Sri Lakshmi Narayana Institute of Medical Sciences

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Date: 02.12.2017

From
DR.V.R Sridhar
Professor and Head,
Department of Psychiatry,
Sri Lakshmi Narayana Institute Of Medical Sciences,
Bharath Institute Of Higher Education And Research,
Chennai.

To
The Dean,
Sri Lakshmi narayana institute of medical sciences,
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Permission to conduct value-added course: Psychotherapy and various techniques

Dear Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: **Psychotherapy and various techniques** on 2/01/2018. We solicit your kind permission for the same.Kind Regards

Dr.V.R. Sridhar

FOR THE USE OF DEANS OFFICE

Names of Committee members for evaluating the course:

The Dean: **Dr. Jayalakshmi**

The HOD: **Dr. Sridhar**

The Expert: **Dr. Arun Seetharaman.**The committee has discussed about the course and is approved.

Dean (Sign & Seal)

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry - 605502.

Subject Expert (Sign & Seal)

Dr. ARUN SEETHARAMAN, MD.,
Reg. No. 91440
Associate Professor, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502

HOD (Sign & Seal)

Dr. V. R. SRIDHAR, MD., D.P.M.,
Reg. No: 30995
Professor & HOD, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.

[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

15.12.2017

Sub: Organising Value-added Course: Psychotherapy and various techniques

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research** is organizing **"Psychotherapy and various techniques"**. The course content and registration form is enclosed below."

The application must reach the institution along with all the necessary documents as mentioned. The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 30 December, 2017. Applications received after the mentioned date shall not be entertained under any circumstances.

Dean

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry - 605502.

Encl: Copy of Course content

Course Proposal

Course Title: **Psychotherapy and various techniques**

Course Objective:

Introduction
Psychoanalysis and Psychoanalytic Psychotherapy
Brief Psychodynamic Psychotherapy
Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama
Family Therapy and Couples Therapy
Dialectical Behavior Therapy
Biofeedback
Cognitive Therapy
Behavior Therapy

Course Outcome:

Course Audience: FINAL YEAR STUDENTS of 2018 Batch
Course Coordinator: Dr.V.R. Sridhar
Course Faculties with Qualification and Designation:
1.Dr.V.R.SRIDHAR, Professor & HOD
2.Dr.Arun, Assistant Professor
Course Curriculum/Topics with schedule (Min of 30 hours)

SlNo	Date	Topic	Resource person	Time	Hours
1.	02.01.2018	Introduction	Dr.Arun	4-5p.m	1
2.	04.01.2018	Psychoanalysis	Dr.Arun	2-3p.m	1
3.	08.01.2018	Psychoanalytic Psychotherapy	Dr.Arun	4-6p.m	2
4.	10.01.2018	Brief Psychodynamic Psychotherapy	Dr.Arun	4-6p.m	2
5.	12.01.2018	Group Psychotherapy	Dr.Arun	4-6p.m	2
6.	16.01.2018	Combined Individual	Dr.Arun	4-5p.m	2
7.	18.01.2018	Group Psychotherapy, and Psychodrama	Dr.Arun	4-5P.M	1
8.	22.01.2018	Family Therapy	Dr.Arun	4-5p.m	1
9.	24.01.2018	Couples Therapy	Dr. Shridhar	4-6p.m	1
10.	26.01.2018	Dialectical Behavior Therapy	Dr.Arun	4-6p.m	2
11.	29.01.2018	Biofeedback	Dr.Arun	4-6p.m	1

12.	31.01.2018	Cognitive Behaviour Therapy	Dr.Arun	4-6p.m	2
13.	02.02.2018	Pre course and Post Course evaluation, Feedback analysis from Likert scale	Dr.Arun	2-5p.m	3
		Practical Class I	Dr. Shridhar		
13.	05.02.2018	Cognitive Therapy	Dr. Shridhar	2-3 PM	1
14.	07.02.2018	Behavior therapy	Dr. Shridhar	2-3 PM	1
15.	09.02.2018	Hypnotherpy	Dr. Shridhar	2-4 PM	2
16.	12.02.2018	Psychodrama	Dr. Shridhar	2-4 PM	2
17.	14.02.2018	Group therapy	Dr. Shridhar	2-4p.m	2
			Total		30 hrs

REFERENCE BOOKS:

- Comprehensive textbook of psychiatry – Kaplan & Saddock
- Oxford Textbook Of Psychiatry
- Synopsis - Kaplan & Saddock

<u>**VALUE ADDED COURSE**</u>

1. Name of the programme & Code

Various Psychological tests and its application in psychiatry & Psychotherapy and various techniques

2. Duration & Period

30 hrs & July– December 2017

3. Information Brochure and Course Content of Value Added Courses

Enclosed as Annexure- I

4. List of students enrolled

Enclosed as Annexure- II

5. Assessment procedures:

Assessment Evolution by MCQ method - *Enclosed as Annexure- III*

6. Certificate model

Enclosed as Annexure- IV

7. No. of times offered during the same year:

1 times July– December 2017

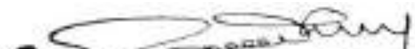
8. Year of discontinuation: 2017

9. Summary report of each program year-wise

Value Added Course- July– December 2017 & January– June 2018					
Sl. No	**Course Code**	**Course Name**	**Resource Persons**	**Target Students**	**Strength & Year**
1	PSYC05	Various Psychological tests and its application in psychiatry	Dr. V.R Sridhar Dr.Arun Seetharaman	Final Year students	15 students July– December 2017

10. Course Feed Back

Enclosed as Annexure- V



RESOURCE PERSON
1. **Dr. V.R Sridhar**
2. **Dr. Arun Seetharaman**

COORDINATOR
Dr. V.R Sridhar

Techniques of psychotherapy

PARTICIPANT HAND BOOK

BIHER SLIMS

COURSE DETAILS

Particulars	**Description**
Course Title	Overview on various psychotherapy techniques
Course Code	PSYC06
Objective	1. Introduction 2. Psychoanalysis and Psychoanalytic Psychotherapy 3.Brief Psychodynamic Psychotherapy 4.Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama 5.Family Therapy and Couples Therapy 6.Dialectical Behavior Therapy 7.Biofeedback 8.Cognitive Therapy 9.Behavior Therapy
Further learning opportunities	Psychotherapy and its techniques
Key Competencies	On successful completion of the course the students will have skill in doing Psychotherapy and its techniques
Target Student	Final year MBBS Students
Duration	30hrs Every January - June 2018
Theory Session	10hrs
Practical Session	20hrs
Assessment Procedure	Multiple choice questions

Psychoanalysis and Psychoanalytic Psychotherapy

As broadly practiced today, psychoanalytic treatment encompasses a wide range of uncovering strategies used in varied degrees and blends.

Despite the inevitable blurring of boundaries in actual application, the original modality of classic psychoanalysis and major modes of psychoanalytic psychotherapy (expressive and supportive) are delineated separately here (Table 28.1-1). Analytical practice in all its complexity resides on a continuum. Individual technique is always a matter of emphasis, as the therapist titrates the treatment according to the needs and capacities of the patient at every moment.

Scope of Psychoanalytic Practice: A Clinical Continuum*a*

Psychoanalysis is virtually synonymous with the renowned name of its founding father, Sigmund Freud (Freud and his theories are discussed in Section 4.1). It is also referred to as “classic” or “orthodox” psychoanalysis to distinguish it from more recent variations known as *psychoanalytic psychotherapy* (discussed below).

