lifestyle changes, such as instituting healthy eating and exercise programs.
- Helping the patient build a sense of mastery and sensible risk taking. Failure is interpreted as a necessary part of growth and of living a full life.

Dialectical Behavioral Therapy

Introduction

- Dialectical Behavioral Therapy (DBT) is a form of Cognitive Behavioral Therapy developed by Marsha Linehan as a specific treatment for persons with Borderline Personality Disorder, a diagnostic population particularly difficult to treat due to treatment dropout, therapist burnout, and lack of treatment efficacy.

Indications

- Borderline Personality Disorder (BPD)
 - Frequent parasuicidal behaviors
 - Poor impulse control
 - Affective instability and poor emotional self-regulating skillsKey Concepts of the Biosocial Theory of BPD:
- Biosocial Theory of BPD. Marsha Linehan hypothesized that the features of BPD develop in individuals who are made vulnerable 1) by their particular biological diathesis and 2) by being raised in an invalidating social environment. Thus, the term “biosocial theory.”
- Biological Diathesis. The biological features that make an individual vulnerable to later development of BPD include an autonomic nervous system that reacts excessively to minor stressful events and takes an abnormally long time to return to baseline.
- Invalidating Social Environment. An invalidating social environment is one in which 1) the child’s communications are disqualified and not seen as valid or accurate. Linehan gives the example of a child who says, “Mommy I’m thirsty” and mother replies, “No you’re not. You just drank.” And 2) the caregivers place an inordinately high value on self-control and self-reliance. Showing any type of negative emotion, from fear to sadness to anger, is seen as a weakness and a lack of self-control. Any failure to live up to standards, often impossibly high or inconsistent standards, is seen as a lack of motivation and a personal failing.
- Emotional Dysregulation. As a result of this invalidating environment, the emotionally vulnerable individual may grow up not having the ability to accurately recognize and understand her feelings nor to judge the adequacy of her behaviors. She will tend to look to other’s responses to her to gauge the nature of her emotional state and the adequacy of her performance. At the same time she does not allow herself to look to others for help. Remember, in her family of origin that would have been a sign of weakness. Also, the invalidated child is likely to grow up with limited abilities in coping with distress, since such feelings were never acknowledged.
- Emotional Oscillation. Given the vulnerable individual’s position of needing others as a mirror to her emotional and behavioral state and the constraints in seeking other’s help, one type of behavioral outcome is an oscillation between a state of emotional inhibition and self-reliance in an attempt to gain acceptance, followed by an opposing series of dramatic emotional displays in an attempt to gain acknowledgment of her powerful feelings and unmet needs.
- The Term ‘Dialectical.’ Dialectical is a term of philosophical argument. Assertions about a particular topic, a ‘Thesis,’ are made. Then assertions supporting the opposing position, ‘Antithesis,’ are made. Finally, a ‘Synthesis’ of the thesis and antithesis is arrived at, in which the contradictions between the two positions are resolved. This synthesis then becomes the thesis of the next round of ‘thesis-antithesis-synthesis.’
- Dialectical Dilemmas. Linehan describes six behavioral patterns that persons with BPD display (behavior is understood broadly as including cognitions, emotions, autonomic responses, relationships and sense of self). She groups these six patterns by two’s into three opposing poles. Since each pattern is dysfunctional, persons with BPD cannot maintain it for long and will eventually swing to the opposing pattern, which, being equally dysfunctional also can not be long maintained. Thus, the patient continues a disruptive oscillation between dysfunctional patterns. Linehan sees the poles as being the thesis and antithesis so to speak, that DBT helps to resolve by helping the client arrive at an effective synthesis. The six patterns are listed below. (Warning: The behaviors do not appear as clear opposites when summarized.)

- Emotional Vulnerability vs. Self-Invalidation. Individuals with BPD swing between emotionally vulnerable behaviors in which they may blame others for their distress and react with rage, AND self-invalidation in which they blame themselves for not being able to meet their standards and reach their goals.
- Unrelenting Crisis vs. Inhibited Grieving. People with BPD also swing between ongoing crises related to their dysfunctional interactional style and emotional dysregulation, AND a state of inhibition in which they cut themselves off from feelings with which they cannot cope, such as guilt, shame and grief.
- Active Passivity vs. Apparent Competence. The third dialectical dilemma occurs when the person with BPD, on the one hand, tries to get others to solve her problems for her and, on the other hand, presents herself as competent to meet the expectations of the invalidating environment. Although this sounds like a positive, the patient's competence is only apparent since it is highly mood dependent and thus, unstable.
- Self-Mutilation & Parasuicidal Behaviors. Failure of the patient to resolve her dialectical dilemmas and continuing to swing between dysfunctional behavioral and emotional patterns leads the patient to engage in extreme behaviors like self-mutilation and parasuicidal behaviors. These are seen as desperate attempts at reaching some sort of resolution and relief from the unremitting distress.
- Note on Sexual Abuse. It is estimated that 50-70% of individuals with BPD have been sexually abused, which is regarded as an extreme form of invalidation. However, a history of sexual abuse is not necessary to the development of BPD. Key Concepts of DBT:
 - Main Therapeutic Dialectic of DBT. DBT tries to help the client reach a synthesis of her alternating, opposing behavioral patterns – those listed above. It's main therapeutic dialectic comprises the following two seemingly opposite goals:
 - Acceptance. DBT includes specific techniques to help the client establish a feeling of acceptance and validation. An initial focus on acceptance is key because if the client is instead immediately confronted with a need for changing her emotional and behavioral problems, she will rightly conclude that she is currently 'broken,' an implicit communication that would simply confirm the client's self-invalidation.
 - Change. While accepting the individual as she is, the DBT therapist helps the client learn more adaptive behavioral patterns by expanding the client's repertoire of skills.
- DBT Therapist Assumptions About the Client. In order to maintain the correct view and working relationship with the client the following therapist assumptions about the client are encouraged in DBT.
 - The patient wants to change and is trying her best at all times to do so even if to an outsider this is not evident.
 - The client may be in such continual anguish that her life may not be currently worth living but the goal is to try to make it so. The DBT therapist always sides with continuing life rather than to view suicide as an acceptable solution.
 - The client's behavioral pattern is understandable given her background of invalidation.
 - In spite of her doing her best, the DBT client needs to try harder and try differently. Her predicament may not be her doing, but responsibility for change is. This includes taking responsibility to maintain her safety.
 - The client cannot fail DBT. If she is not improving then the treatment is failing. The therapist must avoid viewing or responding to the patient in pejorative terms. Clients with Borderline Personality Disorder are not manipulative.
 - Manipulation suggests effective management and control over others, which the client with BPD clearly has not achieved. Rather the client is interacting with others in the best way she knows how.

- **Therapist Communication Style.** The DBT therapist communicates to the client in two opposing (dialectical) ways.
 - o **Reciprocal Communication:** A style that is warm, responsive, accepting, and genuine.
 - o **Irreverent Communication:** A style that jolts the client out of her habitual pattern of understanding and interpreting events through irreverence (sarcasm). This style is challenging and needs to be used more sparingly than the first style. An example would be, "So you think your mother will just accept your decision to quit your job," the therapist says ostentatiously looking out the window. "I'm just checking for hooved animals overhead... because that'll happen when donkeys fly." In effect, the therapist attempts to share a joke with the client without it seeming to be at her expense.

Interventions

- **Components of Treatment.**
 - **Individual Therapy.** Individual therapy is the mainstay of DBT and includes cognitive restructuring techniques, exposure techniques, psycho-education and contingency management (CM). CM refers to the systematic reinforcement of targeted adaptive behaviors while avoiding reinforcing any maladaptive behaviors. CM permeates each treatment interaction with the individual therapist and group leader. Remember that throughout treatment, the therapist maintains the dialectic of accepting the client as she is while helping her change. The therapist is firm and yet flexible, nurturing yet demanding (further therapeutic dialectics).
 - **Group Skill Training.** The content of the Skill Training Modules are described in the next section. The format of the group therapy sessions in different institutions differs. Commonly, each module is presented sequentially and lasts from 4 weeks to 6 months. The groups meet intensively, several times a week for several hours a week. Often the groups are 'closed,' not permitting new members from joining after the start of the sessions.
- **Telephone Contact.** Clients are offered support through telephone contact with their individual therapist. DBT recognizes that clients are frequently in crisis and engage parasuicidal behaviors. Especially early in treatment when clients have not developed emotion regulation and distress management skills, clients are given the opportunity to maintain between session telephone contact with their individual therapist, who guides them in using their nascent self-regulating skills. An acceptable reason for the client to call is to avoid an episode of self-injury, while calling after self-injury is not acceptable, because such a use would be reinforcing of the self-injurious behavior. In the event of self-injury, the therapist would assure the client's immediate safety and then not accept calls for the next 24 hours. Of course, the number and time of calls and acceptable reasons for them are details worked out between client and therapist in treatment.
- **Therapist Consultation.** This last component of DBT does not include the participation of the client. Rather all DBT therapists are required to attend DBT support groups comprised of other therapists. DBT is aware of the intense and draining relationship that clients can form with therapists who are in danger of burnout or of countertherapeutic interactions.
- **Psychiatric Treatment (Outside of DBT).** DBT recognizes that many clients benefit from treatment with psychotropics, especially for comorbid psychiatric conditions. The DBT therapist seeks to work with the psychiatrist to maintain the flow of information and to help the psychiatrist maintain appropriate contingency management techniques, meaning, not rewarding the patient for harmful behaviors.

• The Four Skill Training Modules

- **Core Mindfulness Skills** include techniques to increase the patient's awareness of their present experience without automatically reacting emotionally or behaviorally. It is, in effect, a method of "Counting to 10."

- Interpersonal Effectiveness Skills have as a focus increasing the client's effectiveness in getting what she wants or needs. It includes practice in maintaining a sense of self and of adequate self-esteem when interacting with others, of knowing how to say 'no,' and of asking for help in appropriate ways (rather than resorting to parasuicidal behavior as a form of communication).
- Emotion Regulation Skills include methods to change one's emotions as they are occurring by reframing the experience and through other cognitive techniques.
- Distress Tolerance Skills include increasing the client's ability to tolerate dysphoria that cannot be changed at the present moment.
- Stages of Therapy. The tasks that need to be accomplished are hierarchical, meaning that the problems associated with an earlier stage need to be addressed and resolved before moving on to later stages. For instance, the therapist does not focus on treating PTSD symptoms with a client who continues to engage in suicidal behaviors. Rather, the PTSD symptoms would be temporarily addressed with Distress Tolerance Skills. The stages are as follows.
 - Pretreatment Stage focuses on assessment and education about BPD and DBT. It also includes negotiation of treatment guidelines between client and therapist.
 - Stage 1 focuses first on controlling suicidal behaviors, then on behaviors that interfere with therapy (e.g., missing sessions, not completing skill module homework or weekly diary cards), and third, on behaviors that interfere with the quality of life (e.g., drug abuse, sexual promiscuity, behaviors that alienate others).
 - Stage 2 focuses on resolving PTSD-related problems (e.g., flashbacks, avoidance) using Exposure-Response Prevention techniques.
 - Stage 3 focuses on issues of self-esteem, quality of life, life goals, and other individual treatment goals that the client and therapist negotiated.

Supportive Therapy

Introduction

- Supportive Therapy is invaluable to two types of patients: the chronically ill, often low functioning patient who needs to have an ongoing support in their lives in order to maintain their functional level and to deal with the challenges of the mental illness and of treatment itself. The therapist can be thought of as a parental figure, a teacher, a mentor, an advocate, or a life-guide. The other type of patient who benefits from supportive therapy is a person in crisis. The patient's premorbid or inter-episodic function may be good, but they are at a point of diminished internal resources and of increased symptoms and dysfunction. Supportive Therapy is an interim external support system until the patient's internal resources recover.

Indications

- The Chronically Mentally Ill Patient
 - Schizophrenia
 - Bipolar Disorder
 - Chronic Major Depressive Disorder
 - Severe character pathology such as BPD
- The Patient in Acute Crisis
 - Severe mood episode
 - Severe anxiety symptoms
 - Acute trauma or loss
 - PTSD

Interventions

- Permit Ventilation: Many patients live either emotionally or physically alone and are experiencing some level of discomfort. Sometimes a sympathetic ear is the most powerful intervention a clinician can offer. For example, shame has inherent in itself the feeling of being different and worse than others. It isolates the sufferer from fellow humans. By giving the patient permission and encouragement to discuss the shameful events the experience becomes less painful. It's called, "Lancing the Shame," like you would a boil.
- Acknowledge and Validate. Many patients need to have their pain or frustration acknowledged as a way of sharing and dissipating it. They also

need to have their own efforts in resolving their problems validated.

- **Accept.** Maintain an attitude of acceptance of the patient as a person, no matter what their level of pathology or dysfunction. Patients want to feel accepted by someone who knows their secrets and doesn't reject them. It helps them "rejoin" the race of human beings.
- **Give Hope.** Patients may feel like freaks or "hopeless cases." An important supportive measure is to instill hope. This can encourage the patient to remain invested in treatment and thus benefit from it. Giving false hope backfires. Fortunately, for almost every patient there is some form of real hope that can be conveyed, even if it isn't for full recovery or cure.
- **Educate.** Many patients benefit from a better understanding of their illness and its treatment. They are more able to see themselves as medically ill and not morally weak or as some kind of freak. Also, it aids in maintaining compliance with other treatment regimens. Remember that many of the meds we prescribe give adverse effects first and benefits second. Educating the patient can decrease their fear and uncertainty and lead to improved treatment compliance.
- **Give "Permission" to (Temporarily) Accept the Sick Role.** Many patients are highly driven individuals who feel guilt and shame at their current disability. Communicate "you can take it easy," "you don't need to do everything at once," and "give yourself a break like you would give one to anyone else."
- **Normalize.** This term means viewing the patient's psychopathology as being a "normal" reaction given the stressors that they faced or the expected and common symptoms of the illness from which they suffer. Normalizing pathology helps a patient admit to a symptom or dysfunction that is shameful or otherwise difficult to admit to. For example, the clinician may say, "Mr. Jones, many people with depression have thoughts about killing or hurting themselves. Have you ever had such thoughts?" Or, "Ms. Smith, many persons who take the type of antidepressant you're taking experience sexual problems. Have you noticed any changes in your sexual function?"
- **Help Problem-Solve.** What do depressed, manic, and psychotic patients have in common? One is poor-solving ability. All three conditions interfere with executive functions. In supportive therapy you can help the patient delineate, prioritize and begin to address problems. Also, you are conveying the broader message that problems are solvable.
- **Advise.** Some patients need our advice. In the right circumstances it is the best thing to do. Let me give an example. I have about a dozen patients who are depressed and whose main stressor is caring for a disabled or demented parent. What I have found is that it is usually one person in the family who does all the caretaking work, my patient. In these cases I advise the patient to directly and unambiguously request help from other family members.
- **Reality test.** Patients with acute or residual psychotic symptoms benefit from a therapist who helps them separate reality from "the tricks that their mind plays on them." For instance, it is often beneficial for a therapist to say, "Mr. Smith, when you hear your neighbors talking about you through the air duct, I believe that they aren't really doing that. I think it's your illness playing tricks on you."
- **Role-Play.** Just because the patient knows that he or she needs to do something doesn't mean that the patient will take action. The patient first needs to know how to perform the action. Role-playing can improve performance. It can help the patient figure out how to approach family members for caretaking assistance or their psychiatrists with problems with their medications.
- **Request Family Meetings.** You can leverage your power for positive change by gathering allies (and neutralizing opponents). Family members can become an extended treatment and monitoring team.
- **Recommend Journaling.** Journaling, the keeping of a daily journal of experiences, is a great source of strength for many patients. However, be sure to advise the patient to not only focus on experiences of pain or failure. Teach them to make daily affirmations.

- Give Referrals to Other Sources of Help and Information. Many patients will gain added benefit from Alcoholics Anonymous or other 12-Step programs. Al-Anon, a 12-Step self-help group for family members of addicted people, has been a godsend for many patients. Also, remember to recommend reading material to patients who can further their understanding of their illness and its treatments.

Psychosocial Rehabilitation

Introduction

- Psychosocial Rehabilitation includes social, educational, occupational, behavioral and cognitive interventions designed to increase the psychosocial capacity in everyday life among the chronically mentally ill.
- Programs generally run 4-6 hours each day, five days each week and include both structured and unstructured drop-in hours. These programs are not usually time limited. Many clients attend for years or decades.