Psychoanalysis is based on the theory of sexual repression and traces the unful□lled infantile libidinal wishes in the individual’s unconscious memories. It remains unsurpassed as a method to discover the meaning and motivation of behavior, especially the unconscious elements that inform thoughts and feelings.

PSYCHOANALYSIS

Psychoanalytic Process

The psychoanalytic process involves bringing to the surface repressed memories and feelings by means of a scrupulous unraveling of hidden meanings of verbalized material and of the unwitting ways in which the patient wards o□ underlying con□icts through defensive forgetting and repetition of the past.

The overall process of analysis is one in which unconscious neurotic con□icts are recovered from memory and verbally expressed, reexperienced in the transference, reconstructed by the analyst, and, ultimately, resolved through understanding. Freud referred to these processes as *recollection, repetition,* and *working through,* which make up the totality of remembering, reliving, and gaining insight.

Recollection entails the extension of memory back to early childhood events, a time in the distant past when the core of neurosis was

formed. The actual reconstruction of these events comes through reminiscence, associations, and autobiographical linking of developmental
events. *Repetition* involves more than mere mental recall; it is an emotional replay of former interactions with signi cant individuals in the
patient's life. The replay occurs within the special context of the analyst as projected parent, a fantasized object from the patient's past with
whom the latter unwittingly reproduces forgotten, unresolved feelings and experiences from childhood. Finally, *working through* is both an
a ective and cognitive integration of previously repressed memories that have been brought into consciousness and through which the
patient is gradually set free (cured of neurosis). The analytical course can be subdivided into three major stages (Table 28.1-2).

Table 28.1-2

Stages of Psychoanalysis

Indications and Contraindications

In general, all of the so-called *psychoneuroses* are suitable for psychoanalysis. These include anxiety disorders, obsessional thinking,
compulsive behavior, conversion disorder, sexual dysfunction, depressive states, and many other nonpsychotic conditions, such as personality
disorders. Signi cant su ering must be present so that patients are motivated to make the sacri ces of time and nancial resources required
for psychoanalysis. Patients who enter analysis must have a genuine wish to understand themselves, not a desperate hunger for symptomatic
relief. They must be able to withstand frustration, anxiety, and other strong a ects that emerge in analysis without eeing or acting out their
feelings in a self-destructive manner. They must also have a reasonable, mature superego that allows them to be honest with the analyst.
Intelligence must be at least average, and above all, they must be psychologically minded in the sense that they can think abstractly and
symbolically about the unconscious meanings of their behavior.
Many contraindications for psychoanalysis are the ip side of the indications. The absence of su ering, poor impulse control, inability to
tolerate frustration and anxiety, and low motivation to understand are all contraindications. The presence of extreme dishonesty or antisocial
personality disorder contraindicates analytic treatment. Concrete thinking or the absence of psychological mindedness is another
contraindication. Some patients who might ordinarily be psychologically minded are not suitable for analysis because they are in the midst
of a major upheaval or life crisis, such as a job loss or a divorce. Serious physical illness can also interfere with a person's ability to invest in
a long-term treatment process. Patients of low intelligence generally do not understand the procedure or cooperate in the process. An age

older than 40 years was once considered a contraindication, but today analysts recognize that patients are malleable and analyzable in their 60s or 70s. One final contraindication is a close relationship with the analyst. Analysts should avoid analyzing friends, relatives, or persons with whom they have other involvements.

Goals

Stated in developmental terms, psychoanalysis aims at the gradual removal of amnesias rooted in early childhood based on the assumption that when all gaps in memory have been filled, the morbid condition will cease because the patient no longer needs to repeat or remain fixated to the past. The patient should be better able to relinquish former regressive patterns and to develop new, more adaptive ones, particularly as he or she learns the reasons for his or her behavior. A related goal of psychoanalysis is for the patient to achieve some measure of self-understanding or insight.

Psychoanalytic goals are often considered formidable (e.g., a total personality change), involving the radical reorganization of old developmental patterns based on earlier affects and the entrenched defenses built up against them. Goals may also be elusive, framed as they are in theoretical intrapsychic terms (e.g., greater ego strength) or conceptually ambiguous ones (resolution of the transference neurosis). Criteria for successful psychoanalysis may be largely intangible and subjective and they are best regarded as conceptual endpoints of treatment that must be translated into more realistic and practical terms.

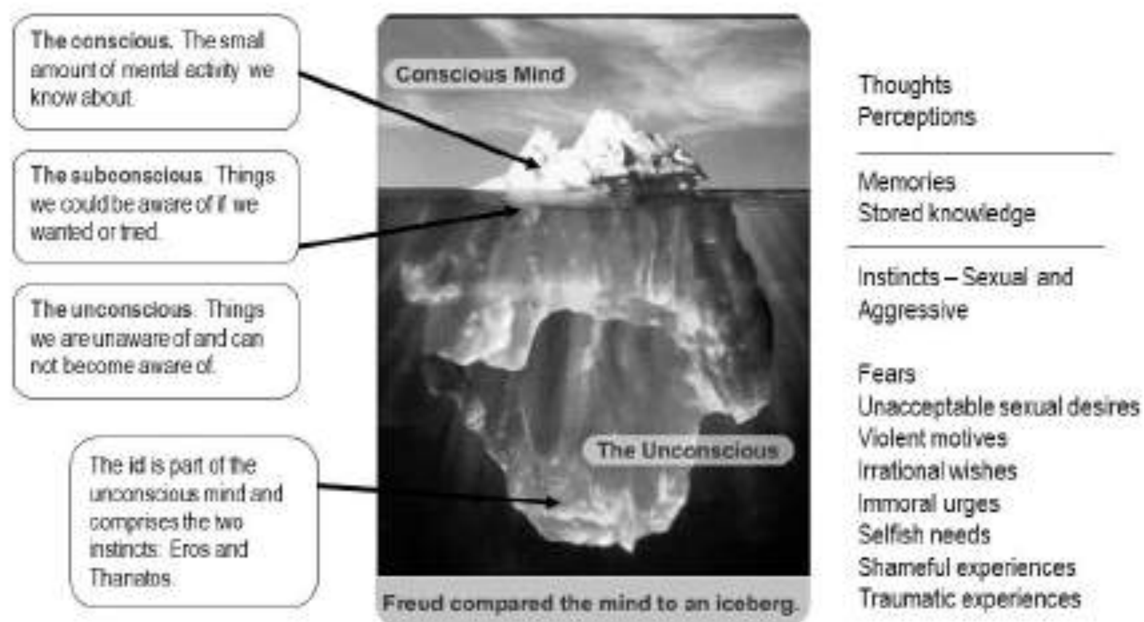
In practice, the goals of psychoanalysis for any patient naturally vary, as do the many manifestations of neuroses. The form that the neurosis takes—unsatisfactory sexual or object relationships, inability to enjoy life, underachievement, and fear of work or academic success, or excessive anxiety, guilt, or depressive ideation—determines the focus of attention and the general direction of treatment, as well as the specific goals. Such goals may change at any time during the course of analysis, especially as many years of treatment may be involved.

Major Approach and Techniques

Structurally, *psychoanalysis* usually refers to individual (dyadic) treatment that is frequent (four or five times per week) and long term (several years). All three features take their precedent from Freud himself.