Indications

Patients with major mental illness

- Schizophrenia and Schizoaffective Disorder
- Bipolar Disorder, and chronic and recurrent forms of Major Depressive Disorder
- Severe Anxiety Disorders
- Patients with concurrent Substance Use Disorders can attend Dual Diagnosis programs. They are also sometimes called:
 - Mental Illness Chemical Addiction (MICA) Programs
 - Mental Illness Substance Abuse (MISA) Programs

Interventions

PSR Programs are comprised of several therapeutic groups:

- Community Group. Many PSR Programs start the day with a Community Group in which news is shared, new members and staff are welcomed and graduating members and leaving staff are bid farewell, problems are raised and resolved, and activities are planned. Community Group, besides having the obvious virtue of increasing a sense of community among patients, also

provides a forum for experiential learning of communication, negotiation and social skills.

- Psycho-Education Groups focus on two areas.
 - Medication Education Groups teach the indications, benefits, and adverse effects of commonly prescribed psychotropics as well as the challenges and importance of maintaining compliance.
 - Psychiatric Disorders Groups teach patients about the symptoms and types of dysfunction they can expect from their illness and ways of coping with them.
- Social Skills Training seeks to correct problems such as these:
 - Problems accepting criticism
 - Problems saying “No”
 - Problems with assertiveness
 - Assuming others know of patient’s needs and getting angry when assumptions are not met
 - Experiencing anxiety when speaking to authority figures
 - Deficits in verbal communication
 - Deficits in nonverbal communication
 - Inability to be on time
- Vocational Assessment & Preparation includes the following:
 - Readiness for Work Assessment. Patients are assessed for their ability to maintain the basic life skills upon which success at work rests. For instance, the patient needs to be engaged in treatment, able to be on time and keep appointments, maintain good hygiene and grooming, and have access to a personal means of transportation or familiarity with public transportation.
 - Job Aptitude Assessment. When patients show a readiness for work, job aptitude is then assessed. The patient is evaluated for their interest in various work options, aptitude at succeeding at their preferred jobs, and need for further training.
 - Work Preparation. Based on the Job Aptitude Assessment, the patient is prepared to enter the job market. The patient is guided in resume writing, interviewing skills, work performance expectations, and job placement options.

- Job coaching. Many patients require ongoing job coaching and many PSR Programs have formal arrangements with area employers and serve as liaisons and job coaches for their members. Common jobs include warehouse, mail room, customer service, stocking, light assembly, janitorial, and home health care work.
- Occupational Skills Training seeks to increase patients' independence in the following areas:
 - Use of the telephone
 - Shopping
 - Food preparation
 - Housekeeping
 - Laundry
 - Transportation
 - Responsibility to comply with medication and other treatment
 - Ability to handle finances
 - Ability to handle chores and repairs
 - Skill in driving an automobile
- Stress Management Skills Training includes:
 - Relaxation training
 - Guided imagery training
 - Healthy lifestyle skills
- Social & Leisure Activities. Members may plan and attend dances, pizza outings, or field trips. As with other activities, social activities provide experiential learning opportunities for communication, negotiation, and social skill development.

Interpersonal Therapy

Introduction

- Interpersonal Therapy is a manual-based brief psychotherapy whose focus is limited to the interpersonal aspects of a patient's functioning (conflicts, role transitions, grief, deficits) that contribute to a depressive disorder. Although IPT has roots that go back to Harry Stack Sullivan and others in the 1930's, IPT in its current operationalized form was developed by Gerald Klerman and Myrna Weissman in the 1980's.
- As a brief structured psychotherapy, IPT usually runs for 16 to 20 once-weekly individual sessions

Indications

- Depressive Disorders (main indication)
- Other Disorders for which IPT has been modified and is in use
 - Bulimia Nervosa
 - Somatization Disorder
 - Substance Abuse Disorders
- Disorders for which IPT is being investigated
 - Anorexia Nervosa
 - Bipolar Disorder
 - PTSD
 - Generalized Anxiety Disorder

Key Concepts

- The Focus of IPT: IPT focuses exclusively on the interpersonal aspects of a patient's life. IPT, however, does not presume that the contributors to a patient's mental illness are limited to interpersonal stressors. It recognizes that genetic vulnerabilities, use of substances, medical illness, life events and personality features may all contribute to the development of psychopathology. IPT does, however, emphasize the interpersonal context of all stressors.
- Depression is seen as having three components
 - Symptom Formation
 - Social Functioning
 - Personality Contributors

- IPT does not focus on the contribution of personality features in the interest of brevity of treatment. Its therapeutic focus remains on social functioning which, if improved, will have a beneficial effect on symptom severity.
- Social Function is divided into 4 areas.
 - Interpersonal Deficits. Some patients may have few and / or inadequate social interactions. Skill training techniques, such as role playing, may be of benefit.
 - Interpersonal Disputes. When patients come into closer interpersonal contact with others, misunderstandings and diverging expectations due to inadequate communications can occur. Also, unrealistic expectations can lead to disappointment on the patient's part and hostility on the other person's part.
 - Role Transitions. Changes in school or work function, family role, or developmental stage can lead to stress and conflict with others. Assessing the differences between old and new roles can help clarify what changes are needed.
 - Grief. IPT defines grief narrowly, reserving the term for the bereavement associated with the death of a loved one. It does not apply to psychosocial losses. IPT may include grief therapy interventions in appropriate cases.
- Therapist Communication Style. The IPT therapist takes a supportive stance with the patient. The therapist educates the patient on the treatment and monitors and guides the patient in maintaining a focus on the one or two interpersonal issues that have been identified as the focus of treatment. The therapist is often more active in the beginning stages of treatment and then allows the patient to become more self-guiding as therapy proceeds. The therapist's goal is to make themselves unneeded so that the patient's gains can be maintained and consolidate long after therapy ends.

Interventions

- Stages of Treatment
 - Stage 1 (Sessions 1-3): Interpersonal Inventory is completed. The patient is asked to make a list of all important relationships in her life. Each relationship is then assessed in terms of the 4 areas of social function (conflict, role transitions, grief, and deficits). Also, the patient's illness is formulated in interpersonal terms.
 - Stage 2 (Sessions 3-14): Relationship problem areas identified in the Interpersonal Inventory are assessed and problem-solving applied.
 - Stage 3 (Sessions 15-16): Termination issues are addressed. Termination is conceptualized as an experience of loss that gives the patient opportunity to develop coping methods for understanding and facing other loss experiences in her life.
- Specific interventions
 - Supportive Listening
 - Communication Analysis is a technique derived from CBT in which communication sequences are analyzed for their effects on the relationship.
 - Role Playing is an experiential learning technique that allows the patient to experiment and practice behavioral solutions to current conflicts and skill deficits.
 - Encouragement of Affect. Patients may be defended against experiencing negative emotions and may need the encouragement of a supportive therapist in the context of a safe environment to express and come to terms with them.

Couples Therapy

Synonyms

Marital Therapy, Couples Counseling, Conjoint Therapy

Introduction:

- Many couples experience conflict at some point in their relationship. Sometimes the stressor is internal to the relationship, related to entering a new developmental stage in the relationship, such as occurs, for instance, with the birth of a child. Sometimes the stressor is external as occurs with the loss of a job. Couples Therapy is a means of resolving problems that the couple is unable to resolve on their own. Couples Therapy includes only the couple. If it includes children or other family members, it is considered Family Therapy.

Indications

- Impending divorce or separation
- Conflicts over money, communication styles, childrearing, life goals and lifestyle issues
- Infidelity
- Sexual dysfunction
- Domestic violence or sexual abuse of spouse
- Alcoholism or drug abuse
- Medical or psychiatric illness
- A child's behavioral or psychiatric disturbances – Couples Therapy can become part of the child's treatment.

Therapy Types

- Psychodynamic Couples Therapy
- Cognitive Behavioral Couples Therapy

Key Concepts

- Communicating in an assertive non-disparaging way
- Negotiating over and sharing of responsibilities
- Active listening
- Cooperating versus competing
- Establishing common life goals
- Recognizing Projective Identification
- Recognizing the Repetition Compulsion

Interventions

Psychodynamic Couples Therapy

- Psychodynamic Couples Therapy focuses on the emotional and interpersonal patterns of each spouse that developed during childhood in their family of origin. Now that they are members of a couple, each person's patterns may now come into conflict.
- Two psychological mechanisms can be assessed, understood, and changed during therapy. Projective Identification occurs when one person in the couple projects onto the other their disavowed personality features and behaves in a way that gets the other person to identify with them. For instance, if the husband has feelings of not measuring up because his father was never satisfied with him, he may act towards his wife in a way to make her feel incompetent or "never good enough." The wife in turn may project her own disavowed characteristics onto her husband and have him identify with those.
- Another psychological mechanism that can be assessed and addressed in therapy is that of the Repetition Compulsion. This occurs when one member of the couple chooses a spouse who is similar to an inadequate or abusive childhood caretaker. The inferred psychological motivation is that the person with the repetition compulsion wishes to gain mastery over or "fix" the painful relationship they experienced as a child by recreating it in adulthood but have it end well. Unfortunately, this happy outcome is rare since the abused and the abuser usually maintain the interactional patterns learned early on. By making these patterns and their motivations explicit, and teaching the members of the couple to develop new patterns, therapy can lead to positive change.

Cognitive Behavioral Therapy

- CBT approaches include a focus on improved communication. Many couples have expectations of their spouse that they do not express and are then disappointed. Also, many couples do not adequately listen to the often nonverbal messages their spouse is attempting to convey. Thus, the therapist guides each person to express

their needs in a non-disparaging but assertive way and to develop their active listening skills. The therapist then helps the couple set guidelines on acceptable communications and negotiation approaches and has the couple practice them, first in the office and then at home.

- Homework assignments can include negotiating over childrearing and money management practices, learning to communicate positive things that you cherish about your spouse, showing affection, resolving disagreements without putdowns or silent withdrawal, and developing intimate and romantic rituals.
- Adjunctive Treatment:
 - Some spouses may have psychopathology, such as depression or anxiety, serious enough to warrant a recommendation for individual psychotherapy or medication treatment.
 - As part of a child or adolescent patient's comprehensive treatment plan, Couples Therapy may be recommended to the parents.
- If a spouse with the identified problem is unwilling or unable to attend Couples Therapy, the other spouse may still benefit from psychotherapeutic intervention.
 - Couples Therapy with Absent Partner. Some therapists will meet with a single spouse, with or without the goal of eventually drawing in the other partner. For example, a therapist may help a spouse develop assertive communication and negotiation skills even without the direct involvement of the other spouse.
 - Interpersonal therapy can also help one spouse develop interpersonal effectiveness skills as well as in gaining an understanding of the dynamics of the relationship.
 - 12 Step groups
 - Alanon is indicated for those with a spouse with a Substance Use Disorder.
 - Emotions Anonymous can help those individuals who have "codependent" interpersonal patterns and seek a more autonomous sense of self.

Family Systems Therapy

Introduction

- Family Therapy comes in several versions. Some are based on psychodynamic principles and others on cognitive-behavioral constructs. However, much of Family Therapy is based on Family Systems Theory which states that the family is its own self-contained system that is more than the sum of its parts.

Indications

Family Systems Therapy is appropriate when evidence of family dysfunction exists. The clinician should be able to identify a direct connection between a child's problems and family dysfunction in order to give focus to the subsequent interventions.

- Families that lack minimal coping skills are not good candidates for family therapy. For example, families that have insufficient structure to attend regular sessions and single parent families with very young children may not be in a position to benefit.

Family System Therapy Types

- Structural Family Therapy
- Strategic Family Therapy
- Transgenerational Family Therapy

Key Concepts

Family Systems Therapy is based on the following assumptions and concepts.

- The family as a whole is a system that has its own rules, strengths and problems that cannot necessarily be predicted by assessing the individuals that make up the family. As such, the family has emergent properties to that of the individuals who comprise the family.
- As such, it is the entire family that is the focus of treatment and not any one or any subgroup of individual members.
- The problems that any family member may be experiencing or behavioral patterns he may be manifesting cannot be understood outside the context of the family.

- Therefore, family therapy deemphasizes assessment of symptoms or traits of individual family members and rather emphasizes relationships and communication patterns among the members.
- Interventions are implemented at the family level and not the level of an individual member.
- **The Identified Patient** is the family member whose symptoms or problem behaviors have identified him as the “patient” in the eyes of a referring clinician, school counselor, or other professional and have brought the family into treatment. The family and the Identified Patient himself may have accepted this designation of being the “patient” or the “problem.” The job of the Family Therapist, therefore, is to prevent the Identified Patient from being “scapegoated” by the family as a way for the other members and for the family as a whole to avoid recognizing their own contributions to the problem.
- **Triangulation** is the concept that whenever two family members are experiencing stress in their relationship, they will try to recruit a third family member to stabilize their relationship. The relationship triangle formed may then overlap with other triangles made up of other family members. This series of interlocking triangles stabilizes the family system, forming what family systems therapists refer to as Homeostasis.
- **Homeostasis** is the supposition of family therapists that families, through such mechanisms as the interlocking triangles, develop a stable organization which resists change. When placed under stress, the family system seeks to maintain its usual organization through the period of stress. It is this seeking to maintain some form of homeostasis that leads individual members to develop symptoms and to become Identified Patients.

Treatment Goals:

- The goal is to improve the smooth functioning of the family as a whole so that individual members no longer need to hold on to symptoms as a way to stabilize the system.
- The family members are thus able to “differentiate,” that is, to pursue their individual goals and maintain a greater sense of individual self while remaining connected to the family unit.
- Another goal is for the family system to become more flexible and more able to handle stressful events.
- On a relationship level, the goals are for the family members to gain greater insight into their patterns of relationship problems, to become more effective communicators, and to permit more flexible roles and behavioral patterns.

Key Interventions

So far, I’ve presented concepts that are broadly shared among Family Therapy practitioners. The following interventions are more specifically related to Structural Family Therapy.

- The interventions fall into three categories: Joining, Diagnosing, and Restructuring.
- **Joining:** Family therapist use the term joining to refer to a specific type of engagement with the family. I explain in a minute. When families present for treatment they are often resistant to change. As I’ve discussed, the homeostatic mechanisms kick in, even when individual members may be in pain. The first step is to engage them in the therapeutic process. The therapist takes pains to establish a relationship with each family member. Also, the therapist joins the family system to become one of its members – hence the term joining. The therapist does this by recognizing the nature of the family’s rules and governing processes and accepting them at the start. The therapist continues to gain insight into the functioning of the family by tracking its style of communication and interaction and the focus of its concerns, as well as through a process of mimesis, which refers to a mirroring of the communication and interactional style of the family members.
- **Diagnosis.** After the therapist has “joined” the family, she is ready to begin the process of diagnosis. This does not refer to DSM-IV psychiatric disorders but rather to discerning the patterns of interaction among the family members that allow (or encourage) the Identified Patient to engage in the problem behavior. In other words, something in the dynamic and structure of the family leads to this problem behavior and it is the therapists job to identify

and characterize these interactional patterns. Family therapists assess them along five dimensions. I list them here without further explanation. They are: structure, resonance, developmental stage, Identified Patient, and conflict resolution. From there the therapist develops a formulation that can guide treatment interventions. In the formulation the therapist infers how certain of the identified interactional patterns permit or encourage the adolescent's acting out.

- **Restructuring:** The therapist uses three types of interventions to bring about change. They are categorized as "working in the Present," "Reframing," and "Working with Boundaries and Alliances."
- **Working in the Present:** The therapist is on the look-out for enactments of problematic interactional patterns taking place in the therapy session. These can include fighting, arguing, criticizing, intimidating, interrupting, or invalidating one another's communications. When they occur the therapist moves to restructure them by intervening right in the middle of their occurrence to interrupt their progression and to redirect them into new and more positive interactions. For instance, the therapist can ask a family member who just made a statement to rephrase it in a more positive way in order to have a better chance of getting his needs met.
- **Reframing:** Reframing refers to changing a person's perspective. A reframe is taking an event or situation or thing and lifting it from its routinely perceived associations and placing it into another category of event, situation, or thing that has a very different set of associations. For example, the therapist, upon observing an angry or invalidating behavior can reframe it as something with a positive intention or outcome, such as powerful emotions that bind the family together and that are, perhaps not the best, a way of keeping communication channels open. The therapist is now in a position to get the family to consider more productive ways of

achieving those ends, ways that do not have the high negative cost associated with them. This technique avoids blaming and invalidating the family, which would further their resistance and is a method that eases change.