The dyadic arrangement is a direct function of the Freudian theory of neurosis as an intrapsychic phenomenon, which takes place within the person as instinctual impulses continually seek discharge. Because dynamic conflicts must be internally resolved if structural personality reorganization is to take place, the individual's memory and perceptions of the repressed past are pivotal.

Freud initially saw patients 6 days a week for 1 hour each day, a routine now reduced to four or ve sessions per week of the classic 50-
minute hour, which leaves time for the analyst to take notes and organize relevant thoughts before the next patient. Long intervals between
sessions are avoided so that the momentum gained in uncovering conictual material is not lost and confronted defenses do not have time to
restrengthen.
Freud's belief that successful psychoanalysis always takes a long time because profound changes in the mind occur slowly still holds. The
process can be likened to the uid sense of time that is characteristic of our unconscious processes. Moreover, because psychoanalysis
involves a detailed recapitulation of present and past events, any compromise in time presents the risk of losing pace with the patient's
mental life.



Psychoanalytic Setting. As with other forms of psychotherapy, psychoanalysis takes place in a professional setting, apart from the
realities of everyday life, in which the patient is offered a temporary sanctuary in which to ease psychic pain and reveal intimate thoughts to
an accepting expert. The psychoanalytic environment is designed to promote relaxation and regression. The setting is usually spartan and
sensorially neutral, and external stimuli are minimized.

USE OF THE COUCH. The couch has several clinical advantages that are both real and symbolic:

(1) the reclining position is relaxing because it
is associated with sleep and so eases the patient’s conscious control of thoughts;
(2) it minimizes the intrusive influence of the analyst, thus
curbing unnecessary cues;
(3) it permits the analyst to make observations of the patient without interruption; and
(4) it holds symbolic value
for both parties, a tangible reminder of the Freudian legacy that gives credibility to the analyst’s professional identity, allegiance, and
expertise. The reclining position of the patient with analyst nearby can also generate threat and discomfort, however, as it recalls anxieties
derived from the earlier parent–child configuration that it physically resembles. It may also have personal meanings—for some, a portent of
dangerous impulses or of submission to an authority figure; for others, a relief from confrontation by the analyst (e.g., fear of use of the
couch and overeagerness to lie down may reflect resistance and, thus, need to be analyzed). Although the use of the couch is requisite to
analytical technique, it is not applied automatically; it is introduced gradually and can be suspended whenever additional regression is
unnecessary or counter-therapeutic.

FUNDAMENTAL RULE. The fundamental rule of free association requires patients to tell the analyst everything that comes into their heads—
however disagreeable, unimportant, or nonsensical—and to let themselves go as they would in a conversation that leads from “cabbages to
kings.” It differs decidedly from ordinary conversation—instead of connecting personal remarks with a rational thread, the patient is asked
to reveal those very thoughts and events that are objectionable precisely because of being averse to doing so.
This directive represents an ideal because free association does not arise freely but is guided and inhibited by a variety of conscious and
unconscious forces. The analyst must not only encourage free association through the physical setting and a nonjudgmental attitude toward
the patient’s verbalizations, but also examine those very instances when the ow of associations is diminished or comes to a halt—they are
as important analytically as the content of the associations. The analyst should also be alert to how individual patients use or misuse the
fundamental rule.
Aside from its primary purpose of eliciting recall of deeply hidden early memories, the fundamental rule reects the analytical priority
placed on verbalization, which translates the patient’s thoughts into words so they are not channeled physically or behaviorally. As a direct

concomitant of the fundamental rule, which prohibits action in favor of verbal expression, patients are expected to postpone making major
alterations in their lives, such as marrying or changing careers, until they discuss and analyze them within the context of treatment.

PRINCIPLE OF EVENLY SUSPENDED ATTENTION. As a reciprocal corollary to the rule that patients communicate everything that occurs to them
without criticism or selection, the principle of evenly suspended attention requires the analyst to suspend judgment and to give impartial
attention to every detail equally. The method consists simply of making no effort to concentrate on anything specific, while maintaining a
neutral, quiet attentiveness to all that is said.
ANALYST AS MIRROR. A second principle is the recommendation that the analyst be impenetrable to the patient and, as a mirror, reflect only
what is shown. Analysts are advised to be neutral blank screens and not to bring their own personalities into treatment. This means that they
are not to bring their own values or attitudes into the discussion or to share personal reactions or mutual conflicts with their patients,
although they may sometimes be tempted to do so. The bringing in of reality and external influences can interrupt or bias the patient's
unconscious projections. Neutrality also allows the analyst to accept without censure all forbidden or objectionable responses.
RULE OF ABSTINENCE. The fundamental rule of abstinence does not mean corporal or sexual abstinence, but refers to the frustration of
emotional needs and wishes that the patient may have toward the analyst or part of the transference. It allows the patient's longings to
persist and serve as driving forces for analytical work and motivation to change. Freud advised that the analyst carry through the analytical
treatment in a state of renunciation. The analyst must deny the patient who is longing for love the satisfaction he or she craves.

PSYCHOANALYTIC PSYCHOTHERAPY

Psychoanalytic psychotherapy, which is based on fundamental dynamic formulations and techniques that derive from psychoanalysis, is
designed to broaden its scope. Psychoanalytic psychotherapy, in its narrowest sense, is the use of insight-oriented methods only. As
generically applied today to an ever-larger clinical spectrum, it incorporates a blend of uncovering and suppressive measures.
The strategies of psychoanalytic psychotherapy currently range from expressive (insight-oriented, uncovering, evocative, or interpretive)
techniques to supportive (relationship-oriented, suggestive, suppressive, or repressive) techniques. Although those two types of methods are

sometimes regarded as antithetical, their precise definitions and the distinctions between them are by no means absolute.
The duration of psychoanalytic psychotherapy is generally shorter and more variable than in psychoanalysis. Treatment may be brief, even
with an initially agreed-upon or fixed time limit, or may extend to a less definite number of months or years. Brief treatment is chiefly used
for selected problems or highly focused conflict, whereas longer treatment may be applied for more chronic conditions or for intermittent
episodes that require ongoing attention to deal with pervasive conflict or recurrent decompensation. Unlike psychoanalysis, psychoanalytic
psychotherapy rarely uses the couch; instead, patient and therapist sit face to face. This posture helps to prevent regression because it
encourages the patient to look on the therapist as a real person from whom to receive direct cues, even though transference and fantasy will
continue. The couch is considered unnecessary because the free-association method is rarely used, except when the therapist wishes to gain
access to fantasy material or dreams to enlighten a particular issue.

Expressive Psychotherapy

Indications and Contraindications. Diagnostically, psychoanalytic psychotherapy in its expressive mode is suited to a range of
psychopathology with mild to moderate ego weakening, including neurotic conflicts, symptom complexes, reactive conditions, and the
whole realm of nonpsychotic character disorders, including those disorders of the self that are among the more transient and less profound
on the severity-of-illness spectrum, such as narcissistic behavior disorders and narcissistic personality disorders. It is also one of the
treatments recommended for patients with borderline personality disorders, although special variations may be required to deal with the
associated turbulent personality characteristics, primitive defense mechanisms, tendencies toward regressive episodes, and irrational
attachments to the analyst.