- **Working with Boundaries and Alliances:** The therapist needs to be aware of the alliances that family members form with one another. I discussed triangulation as a common interactional pattern that can maintain behaviors. The therapist works with the boundaries and alliances to make splitting of parents by the children less likely. The parents (or parental figures) need to be able to function as a united voice and decision-making body. In families that are having problems it is common that the parents are at odds with each other allied with a different child or set of children. This makes family 'governance' difficult and unpredictable. This break-down can give undue power to the children to engage in disruptive, drug-using, or delinquent behaviors.

Group Therapy

Introduction

- Group Therapy is used by therapists of various theoretical orientations. What the different approaches to Group Therapy have in common is that they permit the establishment of guided interpersonal interactions for the benefit of the participants.

Indications

It may be beneficial for the following categories of problems.

Category 1: For persons with trust, shame, intimacy problems

- Problems with trust and intimacy
- Problems with self-esteem
- Problems with shame and embarrassment
- PTSD and childhood abuse

Category 2: For persons with social / emotional / life skill deficits

- Schizophrenia
- Mental retardation
- Social Anxiety Disorder, Avoidant PD
- Borderline Personality Disorder (DBT Skills Groups)

Category 3: For persons prone to denial and/or deception

- Substance Use Disorders
- Other addictive disorders, e.g., pathological gamblers
- Antisocial Personality Disorders
- Eating Disorders

Contraindications

- Manic, hypomanic, or prominently paranoid patients.
- Members who are too heterogeneous in level of function, ego development, or type of problem.
- Patients who are too socially avoidant or shame-filled to disclose issues important to them.
- Patients with Borderline Personality Disorder (BPD) may not do well in a group without a clear focus and firm rules. Dialectical Behavioral Therapy Skill Groups meet these strict criteria

and are therefore, indicated for patients with BPD.

Therapy Types

- Psychodynamic Group Therapy
- CBT and DBT
- Skill Training Groups (also see section on Psychosocial Rehab)
- 12 Step Groups
- Support Groups (for persons facing similar problems)

Role of the Leader:

- Establish and monitor group ground rules (e.g., no violence or threats; one person speaks at a time; an attitude of caring, respect, and problem-solving is to be shown; confidentiality of disclosed material is to be maintained)
- Explain theoretical underpinnings (e.g., "Learning within the group to communicate your needs without resulting to threats or violence and to negotiate with others so that everyone's needs are met will give you skills you can use outside of group.")
- Set date, time, fee, and attendance requirements
- Encourage participation of quiet or withdrawn members
- Explain, clarify, and interpret members' feelings and behaviors and the consequences of these feelings and behaviors, whether positive or negative
- Maintain even-handedness, avoid playing favorites, avoid providing special arrangements (for some patients the group plays the role of a surrogate family and members may recreate the pathological dynamics of their family of origin. The leader's job is to avoid succumbing to these dynamics and instead interpreting them and / or displaying more positive responses in order to help establish new patterns).

Key Concepts

The theoretical assumption is that compared to individual therapy Group Therapy enhances:

- Learning. Learning is explicit: group members share advice and coach each other. Learning is implicit: participants are able to observe other

members' behaviors in response to challenges. They also learn to identify and understand unacknowledged feelings by seeing them expressed by others. Learning is experiential: participants can try out new behaviors and practice skills.

- **Feedback.** Rather than being restricted to a single source of feedback (the therapist) group members have the opportunity to receive feedback from all group members. The feedback from group members often has a more powerful effect on the client because it is from a peer rather than from a person with whom the client may not fully identify (the therapist). Also, when feedback, especially negative feedback, is similar from several peers, the client may find it more difficult to deny it or dismiss it as the distortion of a single person. For certain types of patients, e.g., addicts or those with Antisocial PD, peers may be able to catch and confront excuses and blind-spots more easily than would a "naïve" therapist.
- **Support.** Being in a group can "normalize" a client's feelings of shame that may have arisen in response to surviving, for instance, childhood sexual abuse. The client learns that he or she is not the only person in the world with such a history and will find it more difficult to feel shame or hatred toward other survivors than it was to harbor such feelings toward oneself, a common consequence of abuse. A sense of dignity and worth can then grow.
- **Mastery.** Being able to observe the problems / limitations / denial of group members and then to provide them with feedback, can help a patient develop a sense of mastery and caring for others. A danger is that patient will defocus from the hard work of making changes in his /her life to focus on other members' problems.

Treatment Goals

To improve interpersonal skills; to decrease depression, anxiety, guilt and shame; to "normalize" one's experience; to confront one's denial of problem behaviors; to re-establish a premorbid level of function or prevent further declines.

Addiction Treatment

Key Concepts of the Addiction Model

Now on with Addiction. Many of the following concepts are adapted from an article by Dr. Terrence T. Gorski, writing for the National Institute of Health publications (NIH 00-4151).

- **Definition:** Substance Addiction is a primary disorder resulting in
 - abusive patterns of substance use
 - physical and psychosocial decline
 - relapse
- **Diagnosis:** The DSM-IV divides the substance use disorders into two levels of severity, Substance Abuse and Substance Dependence. Substance Abuse focuses on substance use despite the negative social consequences. Substance Dependence focuses on symptoms of physiological dependence and of loss of control. It includes use despite negative medical consequences.
- **Biopsychosocial Model:** Addiction can best be understood through application of the biopsychosocial model. Biological, psychological, and social factors both contribute to and result from the addictive process. Both aspects are discussed below.
- **Biological Factors:**
 - **Genetic diathesis:** Many addicted individuals have a genetic family history of addictive, mood, anxiety, and other psychiatric disorders.
 - **Brain Dysfunction:** Heavy substance use leads to brain dysfunction which manifest not only during periods of intoxication but also during short-term and long-term withdrawal. Patients with a family history of addiction appear to be more susceptible to brain dysfunction resulting from substance consumption.
 - **Consequences:** Substance-induced brain dysfunction, through disruption of cognitive, emotional, and executive functions, then contributes to disorganization of personality and of social and occupational function.

- **Psychological Factors**

- Role of Dysfunctional Family: A dysfunctional family-of-origin does not “cause” an individual to develop an addiction. An addictive disorder can develop irrespective of whether an individual was raised in an adequate or a dysfunctional family environment. However, being raised in a chaotic, neglectful, or abusive childhood environment can lead to “self-defeating personality traits,” which in turn can lead to a more rapid and severe progression of the addictive disorder, to one that is less responsive to treatment, or to one with a higher rate of relapse. Comprehensive addiction treatment thus needs to address family-of-origin and characterological problems to be fully effective.
- Substance-induced brain dysfunction can lead to personality disorganization through interference with normal thinking, feeling, and acting. Some of the personality disorganization is temporary and will gradually remit with abstinence as the brain recovers from the cumulative effects of the drug on the brain. However, some of the changes in thinking, feeling, and acting can become chronic and self-sustaining and thus in need of a specific focus of treatment.

- **Social Factors**

- Addiction is influenced by availability of the substances of abuse. For example, in most parts of the United States, alcohol is so widely available that any individual with susceptibility to abuse or dependence will develop these disorders. The illegal substances are less widely abused because of their lesser availability. Methamphetamine use varies widely by geographic area due to its widely differing availability.
- Addiction is influenced by social norms. For example, France has a much higher prevalence of alcoholism than does Italy due to differing attitudes and social consumption patterns. In the United States hallucinogen use has changed dramatically across the last five decades.
- Addiction leads to social dysfunction and often includes disruption of family, social, and

work roles and can lead to legal and financial problems. The mechanism through which this occurs is the substance-induced brain dysfunction and personality disorganization.

- **Course of Illness**

- Addiction is a chronic disease that has a tendency toward relapse, which is an integral component of the illness. Relapse is the process of becoming dysfunctional in recovery, which leads to renewed drug use and also to physical, psychological and social dysfunction.
- As the addiction progresses, the symptoms of this brain dysfunction cause difficulty in thinking clearly, managing feelings and emotions, remembering things, sleeping restfully, recognizing and managing stress, and psychomotor coordination.
- The symptoms are most severe during the first 6 to 18 months of sobriety, but there is a lifelong tendency of these symptoms to return during times of physical or psychosocial stress.
- The chronic nature of the dysfunction associated with an addictive disorder as well as the risk of relapse are the reasons that the diagnosis of Substance Dependence should in many cases be maintained, even when sobriety is maintained over long periods of time.

- **Categories of Symptoms**

- Drug-based symptoms manifest themselves during active episodes of substance use.
- Sobriety-based symptoms emerge during periods of abstinence. Relapse is the process of developing increasingly dysfunctional thinking, feeling, and acting patterns that occur during sobriety. This process of relapse follows predictable patterns and often leads to the following:
 - renewed substance use
 - development of comorbid psychiatric disorders
 - loss of family, friends, job or to episodes of violence, e.g. suicide or murder-suicide.
 - loss of emotional resiliency and flexibility
 - loss of normal problem-solving and life-efficacy skills

Overview of Rehabilitation Treatment

- Substance use treatment has two phases, detoxification and rehabilitation. The two main goals of the rehabilitative phase of treatment are 1) maintaining the patient's continued abstinence from the drugs of abuse and 2) the establishment or reestablishment of the patient's biopsychosocial well-being. The two main treatment categories are 1) Rehabilitation Treatment administered by medical, often psychiatric, personnel and by licensed counselors and 2) peer 12 Step programs. Below we take a look at each.

Comprehensive Assessment

- Psychiatric management of patients with substance use disorders, that is, substance dependence or substance abuse, begins with a comprehensive assessment. The comprehensive assessment begins with a general psychiatric assessment to identify any psychiatric and medical comorbidities, both of which are common in persons with substance use disorders. Then a detailed substance use assessment is obtained that focuses on the patient's pattern of substance consumption and the consequences of use, including the physiological, psychological, social / relational consequences.
- In a comprehensive assessment, a medical evaluation is also usually indicated including a physical exam and labs for evidence of continued use (e.g., urine toxicology screens), organ damage (e.g., LFTs) and infections (e.g., HIV and STD screens). Remember that obtaining a history of prior treatments and their efficacy is crucial. A family and childhood history sheds further light on the issues involved.

Assessing Recovery

- The area of assessment covered the least well by candidates is the nature of the patient's recovery. Most candidates know how to assess level and pattern of use and the consequences of use, but don't know how to assess recovery. So, if the patient is currently maintaining sobriety, ask a few of the following:

- Where are you in your recovery?
- Are you in a Rehab Program? Tell me a little about it.
- Are you attending AA? How often do you go?
- Do you have a sponsor?
- Do you have cravings?
- Have you had any slips? Tell me a little about it.
- One thing I've noticed is that patients will often fail to report "slip ups." They will report with a certain pride a long period of sobriety like, for example, a year. The clinician can then feel that the patient's sobriety / recovery is stable, that the patient is "out of the woods." However, by asking about "slips ups" or "falls off the wagon," you may very well find out that the last use of drug was a mere weeks or days ago. Somehow, these "slips ups" are discounted by patients to the point of not being regarded as relapses at all. Aah, the power of denial! The motto is: Ask and be ready to be surprised.

Therapeutic Alliance & Treatment

- Addiction Treatment begins with a focus on establishing a therapeutic alliance, which may be difficult with some patients who are defensive, ashamed, or guarded.
- The clinician also maintains a focus on monitoring for signs of relapse or impending relapse.
- Urine Toxicologies obtained at random intervals are common but must be approached sensitively in order not to disrupt the alliance. Different programs have differing guidelines for their use of urine "drops."
- The clinician also monitors for the possible emergence of any psychiatric or behavioral symptoms, including, of course, for suicidal or homicidal thoughts or impulses. Any comorbid psychiatric and medical conditions are treated.

Types of Interventions

Intensive or Moderately Intensive Rehabilitation Programs frequently include attendance in structured groups.

- Groups include educational, supportive, and skill-training groups as well as CBT-based groups

like Motivational Enhancement Therapy and Relapse Prevention Therapy (discussed below). Some Rehab programs include more expressive psychodynamic-like therapy groups.

- Patients, irrespective of the level of intensity of their program, also meet regularly with a case manager who tailors treatment, maintains contact with the treating psychiatrist, conducts individual and / or family therapy, monitors sobriety and psychosocial adjustment, and helps the patient navigate through the details of, for instance, returning to work or of obtaining benefits.
- Discharge planning is crucial in all cases to increase the likelihood of success as the patient resumes more and more daily life activities while stepping down to lower levels of care.
- Intensive Rehab Programs can be inpatient or outpatient based. If outpatient, the groups may occur during the day or in the evening, for clients who may be participating while continuing to work.

Social Skills Training Groups

- Many recently sober individuals may have little recent experience in interacting and socializing with others while sober and when not trying to “score” drugs. They often feel at a total loss at how to behave and what to talk about when having to engage in social activities while sober. Also, they are asked (required) to avoid their circle of substance abusing associates and are often left with few or no friends, no hobbies, and plenty of time to fill that had been used for drug-seeking and intoxication. Many patients benefit from social skill training and from direction on how to establish healthier interpersonal relationships. For instance, some individuals may have little experience being intimate and engaging in sexual relations when sober. Their level of awkwardness and embarrassment keeps many of them isolated unless treatment steps are taken. Similar issues apply regarding the work life. Many clients are in need of and benefit from vocational rehabilitation also.

- Now, let’s take a closer look at some of the CBT-based psychotherapies developed for use in Rehabilitation treatment. We’ll end by reviewing 12 step programs.

Motivation Enhancement Therapy

Motivation Enhancement Therapy (MET) is a very brief therapy of 2 to 4 sessions that seeks to aid the patient to

- identify their goals for change
- develop a plan for change
- increase their motivation to achieve change
- make a commitment for change

In the case of substance use disorders, the change most often sought is sobriety. The patient’s goals and the specific steps taken to reach them (the objectives) are set by the patient. The counselor, however, does intervene to recommend full abstinence if the patient has as a goal continued use of the substance.

The foundational belief of MET is that the patient’s behaviors are at least partially under the patient’s control and can be changed with the right motivation and plan of action. A focus on increasing motivation to maintain sobriety is deemed necessary because drugs of abuse have built-in motivation for continued use. This self-motivating and self-perpetuating aspect of drug use is the essence of addiction. MET is seen as a counterweight to the pull of the addiction. MET has been shown to increase patients’ compliance with further treatment and thus to increase rates of abstinence.

MET is based on principles of learning theory, using the same foundation as Cognitive Therapy. For example, in CBT a main goal is to gain awareness of the distortions (inaccuracies) in one’s current thought patterns. In effect, one needs to come to realize the discrepancy between one’s current thoughts and more accurate interpretations of events prior to having the motivation to change. In MET, the same general method is used. The counselor has the patient gain awareness of the discrepancy between their life goals and their continued drug use. Resolving the cognitive dissonance between the goals and the reality becomes the basis for increasing motivation for and commitment to change.

Because the goal of MET is to develop the patient's motivation for change, it is often the initial form of addiction therapy. After the patient has shown a motivation for change, made a commitment to change, and has a general plan of action, he is then ready to enter the next stage of treatment, in which the necessary behavioral changes are taken. This is our next topic.

Relapse Prevention Therapy

- Relapse Prevention Therapy (RPT) is often also a brief form of therapy that seeks to decrease relapse in substance use disorders. It has been used most extensively in treatment of cocaine and alcohol addiction.
- RPT's foundational belief is that relapse is an avoidable behavior that can be affected by teaching the patient principles of self-control. Specific techniques include
 - Motivational enhancement through discussion of the negative consequences for the patient of continued use and positive consequences of sobriety.
 - Engendering a commitment to sobriety.
 - Identification of high-risk relapse scenarios and methods for anticipating and avoiding them.
 - Strategies for coping with drug cravings, loneliness, and emotional distress.
- As can be seen, some of the techniques of RPT overlap with those of MET. RPT is sometimes used as initial therapy or can be implemented after MET concludes.
- For many patients, relapse remains an ongoing concern for months to years, sometimes for a lifetime. RPT techniques are useful in assessing the cycle of thoughts, feelings and behaviors that lead down the road to relapse. People with addictions know that they don't relapse when they've had that first drink. There is usually a pattern of thinking, feeling, acting that inexorably leads to that first drink and that can start days or weeks prior to the actual use of the substance. Analyzing that cycle of relapse is a crucial aspect of individual and group therapy.