Goals. The overall goals of expressive psychotherapy are to increase the patient's self-awareness and to improve object relations through
exploration of current interpersonal events and perceptions. In contrast to psychoanalysis, major structural changes in ego function and
defenses are modified in light of patient limitations. The aim is to achieve a more limited and, thus, select and focused understanding of
one's problems. Rather than uncovering deeply hidden and past motives and tracing them back to their origins in infancy, the major thrust is
to deal with preconscious or conscious derivatives of conflicts as they became manifest in present interactions. Although insight is sought, it
is less extensive; instead of delving to a genetic level, greater emphasis is on clarifying recent dynamic patterns and maladaptive behaviors in

the present.

Major Approach and Techniques. The major modus operandi involves establishment of a therapeutic alliance and early recognition and interpretation of negative transference. Only limited or controlled regression is encouraged, and positive transference manifestations are generally left unexplored, unless they are impeding therapeutic progress; even here, the emphasis is on shedding light on current dynamic patterns and defenses.

Limitations. A general limitation of expressive psychotherapy, as of psychoanalysis, is the problem of emotional integration of cognitive awareness. The major danger for patients who are at the more disorganized end of the diagnostic spectrum, however, may have less to do with the overintellectualization that is sometimes seen in neurotic patients than with the threat of decompensation from, or acting out of, deep or frequent interpretations that the patient is unable to integrate properly.

Supportive Psychotherapy

Supportive psychotherapy aims at the creation of a therapeutic relationship as a temporary buttress or bridge for the deficient patient. It has roots in virtually every therapy that recognizes the ameliorative effects of emotional support and a stable, caring atmosphere in the management of patients. As a nonspecific attitude toward mental illness, it predates scientific psychiatry, with foundations in 18th-century moral treatment, whereby for the first time patients were treated with understanding and kindness in a humane, interpersonal environment free from mechanical restraints.

Supportive psychotherapy has been the chief form used in the general practice of medicine and rehabilitation, frequently to augment extratherapeutic measures, such as prescriptions of medication to suppress symptoms, rest to remove the patient from excessive stimulation, or hospitalization to provide a structured therapeutic environment, protection, and control of the patient. It can be applied as primary or ancillary treatment. The global perspective of supportive psychotherapy (often part of a combined treatment approach) places major etiological emphasis on external rather than intrapsychic events, particularly on stressful environmental and interpersonal influences on a severely damaged self.

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Goals. The general aim of supportive treatment is the amelioration or relief of symptoms through behavioral or environmental restructuring within the existing psychic framework. This often means helping the patient to adapt better to problems and to live more

comfortably with his or her psychopathology. To restore the disorganized, fragile, or decompensated patient to a state of relative equilibrium, the major goal is to suppress or control symptomatology and to stabilize the patient in a protective and reassuring benign atmosphere that militates against overwhelming external and internal pressures. The ultimate goal is to maximize the integrative or adaptive capacities so that the patient increases the ability to cope, while decreasing vulnerability by reinforcing assets and strengthening defenses.

Major Approach and Techniques. Supportive therapy uses several methods, either singly or in combination, including warm, friendly, strong leadership; partial gratification of dependency needs; support in the ultimate development of legitimate independence; help in developing pleasurable activities (e.g., hobbies); adequate rest and diversion; removal of excessive strain, when possible; hospitalization, when indicated; medication to alleviate symptoms; and guidance and advice in dealing with current issues. This therapy uses techniques to help patients feel secure, accepted, protected, encouraged, safe, and not anxious.

Limitations. To the extent that much supportive therapy is spent on practical, everyday realities and on dealing with the external environment of the patient, it may be viewed as more mundane and superficial than depth approaches. Because those patients are seen intermittently and less frequently, the interpersonal commitment may not be as compelling on the part of either the patient or the therapist.

Greater severity of illness (and possible psychoses) also makes such treatment potentially more erratic, demanding, and frustrating. The need for the therapist to deal with other family members, caretakers, or agencies (auxiliary treatment, hospitalization) can become an additional complication, because the therapist comes to serve as an ombudsman to negotiate with the outside world of the patient and with other professional peers. Finally, the supportive therapist must be able to accept personal limitations and the patient's limited psychological resources and to tolerate the often unrewarded efforts until small gains are made.

CORRECTIVE EMOTIONAL EXPERIENCE. The relationship between therapist and patient gives a therapist an opportunity to display behavior different from the destructive or unproductive behavior of a patient's parent. At times, such experiences seem to neutralize or reverse some effects of the parents' mistakes. If the patient had overly authoritarian parents, the therapist's friendly, flexible, nonjudgmental, nonauthoritarian—but at times firm and limit setting—attitude gives the patient an opportunity to adjust to, be led by, and identify with a new parent figure. Franz Alexander described this process as a corrective emotional experience. It draws on elements of both psychoanalysis

and psychoanalytic psychotherapy.

28.2 Brief Psychodynamic Psychotherapy

The growth of psychotherapy in general and of dynamic psychotherapies derived from the psychoanalytic framework in particular represents a landmark achievement in the history of psychiatry. Brief psychodynamic psychotherapy has gained widespread popularity, partly because of the great pressure on health care professionals to contain treatment costs. It is also easier to evaluate treatment eficacy by comparing groups of persons who have had short-term therapy for mental illness with control groups than it is to measure the results of long-term psychotherapy. Thus, short-term therapies have been the subject of much research, especially on outcome measures, which have found them to be effective. Other short-term methods include interpersonal therapy (discussed in Section 28.10) and cognitive-behavioral therapy (discussed in Section 28.7).

Brief psychodynamic psychotherapy is a time-limited treatment (10 to 12 sessions) that is based on psychoanalysis and psychodynamic theory. It is used to help persons with depression, anxiety, and posttraumatic stress disorder, among others. There are several methods, each having its own treatment technique and specific criteria for selecting patients; however, they are more similar than different.

In 1946, Franz Alexander and Thomas French identified the basic characteristics of brief psychodynamic psychotherapy. They described a therapeutic experience designed to put patients at ease, to manipulate the transference, and to use trial interpretations flexibly. Alexander and French conceived psychotherapy as a corrective emotional experience capable of repairing traumatic events of the past and convincing patients that new ways of thinking, feeling, and behaving are possible. At about the same time, Eric Lindemann established a consultation service at Massachusetts General Hospital in Boston for persons experiencing a crisis. He developed new treatment methods to deal with these situations and eventually applied these techniques to persons who were not in crisis, but who were experiencing various kinds of emotional distress. Since then, the field has been influenced by many workers such as David Malan in England, Peter Sifneos in the United States, and Habib Davanloo in Canada.

TYPES

Brief Focal Psychotherapy (Tavistock–Malan)

Brief focal psychotherapy was originally developed in the 1950s by the Balint team at the Tavistock Clinic in London. Malan, a member of

the team, reported the results of the therapy. Malan's selection criteria for treatment included eliminating absolute contraindications,
rejecting patients for whom certain dangers seemed inevitable, clearly assessing patients' psychopathology, and determining patients'
capacities to consider problems in emotional terms, face disturbing material, respond to interpretations, and endure the stress of the
treatment. Malan found that high motivation invariably correlated with a successful outcome. Contraindications to treatment were serious
suicide attempts, substance dependence, chronic alcohol abuse, incapacitating chronic obsessional symptoms, incapacitating chronic phobic
symptoms, and gross destructive or self-destructive acting out.