12 Step Programs

- 12 Step Programs are important components of successful rehabilitation but for many patients are not sufficient in and of themselves. 12 Step Programs include Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous as well as Al-Anon for family members and significant others of people with substance use disorders. Alateen is for teenage family members. 12 Step Programs also include programs for myriad behavioral problems, such as Gamblers Anonymous, Overeaters Anonymous, Sexual Addicts Anonymous, and Abuse Survivors Anonymous. There are hundreds of specialized programs.
- Some 12 Step groups are more overtly religious than others. There are also alternative 12 Step programs that are not based on the concept of a "higher being." Some groups are intolerant of participants taking psychotropics while other groups are accepting and even encouraging of their use. Dually diagnosed individuals, i.e., those with a major mental illness and a substance use disorder, will often not achieve a good fit in a "run of the mill" 12 Step group. However, 12 Step Programs do exist that are associated with a Dual Diagnosis Day Program and, thus, are comprised of individuals dealing with dual diagnostic conditions.

12 Step Programs Provide Three Main Interventions

1. Attending self-help support groups in which participants share their drug abuse stories and discuss the challenges of and techniques of maintaining sobriety.
2. Reading the "Big Book" and working the steps. The "Big Book" was written in the 1930's by the founders of AA, themselves recovering alcoholics. This text outlines the founders' personal stories of addiction and recovery and the guiding principles of AA. Workbooks to help AA participants take a systematic approach to working their steps are available. Formal groups that lead participants through the 12 steps exist in many communities and are useful adjuncts to many recovering addicts.

3. Maintaining contact with one's sponsor. The sponsor is a member of the 12 Step Program who is stable in his or her sobriety and whose role it is to guide and mentor the recovering abuser. When the at-risk individual has problems of whatever type and especially when risk of relapse is heightened, the person in recovery knows that they can always call their sponsor for support and advice, even in the middle of the night.

The 12 Steps:

1. We admit we are powerless over alcohol
2. Came to believe that a power greater than we can restore us to sanity
3. We made a decision to turn our lives over to the our Higher Power
4. We made a searching and fearless moral inventory of ourselves
5. We admitted to God and another human being the exact nature of our wrongs
6. We were entirely ready to have God remove all our defects of character
7. We humbly asked him to remove our shortcomings and strengthen our assets
8. We made a list of all the persons we harmed
9. We made amends to people wherever possible
10. We continued to take personal inventory
11. We sought to improve conscious contact with our Higher Power
12. We tried to carry this message to others

Anger Management Therapy

Introduction

- Anger Management Therapy (AMT) is a form of Cognitive Behavioral Therapy. The mainstays of AMT interventions include cognitive restructuring techniques, relaxation techniques, and communication improvement techniques.
- AMT is commonly provided as a 12 session, manual-based group program with each session lasting on average 90 minutes.

Indications

- Substance Use Disorders
- PTSD
- Mood Disorders
- Psychosis
- Intermittent Explosive Disorder
- Adolescents with conduct disturbances. The psychiatric disorders these adolescents may suffer from include Conduct Disorder, Attention Deficit Hyperactivity Disorder, PTSD, Mood Disorders and Substance Use Disorders.
- Any patient with Anger Control Problems

Key Concepts

- Definitions:
 - Anger is an emotion. It is most commonly triggered when a person feels under threat, feels frustrated in reaching his goals, or feels wronged.
 - Aggression is a behavior. It includes not only violence but the threat of violence. The aggressive behavior is designed to cause harm to another person or cause property damage. Its motivation can include protecting oneself or another person against a perceived threat, reaching one's goals even if it means harming another person, and in exacting vengeance for a perceived wrong that was done to one.
 - Hostility is a complex of attitudes that make aggressive behavior more likely to occur. It can include a series of beliefs that other people are threatening, disrespecting, or waiting to take advantage of one. Thus, the person has an attitude of negative evaluation of others and of needing to be vigilant.

- **Provoking Events:** These are the events, usually involving another person, that trigger anger in a person with anger control problems and can lead to aggression.
- **Cognitive Distortions:** People with anger control problems have been found to have the following cognitive profile.
 - **Cognitive Deficits:** They often have few adaptive responses to provoking events. Research has shown that angry people, when asked how they would solve provocative situations, have fewer ideas than people without anger problems and the ideas they do have tend to be hostile and to involve violence as a solution.
 - **Frequent False Positives:** They often interpret neutral or innocuous events in a manner that they feel provoked by them. They are chronically vigilant for evidence that people are deliberately disrespecting them, hassling them, or trying to take advantage of them. Due to their biased interpretations, they more often feel anger, activate their hostile attitudes, and react with aggression.
 - **Rigid Beliefs:** They often possess the belief that they are justified in their aggressive behaviors so that they believe their aggressive behavior to be a legitimate response. Examples of such beliefs include, "Going off on someone is okay if they did something to deserve it." or "Showing your anger is effective in getting what you want." or "People are selfish and entitled and if you don't stand up for yourself they'll walk all over you."
 - **Difficulty Anticipating Negative Outcomes From Aggressive Behaviors:** People without anger control problems inhibit their aggressive behaviors when they are angry by considering the negative outcomes of acting aggressively. For instance, a person who is able to control their hostile impulse may consider that they may be arrested and convicted as a result of their violence, that they could get hurt by the other party, or that when they cool off they may feel regret over their aggressive behaviors. Conversely, people with anger control problems will often act impulsively and without forethought.

Interventions

Since the VA medical system is the largest provider of Anger Management Therapy, we can regard the VA model of AMT as the standard approach. These are the AMT interventions as practiced at VA medical centers.

- Introduce the goals of AMT treatment. The goals are to:
 - Learn to manage anger
 - Stop violence or the threat of violence
 - Develop self-control of your thoughts and actions
 - Receive support and feedback from others
- Introduce the Group Rules. These are the most important rules each member commits to following.
 - No violence or threat of violence towards members or group leaders is permitted.
 - Confidentiality. Members are not permitted to discuss with persons outside the group what group members have said. There are limits, such as when the member or someone else is at risk from the member.
 - Homework assignments are part of treatment and members are expected to complete them.
 - Time-Outs. When the group leader judges that a member becomes angry and hostile and threatens violence or at is at risk of becoming violent, the group leader can call a time out. The time out means that the at-risk member as well as the entire group take a time-out from the topic that is provoking the at-risk member. If this intervention does not de-escalate the at-risk member, then the group leader can ask that member to leave the group for 5 to 10 minutes to de-escalate. The at-risk member can return when he feels he can continue with the group without becoming at risk of behaving aggressively.
- Address Myths (Cognitive Distortions) related to Anger and Aggression.
 - Myth #1: Anger is inherited. The fact is the way that a person expresses anger is a learned behavior. Other, more productive ways of expressing one's anger can be learned.
 - Myth #2: Anger Automatically Leads to Aggression. The fact is that many people feel

anger but few express it in inappropriate aggression. It is commonly thought that anger is something that builds and escalates to the point of an aggressive outburst. As has been said, however, anger does not necessarily lead to aggression. In fact, effective anger management involves controlling the escalation of anger by learning assertiveness skills, changing negative and hostile “self-talk,” challenging irrational beliefs, and employing a variety of behavioral strategies. These skills, techniques, and strategies will be discussed in later sessions.

- Myth #3: People Must Be Aggressive to Get What They Want. The fact is that aggression is often the method used by people who have not learned other more effective methods of getting what they want, such as through assertiveness techniques. Although aggression works its benefits only last as long as that person can dominate and intimidate another. Its effects disappear as soon as that person is no longer in a position to dominate or intimidate.
- Myth #4: Venting Anger is Always Desirable. The fact is that expressing one’s anger through aggression simply reinforces aggressive behaviors and makes their occurrence more likely.
- Homework Assignments: Three Steps to Anger Control
 - Become aware of your anger. The group member practices attending to situations that cause his anger to escalate. He begins to notice what situations and events trigger his anger. He then uses the Anger Meter. This is a 1 to 10 scale with 1 representing no anger and 10 representing an expression of anger that has negative consequences such as assaulting someone or threatening one’s boss. The member begins to understand how his anger escalates. He is now ready for the next step.
 - Practice Immediate Strategies to Control Anger. The member who now has the ability to become aware of his uncontrolled anger response is ready to develop an anger management plan. When the member finds himself in a provoking situation and becomes aware of his escalating anger, he uses techniques to immediately abort his anger and aggressive responses. Techniques included in an anger management plan include taking a ‘Time Out’ from the situation. This may mean counting to 10, leaving the site of the provoking event, engaging in thought stopping and thought distraction, and relaxing through deep breathing exercises. In conjunction to these immediate strategies, the member practices longer-term preventive strategies.
- Practice Preventive Strategies to Control Anger. Techniques in this category can include regular exercise, refinement of conflict resolution and assertiveness techniques, attending 12-Step groups, and exploring the source of one’s hostile attitudes.
- The Check-In Procedure. After group members have completed their homework assignments, they return to group to report on their experiences and progress. The Check-in procedure is a version of the triple column techniques introduced in the Cognitive Restructuring section of CBT.
 - The first column is for noting the provoking event.
 - The second column is for noting the member’s response. In particular the member notes the cues he received that he was beginning to escalate into the anger response.
 - And the third column is used by the member to note the anger control strategy he used in order to abort his anger response.
 - Members take turns reporting the results of their triple column record for the week and receive feedback and support.
- Learning and Practicing Therapeutic Techniques. Significant group time is spent on learning and practicing the techniques of anger control, such as the ones I discussed (e.g., relaxation, deep breathing, thought stopping, thought distraction, etc.)