Requirements and Techniques. In Malan's routine, therapists should identify the transference early and interpret it and the
negative transference. They should then link the transferences to patients' relationships with their parents. Both patients and therapists
should be willing to become deeply involved and to bear the ensuing tension. Therapists should formulate a circumscribed focus and set a
termination date in advance, and patients should work through grief and anger about termination. An experienced therapist should allow
about 20 sessions as an average length for the therapy; a trainee should allow about 30 sessions. Malan himself did not exceed 40 interviews
with his patients.

Time-Limited Psychotherapy (Boston University–Mann)

A psychotherapeutic model of exactly 12 interviews focusing on a speciﬁed central issue was developed at Boston University by James
Mann and his colleagues in the early 1970s. In contrast with Malan's emphasis on clear-cut selection and rejection criteria, Mann has not
been as explicit about the appropriate candidates for time-limited psychotherapy. Mann considered the major emphases of his theory to be
determining a patient's central conﬂict reasonably correctly and exploring young persons' maturational crises with many psychological and
somatic complaints. Mann's exceptions, similar to his rejection criteria, include persons with major depressive disorder that interferes with
the treatment agreement, those with acute psychotic states, and desperate patients who need, but cannot tolerate, object relations.

Requirements and Techniques. Mann's technical requirements included strict limitation to 12 sessions, positive transference
predominating early, specification and strict adherence to a central issue involving transference, positive identification, making separation a
maturational event for patients, absolute prospect of termination to avoid development of dependence, clarification of present and past
experiences and resistances, active therapists who support and encourage patients, and education of patients through direct information,

reeducation, and manipulation. The conflicts likely to be encountered included independence versus dependence, activity versus passivity,
unresolved or delayed grief, and adequate versus inadequate self-esteem.

Short-Term Dynamic Psychotherapy (McGill University–Davanloo)

As conducted by Davanloo at McGill University, short-term dynamic psychotherapy encompasses nearly all varieties of brief psychotherapy
and crisis intervention. Patients treated in Davanloo's series are classified as those whose psychological conflicts are predominantly oedipal,
those whose conflicts are not oedipal, and those whose conflicts have more than one focus. Davanloo also devised a specific
psychotherapeutic technique for patients with severe, long-standing neurotic problems, specifically those with incapacitating obsessivecompulsive
disorders and phobias.

Davanloo's selection criteria emphasize evaluating those ego functions of primary importance to psychotherapeutic work: the
establishment of a psychotherapeutic focus; the psychodynamic formulation of the patient's psychological problems; the ability to interact
emotionally with evaluators; a history of give-and-take relationships with a significant person in the patient's life; the patient's ability to
experience and tolerate anxiety, guilt, and depression; the patient's motivations for change, psychological mindedness, and an ability to
respond to interpretation and to link evaluators with persons in the present and past. Both Malan and Davanloo emphasized a patient's
responses to interpretation as an important selection and prognostic criterion.

Requirements and Techniques. The highlights of Davanloo's psychotherapeutic approach are flexibility (therapists should adapt
the technique to the patient's needs), control, the patient's regressive tendencies, active intervention to avoid having the patient develop
overdependence on a therapist, and the patient's intellectual insight and emotional experiences in the transference. These emotional
experiences become corrective as a result of the interpretation.

Short-Term Anxiety-Provoking Psychotherapy (Harvard University–Sifneos)

Sifneos developed short-term anxiety-provoking psychotherapy at the Massachusetts General Hospital in Boston during the 1950s. He used
the following criteria for selection: a circumscribed chief complaint (implying a patient's ability to select one of a variety of problems to be
given top priority and the patient's desire to resolve the problem in treatment), one meaningful or give-and-take relationship during early
childhood, the ability to interact flexibly with an evaluator and to express feelings appropriately, above-average psychological sophistication

(implying not only above-average intelligence but also an ability to respond to interpretations), a speci□c psychodynamic formulation
(usually a set of psychological con□icts underlying a patient's dificulties and centering on an oedipal focus), a contract between therapist
and patient to work on the speci□ed focus and the formulation of minimal expectations of outcome, and good to excellent motivation for
change, not just for symptom relief.

Requirements and Techniques. Treatment can be divided into four major phases: patient–therapist encounter, early therapy, height
of treatment, and evidence of change and termination. Therapists use the following techniques during the four phases.

PATIENT–THERAPIST ENCOUNTER. A therapist establishes a working alliance by using the patient's quick rapport with, and positive feelings for,
the therapist that appear in this phase. Judicious use of open-ended and forced-choice questions enables the therapist to outline and
concentrate on a therapeutic focus. The therapist specifies the minimal expectations of outcome to be achieved by the therapy.

EARLY THERAPY. In transference, feelings for the therapist are clarified as soon as they appear, a technique that leads to the establishment of
a true therapeutic alliance.

HEIGHT OF THE TREATMENT. Height of treatment emphasizes active concentration on the oedipal conflicts that have been chosen as the
therapeutic focus; repeated use of anxiety-provoking questions and confrontations; avoidance of pregenital characterological issues, which
the patient uses defensively to avoid dealing with the therapist's anxiety-provoking techniques; avoidance at all costs of a transference
neurosis; repetitive demonstration of the patient's neurotic ways or maladaptive patterns of behavior; concentration on the anxiety-laden
material, even before the defense mechanisms have been clarified; repeated demonstrations of parent-transference links by the use of
properly timed interpretations based on material given by the patient; establishment of a corrective emotional experience; encouragement
and support of the patient, who becomes anxious while struggling to understand the conflicts; new learning and problem-solving patterns;
and repeated presentations and recapitulations of the patient's psychodynamics until the defense mechanisms used in dealing with oedipal
conflicts are understood.

EVIDENCE OF CHANGE AND TERMINATION OF PSYCHOTHERAPY. The final phase of therapy emphasizes the tangible demonstration of change in the
patient's behavior outside therapy, evidence that adaptive patterns of behavior are being used, and initiation of talk about terminating the
treatment.

OVERVIEW AND RESULTS

The shared techniques of all the brief psychotherapies described above outdistance their di�erences. They share the therapeutic alliance or dynamic interaction between therapist and patient, the use of transference, the active interpretation of a therapeutic focus or central issue, the repetitive links between parental and transference issues, and the early termination of therapy.

The outcomes of these brief treatments have been investigated extensively. Contrary to prevailing ideas that the therapeutic factors in psychotherapy are nonspeci�c, controlled studies and other assessment methods (e.g., interviews with unbiased evaluators, patients' selfevaluations) point to the importance of the speci�c techniques used. The capacity for genuine recovery in certain patients is far greater than was thought. A certain type of patient receiving brief psychotherapy can bene�t greatly from a practical working through of his or her nuclear con�ict in the transference. Such patients can be recognized in advance through a process of dynamic interaction, because they are responsive, motivated, and able to face disturbing feelings and because a circumscribed focus can be formulated for them. The more radical the technique in terms of transference, depth of interpretation, and the link to childhood, the more radical the therapeutic e�ects will be.

For some disturbed patients, a carefully chosen partial focus can be therapeutically effective.

Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama

Group psychotherapy is a modality that employs a professionally trained leader who selects, composes, organizes, and leads a collection of members to work together toward the maximal attainment of the goals for each individual in the group and for the group itself. Certain properties present in groups, such as mutual support, can be harnessed in the service of providing relief from psychological suffering and supply peer support to counter isolation experienced by many who seek psychiatric help. Similarly, homogeneously composed small groups are ideal settings for the dissemination of accurate information about a condition shared by group members. Medical illness, substance abuse, and chronic and persistent severe psychiatric conditions, including schizophrenia and major affective disorders, are cases in point.

A widely accepted psychiatric treatment modality, group psychotherapy uses therapeutic forces within the group, constructive interactions among members, and interventions of a trained leader to change the maladaptive behaviors, thoughts, and feelings of emotionally distressed

individuals. In an era of increasingly stringent nancial constraints, decreasing emphasis on individual psychotherapies, and expanding use
of psychopharmacological approaches, more patients have been treated with group psychotherapy than with any other form of verbal
therapy. Group therapy is applicable to inpatient and outpatient settings, institutional work, partial hospitalization units, halfway houses,
community settings, and private practice. Group psychotherapy is also widely used by those who are not mental health professionals in the
adjuvant treatment of physical disorders. The principles of group psychotherapy have also been applied with success in the elds of
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therapist and help one another eect personality change. By using a variety of technical maneuvers and theoretical constructs, the leader
directs group members' interactions to bring about changes.

CLASSIFICATION

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group members; behavioral group therapy, which relies on conditioning techniques based on learning theory; Gestalt group therapy, which
was created from the theories of Frederick Perls, enables patients to abreact and express themselves fully; and client-centered group
psychotherapy, which was developed by Carl Rogers and is based on the nonjudgmental expression of feelings among group members.

Comparison of Types of Group Psychotherapy

PATIENT SELECTION

To determine a patient's suitability for group psychotherapy, a therapist needs a great deal of information, which is gathered in a screening
interview. The psychiatrist should take a psychiatric history and perform a mental status examination to obtain certain dynamic, behavioral,
and diagnostic information.

Therapist's Role in Group Therapy

Authority Anxiety

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may do well in group therapy because they are more comfortable in a group and more likely to do better in a group than in a dyadic (oneto-
one) setting. Patients with a great deal of authority anxiety may be blocked, anxious, resistant, and unwilling to verbalize thoughts and

feelings in an individual setting, generally for fear of the therapist's censure or disapproval. Thus, they may welcome the suggestion of group psychotherapy to avoid the scrutiny of the dyadic situation. Conversely, if a patient reacts negatively to the suggestion of group psychotherapy or openly resists the idea, the therapist should consider the possibility that the patient has high peer anxiety.

Peer Anxiety

Patients with conditions such as borderline and schizoid personality disorders who have destructive relationships with their peer groups or who have been extremely isolated from peer group contact generally react negatively or anxiously when placed in a group setting. When such patients can work through their anxiety, however, group therapy can be beneficial.

Robert entered therapy seeking to understand why he was unable to maintain close or lasting relationships. A handsome and successful businessman, he had made a painful and courageous transition away from self-centered, dysfunctional parents early in his life. Although he made good initial impressions in his jobs, he was always puzzled and disappointed when his superiors gradually lost interest in him and his colleagues avoided him. In one-on-one therapy, he was charming and entertaining, but was easily injured by perceived narcissistic slights and would become angry and attacking. Group psychotherapy was suggested when his transference feelings remained intense and therapy was at a seeming impasse. Initially, Robert charmed the group and strove to be the center of attention. Visibly annoyed whenever he felt the group leader was paying more attention to other members, Robert was especially critical and hostile toward older people in the group and displayed little empathy for others. After repeated and forceful confrontations from the group about his antagonistic behavior, he gradually realized that he was repeating childhood patterns in his family of desperately seeking the attention of unloving parents and then entering violent rages when they lost interest. (Courtesy of Normund Wong, M.D.)

Diagnosis

The diagnosis of patients' disorders is important in determining the best therapeutic approach and in evaluating patients' motivations for treatment, capacities for change, and personality structure strengths and weaknesses. Few contraindications exist to group therapy. Antisocial patients generally do poorly in a heterogeneous group setting because they cannot adhere to group standards; but if the group is composed of other antisocial patients, they may respond better to peers than to perceived authority figures. Depressed patients profit from group

therapy after they have established a trusting relationship with the therapist. Patients who are actively suicidal or severely depressed should
not be treated solely in a group setting. Patients who are manic are disruptive but, once under pharmacological control, do well in the
group setting. Patients who are delusional and who may incorporate the group into their delusional system should be excluded, as should
patients who pose a physical threat to other members because of uncontrollable aggressive outbursts.

PREPARATION

Patients prepared by a therapist for a group experience tend to continue in treatment longer and report less initial anxiety than those who
are not prepared. The preparation consists of having a therapist explain the procedure in as much detail as possible and answer the
patient's questions before the first session.

STRUCTURAL ORGANIZATION

some of the critical tasks that a group therapist must face when organizing a group.

Size

Group therapy has been successful with as few as 3 members and as many as 15, but most therapists consider 8 to 10 members the optimal
size. Interaction may be insuficient with fewer members unless they are especially verbal, and with more than 10 members, the interaction
may be too great for the members or the therapist to follow.

Frequency and Length of Sessions

Most group psychotherapists conduct group sessions once a week. Maintaining continuity in sessions is important. When there are alternate
sessions, the group meets twice a week, once with and once without the therapist. Group sessions generally last anywhere from 1 to 2 hours,
but the time limit should be constant.

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the group meets continuously for 12 to 72 hours. Enforced interactional proximity and, during the longest time-extended sessions, sleep
deprivation break down certain ego defenses, release a□ective processes, and theoretically promote open communication. Time-extended
sessions, however, can be dangerous for patients with weak ego structures, such as persons with schizophrenia or borderline personality
disorder.

Homogeneous versus Heterogeneous Groups

Most therapists believe that groups should be as heterogeneous as possible to ensure maximal interaction. Members with di□erent diagnostic
categories and varied behavioral patterns; from all races, social levels, and educational backgrounds; and of varying ages and both sexes

should be brought together. Patients between the ages of 20 and 65 years can be included effectively in the same group. Age differences help
in developing parent–child and brother–sister models, and patients have the opportunity to relive and rectify interpersonal dificulties that
may have appeared insurmountable.
Both children and adolescents are best treated in groups comprising mostly persons in their own age groups. Some adolescent patients are
capable of assimilating the material of an adult group, regardless of content, but they should not be deprived of a constructive peer
experience that they might otherwise not have.

Open versus Closed Groups

Closed groups have a set number and composition of patients. If members leave, no new members are accepted. In open groups,
membership is more fluid, and new members are taken on whenever old members leave.

MECHANISMS

Group Formation

Each patient approaches group therapy differently and, in this sense, groups are microcosms. Patients use typical adaptive abilities, defense
mechanisms, and ways of relating, and when these tactics are ultimately reflected back to them by the group, they learn to be introspective
about their personality functioning. A process inherent in group formation requires that patients suspend their previous ways of coping. In
entering the group, they allow their executive ego functions—reality testing, adaptation to and mastery of the environment, and perception
—to be assumed, to some degree, by the collective assessment provided by the total membership, including the leader.

Twenty Therapeutic Factors in Group Psychotherapy

ROLE OF THE THERAPIST

Although opinions differ about how active or passive a group therapist should be, the consensus is that the therapist's role is primarily
facilitative. Ideally, the group members themselves are the primary source of cure and change. The climate produced by the therapist's
personality is a potent agent of change. The therapist is more than an expert applying techniques; he or she exerts a personal influence that
taps such variables as empathy, warmth, and respect.