Eye Movement Desensitization & Reprocessing Therapy (EMDR)

Introduction

- **EMDR** is a treatment intervention that is now firmly established in the psychiatric and mental health armamentarium. Dr. Francine Shapiro introduced EMDR to a wider audience in 1989 with the publication of a Research Controlled Trial showing EMDR's effectiveness in the treatment of PTSD. EMDR continued to be a focus of ongoing research and in 2005 Dr. Rebekah Bradley and colleagues published a meta-analysis of EMDR that took this psychotherapy's exposure to a much higher level.
- What Bradley et al was able to demonstrate was that three psychotherapeutic modalities were effective in treating PTSD: CBT (primarily Cognitive Restructuring), Exposure Therapy, and EMDR. You can read the entire Bradley et al meta-analysis article here. <http://ajp.psychiatryonline.org/cgi/reprint/162/2/214>
- The hypothesis upon which EMDR is built is that EMDR's effectiveness stems from its ability to process traumatic memories. Memories are understood broadly as including both mental recollections and physical sensations.

Indications

- PTSD (primary indication)
- Chronic pain
- Borderline Personality Disorder
- Specific Phobias
- Conduct Disorder

PTSD Treatment Algorithms

- The APA Practice Guidelines for PTSD (2009) present these psychotherapies as being effective:
 - CBT (primarily Cognitive Restructuring)
 - Exposure Therapy
 - EMDR
 - Trauma-Focused Psychodynamic Therapy.
 - Other measures that should also be considered are: stress inoculation, prolonged exposure, and imagery rehearsal.
- Also, the Dept of Veterans Affairs and the Dept of Defense in their VA/DOD "Clinical Practice

Guideline for the Management of Post Traumatic Stress" state that EMDR is in Category 'A' as strongly recommended for the treatment of post-traumatic stress. The other Category 'A' interventions are Cognitive Therapy, Stress Inoculation Training, and Exposure Therapy.

Interventions

- **Dual Attention:** EMDR achieves its results by forcing the patient to maintain 'dual attention.' Internally, the patient focuses on the traumatic experiences and externally, she focuses on a series of visual, auditory, and tactile sensations that are presented to the patient.
- Specifically, the patient is asked to recall 1. an especially vivid traumatic memory, 2. the associated bodily sensations and emotions, and 3. a negative belief about self WHILE AT THE SAME TIME focusing her attention on the external stimuli presented by the therapist.
- Visual stimuli are lights that move across the patient's field of view (or even just the therapist's finger doing so).
- Auditory stimuli are series of bleeps
- Tactile stimuli are light touches on the patient's hand.
- If you want to see EMDR in action go to this video on YouTube from a news show. http://www.youtube.com/watch?v=LM_nw5N3n-I
- After each presentation of stimuli, which last for about 20-30 seconds, the patient is guided to have her mind go blank and to notice what comes to mind. These 'free associations' are discussed with the therapist. The presentation of stimuli are repeated many times while the patient continues to maintain focus on her chosen traumatic memory (and associated bodily sensations and emotions and self-beliefs). When the patient is able to recall this memory without much stress or anxiety, the therapist then guides the patient to focus on a positive belief that the patient has about herself WHILE AT THE SAME TIME attending to the same presentation of the visual, auditory, and tactile stimuli. This has the effect of decreasing the negative associations and increasing positive ones.

- As therapy proceeds the patient is guided to focus on other distressing memories so that as many traumatic memories and body sensations are processed as possible, thus reducing the number and intensity of triggers for the traumatic event.

Assertive Community Treatment

Indications

ACT is a "service delivery system" that delivers services to clients with the following:

- Most severe level of psychiatric symptoms
- Greatest degree of dysfunction
- For whom less intensive treatment has failed

Main Concepts

- ACT is team based. Each team has 10-12 members and treats about 100 clients.
- Unlike case management services, the ACT team is responsible for providing most of their services directly.
- Most services are provided "in vivo," meaning that team members meet with the client in their homes, work places, and other places in the community.
- ACT team members sometimes meet with homeless clients in shelters or in the street. They may go to the Police Station to meet with a client who has been arrested.
- Team members are available 7 days a week / 24 hours a day to go into the field to intervene in emergencies. They may meet with a client even several times a day if necessary.
- There is no time limit to the services provided. Some clients receive treatment over many years.

Team Members

ACT team members have the following experience:

- psychiatry, including in substance abuse treatment
- social work
- nursing
- housing
- vocational rehab and employment

Services Provided

- Delivery of prescribed medications, including giving injections to those on depot medications
- Performing psychiatric assessments
- Taking of vital signs, performing screening physical exams, drawing blood / obtaining urine for labs
- Transporting clients for medical care
- Providing drug abuse counseling and monitoring sobriety
- Finding housing
- Providing vocational assessments and rehabilitation
- Educating the patient and significant others on illness and treatment
- Providing various problem-solving and life skill training

Client Outcomes

- keep clients out of the hospital
- keep clients in their homes
- help clients achieve and maintain their sobriety
- help clients pursue education or employment
- help clients avoid arrests and other brushes with the law
- help clients reach other personal goals

Types of Housing Available to Persons with Mental Illness

Introduction

- Persons with severe psychiatric disorders are often in need of temporary or permanent housing. Below I outline the various categories of housing that is available.

Populations in Need:

- Those with severe and chronic mental illness including those with primary or comorbid Substance Use Disorders
- Victims of domestic violence – who may or may not have a psychiatric condition.
- Individuals or families who have lost their home related to various adverse financial conditions.

Phases and Types of Housing Programs:

- **Emergency Housing.** Sometimes called Shelters, these emergency housing facilities provide shelter on an acute and short term basis. Short term service may be defined anywhere from one week to two months. Some facilities provide little more than a bed and evening and morning meals. However, at their best Emergency Housing Facilities offer more comprehensive services. They may include
 - Stabilization, that is, the provision of a safe environment, regular meals, clean clothes.
 - Comprehensive needs analysis including the homeless person's social, physical, and housing needs.
 - Development of "Individual Service Plans" in which the client's needs are addressed through direct intervention and appropriate referral.
 - Referrals. Common referrals include referral for medical care, psychiatric care, and social work intervention.
 - Disposition. The homeless individual may be able to return to family, may need to be hospitalized acutely on a psychiatric unit, may enter a Drug Rehabilitation Residential Treatment Program, or may transition to a transitional housing program (discussed below).
- **Transitional Housing.** Individuals or families who have had their immediate needs met and who require more intensive and specialized services to achieve residential and financial stability are candidates for Transitional Housing. The duration of residency in one of these programs is limited to six to nine months, and in some programs to up to one year. The goal here is to transition the person to independent living and, if that cannot be accomplished due to the person's medical, psychiatric, intellectual limitations, to transition the person into a supervised permanent housing program. The services often provided by transitional living facilities include the following.
 - Case management to coordinate all of the following.
 - Psychiatric and substance abuse treatment
 - Domestic violence intervention programs
 - Vocational and educational training
 - Life skill and effectiveness training
 - Job placement services for those eligible
 - Access to entitlement benefits as applicable
 - Day care services may be available in programs geared towards mothers with children
- **Permanent Housing.** Permanent housing options may include Single Room Occupancy (SROs), project-based, scattered-site, market-rate, and subsidized housing. Some permanent housing options are not associated with ongoing case management or supervision while others are associated with ongoing case management programs to help maintain the person at a high level of independent living and self-sufficiency.