INPATIENT GROUP PSYCHOTHERAPY

Group therapy is an important part of hospitalized patients' therapeutic experiences. Groups can be organized in many ways on a ward. In a
community meeting, an entire inpatient unit meets with all the staff members (e.g., psychiatrists, psychologists, and nurses). In team
meetings, 15 to 20 patients and staff members meet; a regular or small group comprising eight to ten patients may meet with one or two

therapists, as in traditional group therapy. Although the goals of each group vary, they all have common purposes: to increase patients'
awareness of themselves through their interactions with the other group members, who provide feedback about their behavior; to provide
patients with improved interpersonal and social skills; to help the members adapt to an inpatient setting; and to improve communication
between patients and sta. In addition, one type of group meeting is attended only by inpatient hospital sta and is meant to improve
communication among the sta members and to provide mutual support and encouragement in their day-to-day work with patients.
Community meetings and team meetings are more helpful for dealing with patient treatment problems than they are for providing insightoriented
therapy, which is the province of the small-group therapy meeting.

Group Composition

Two key factors of inpatient groups common to all short-term therapies are the heterogeneity of the members and the rapid turnover of
patients. Outside the hospital, therapists have large caseloads from which to select patients for group therapy. On the ward, therapists have a
limited number of patients to choose from and are further restricted to those patients who are both willing to participate and suitable for a
small-group experience. In certain settings, group participation may be mandatory (e.g., in substance abuse and alcohol dependence units),
but mandatory attendance does not usually apply in a general psychiatry unit. In fact, most group experiences are more productive when the
patients themselves choose to enter them.
More sessions are preferable to fewer. During patients' hospital stays, groups may meet daily to allow interactional continuity and the
carryover of themes from one session to the next. A new member of a group can be brought up to date quickly, either by the therapist in an
orientation meeting or by one of the members. A newly admitted patient has often learned many details about the small-group program
from another patient before actually attending the rst session. The less frequently the group sessions are held, the greater the need for a
therapist to structure the group and be active in it.

Inpatient versus Outpatient Groups

Although the therapeutic factors that account for change in small inpatient groups are similar to those in the outpatient settings, there are
qualitative dierences. For example, the relatively high turnover of patients in inpatient groups complicates the process of cohesion. But the
fact that all the group members are together in the hospital aids cohesion, as do the therapists' eorts to foster the process. Sharing of
information, universalization, and catharsis are the main therapeutic factors at work in inpatient groups. Although insight more likely occurs

in outpatient groups because of their long-term nature, some patients can obtain a new understanding of their psychological makeup within
the con�nes of a single group session. A unique quality of inpatient groups is the patients’ extragroup contacts, which are extensive because
they live together on the same ward. Verbalizing their thoughts and feelings about such contacts in the therapy sessions encourages
interpersonal learning. In addition, conflicts between patients or between patients and staff members can be anticipated and resolved.
Twelve former psychiatric inpatients who attended the monthly medication clinic would meet for 1 hour before their individual
appointments with the psychiatrist to review their current social situation and medications. All had been treated by the same ward doctor
and had known one another while on the inpatient service. The psychiatrist who performed the medication reviews also served as the
group leader. Periodically, he was assisted by a sta� member who was also familiar with the patients. Co�ee was available, and the
patients often brought pastries from home. The patients socialized with one another during the hour and frequently exchanged helpful
ideas and tips about job opportunities. Those without cars shared rides with other members. The group was open ended and well
attended. Most of the patients were single and had a long history of psychotic illness. For most, this meeting was their only opportunity
to socialize and be among peers. Frequently, on learning that a member had been rehospitalized, many in the group would visit their
colleague on the ward. (Courtesy of Normund Wong, M.D.)

SELF-HELP

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Inpatient versus Outpatient Groups

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SELF-HELP GROUPS

Self-help groups comprise persons who are trying to cope with a specific problem or life crisis and are usually organized with a particular task in mind. Such groups do not attempt to explore individual psychodynamics in great depth or to change personality functioning significantly, but self-help groups have improved the emotional health and well-being of many persons.

A distinguishing characteristic of the self-help groups is their homogeneity. The members have the same disorders and share their experiences—good and bad, successful and unsuccessful—with one another. By so doing, they educate one another, provide mutual support, and alleviate the sense of alienation usually felt by persons drawn to this kind of group.

Self-help groups emphasize cohesion, which is exceptionally strong in these groups. Because the group members have similar problems and symptoms, they develop a strong emotional bond. Each group may have its unique characteristics, to which the members can attribute magical qualities of healing. Examples of self-help groups are Alcoholics Anonymous (AA), Gamblers Anonymous (GA), and Overeaters Anonymous (OA).

The self-help group movement is presently in ascendancy. These groups meet their members’ needs by providing acceptance, mutual
support, and help in overcoming maladaptive patterns of behavior or states of feeling that traditional mental health and medical
professionals have not generally dealt with successfully. Self-help groups and therapy groups have begun to converge. Self-help groups have
enabled their members to give up patterns of unwanted behavior; therapy groups have helped their members understand why and how they
got to be the way they were or are.

COMBINED INDIVIDUAL AND GROUP PSYCHOTHERAPY

In combined individual and group psychotherapy, patients see a therapist individually and also take part in group sessions. The therapist for
the group and individual sessions is usually the same person. Groups can vary in size from 3 to 15 members, but the most helpful size is 8 to
10. Patients must attend all group sessions. Attendance at individual sessions is also important, and failure to attend either group or
individual sessions should be examined as part of the therapeutic process.
Combined therapy is a particular treatment modality, not a system by which individual therapy is augmented by an occasional group
session or a group therapy in which a participant meets alone with a therapist from time to time. Rather, it is an ongoing plan in which
meaningful integration of the group experience with the individual sessions yields reciprocal feedback to help form an integrated
therapeutic experience. Although the one-to-one doctor–patient relationship makes a deep examination of the transference reaction possible
for some patients, it may not provide other patients with the corrective emotional experiences necessary for therapeutic change. The group
gives patients a variety of persons with whom they can have transferential reactions. In the microcosm of the group, patients can relive and
work through familial and other important influences.

Techniques

Di�ering techniques based on varying theoretical frameworks have been used in the combined therapy format. Some clinicians increase the
frequency of individual sessions to encourage the emergence of the transference neurosis. In the behavioral model, individual sessions are
scheduled regularly, but they tend to be less frequent than in other approaches. Whether patients use a couch or a chair during individual
sessions depends on a therapist’s orientation. Techniques such as alternate meetings or “after-sessions” without the therapist present may be
used. A combined therapy approach called *structured interactional group psychotherapy* has a di�erent group member as the focus of each
weekly group session who is discussed in depth by the other members.

Results

Most workers in the field believe that combined therapy has the advantages of both dyadic and group settings, without sacrificing the qualities of either. Generally, the dropout rate in combined therapy is lower than that in group therapy alone. In many cases, combined therapy appears to bring problems to the surface and to resolve them more quickly than might be possible with either method alone.

PSYCHODRAMA

Psychodrama is a method of group psychotherapy originated by the Viennese-born psychiatrist Jacob Moreno in which personality makeup, interpersonal relationships, conflicts, and emotional problems are explored by means of special dramatic methods. Therapeutic dramatization of emotional problems includes the protagonist or patient, the person who acts out problems with the help of auxiliary egos, persons who enact varying aspects of the patient, and the director, psychodramatist, or therapist, the person who guides those in the drama toward the acquisition of insight.

Roles

Director. The director is the leader or therapist and so must be an active participant. He or she has a catalytic function by encouraging the members of the group to be spontaneous. The director must also be available to meet the group's needs without superimposing his or her values. Of all the group psychotherapies, psychodrama requires the most participation from the therapist.

Protagonist. The protagonist is the patient in conflict. The patient chooses the situation to portray in the dramatic scene, or the therapist chooses it if the patient so desires.

Auxiliary Ego. An auxiliary ego is another group member who represents something or someone in the protagonist's experience. The auxiliary egos help account for the great range of therapeutic effects available in psychodrama.

Group. The members of the psychodrama and the audience make up the group. Some are participants, and others are observers, but all benefit from the experience to the extent that they can identify with the ongoing events. The concept of spontaneity in psychodrama refers to the ability of each member of the group, especially the protagonist, to experience the thoughts and feelings of the moment and to communicate emotion as authentically as possible.

Techniques

The psychodrama can focus on any special area of functioning (a dream, a family, or a community situation), a symbolic role, an unconscious attitude, or an imagined future situation. Such symptoms as delusions and hallucinations can also be acted out in the group.

Techniques to advance the therapeutic process and to increase productivity and creativity include the soliloquy (a recital of overt and hidden
thoughts and feelings), role reversal (the exchange of the patient's role for the role of a signi□cant person), the double (an auxiliary ego
acting as the patient), the multiple double (several egos acting as the patient did on varying occasions), and the mirror technique (an ego
imitating the patient and speaking for him or her). Other techniques include the use of hypnosis and psychoactive drugs to modify the acting
behavior in various ways.

ETHICAL AND LEGAL ISSUES

Confidentiality

Except where disclosure is required by law, the group therapist legally and ethically gives information about the group members to others
only after obtaining appropriate patient consent. The therapist is obligated to take appropriate steps to be responsible to society, as well as
to patients, when patients pose a danger to themselves or to others. The guidelines for ethics of the American Group Psychotherapy
Association state that therapists must obtain speci□c permission to confer with the referring therapist or with the individual therapist when
the patient is in conjoint therapy.

Although the group members, as well as the therapist, should protect the identity of the members and maintain con□dentiality, the group
members are not legally bound to do so. During the preparation of patients for group psychotherapy, therapists should routinely instruct the
prospective members to keep all material discussed in the group con□dential. Theoretically, in a legal case, one member of a group can be
asked to testify against another, but such a situation has not yet occurred.

A therapist must exercise clinical judgment and caution in placing a patient in a group if he or she thinks that the burdens of maintaining
secrets will be too great for some potential members or if a prospective group patient harbors a secret of such magnitude or notoriety that
membership in a group would not be wise.

Violence and Aggression

Although reports of violence and aggression are rare, the potential exists that a group member may physically attack another patient or a
therapist. The attack may occur within the group or outside the group. The likelihood of such an event can be diminished through the
careful selection of group members. Patients with a demonstrated history of assaultive behavior and psychotic patients who pose a potential
for violence should not be placed in a group. In institutional settings, in which group therapy is commonly practiced, suficient safeguards
must be in place to discourage any physical danger to others—for example, guards or attendants can act as observers.

Sexual Behavior

For therapists, sexual intercourse with a patient or a former patient is unethical; in many states, such behavior is considered a criminal act.

The issue is complicated in group psychotherapy, however, because members may engage in sexual activities with one another. The issues of pregnancy, rape, and the transmission of acquired immunodeficiency syndrome (AIDS) by group members are open questions. If a patient is injured as a result of sexual activity by group members, the therapist could be held accountable for not preventing such behavior. The therapist should advise prospective group members that each patient is responsible for reporting any sexual contact between members. The therapist cannot anticipate every group sexual encounter or prevent sexual relationships from developing, but he or she is obligated to provide patients with guidelines of acceptable behavior. The therapist should identify sexual, vulnerable, or exploitive patients in the selection and preparation of patients for the group. Sociopathic patients who sexually exploit others should be informed that such behavior is explicitly not acceptable in the group and that such behavior should be verbalized rather than acted out. The group must be conducted in such a way that the therapist does not encourage or tacitly allow sexual activity. Patients with AIDS are encouraged to reveal that they harbor the virus. To protect members if sexual relationships occur, some therapists do not accept patients with AIDS into a group unless they agree to reveal their condition. In those situations, the therapist discusses the issue of AIDS with the patient and the group into which the patient is to be placed.

28.4 Family Therapy and Couples Therapy

FAMILY THERAPY

The family is the foundation on which most societies are built. The study of families in different cultures has been a subject of fascination and scientific interest from viewpoints as diverse as sociology, group dynamics, anthropology, ethnicity, race, evolutionary biology, and, of course, the mental health field. The confluence of information gleaned from family studies has set the backdrop against which the contemporary practice of family therapy has evolved.

Family therapy can be defined as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and the functioning of individual members of the family. Both family therapy and couple therapy aim at some change in relational functioning. In most cases, they also aim at some other change, typically in the functioning of specific individuals in the family. Family therapy meant to heal a rift between parents and their

adult children is an example of the use of family therapy centered on relationship goals. Family therapy aimed at increasing the family's
coping with schizophrenia and at reducing the family's expressed emotion is an example of family therapy aimed at individual goals (in this
case, the functioning of the person with schizophrenia), as well as family goals. In the early years of family therapy, change in the family
system was seen as being suficient to produce individual change. More recent treatments aimed at change in individuals, as well as in the
family system, tend to supplement the interventions that focus on interpersonal relationships with specific strategies that focus on individual
behavior.

Indications

The presence of a relational dificulty is a clear indication for family and couple therapy. Couples and family therapies are the only
treatments that have been shown to be eficacious for such problems as marital maladjustment, and other methods, such as individual
therapy, have been shown to often have deleterious effects in these situations. Couples and family therapy has also been demonstrated to
have a clear and important role in the treatment of numerous specific psychiatric disorders, often as a component within a multimethod
treatment.

Of course, as with any therapy, the indications for family and couple therapy are broad and vary from case to case. Family therapy is a
therapeutic collage of ideas regarding the underpinnings of family and individual stability and change, psychopathology, and problems in
living, as well as relational ethics. Family therapy might better be called *systemically sensitive therapy* and, in this sense, reflects a basic
worldview as much as a clinical treatment methodology. For therapists thus inclined, then, all clinical problems involve salient interactional
components; thus, some kind of family (or other functionally significant other's) involvement in therapy is always called for, even in
treatment that emphasizes individual problems.

An impressive array now exists of common clinical disorders and problems, including child, adolescent, and adult disorders, for which
research has demonstrated family or couple treatment methods to be effective. In a few instances, couple and family interventions are
probably even the treatment of choice, and for several disorders, the research argues for family intervention to be an essential part of
treatment.

Techniques

Initial Consultation. Family therapy is familiar enough to the general public for families with a high level of conflict to request it

specifically. When the initial complaint is about an individual family member, however, pretreatment work may be needed. Underlying
resistance to a family approach typically includes fears by parents that they will be blamed for their child's difficulties, that the entire family
will be pronounced sick, that a spouse will object, and that open discussion of one child's misbehavior will have a negative influence on
siblings. Refusal by an adolescent or young adult patient to participate in family therapy is frequently a disguised collusion with the fears of
one or both parents.

Interview Technique. The special quality of a family interview springs from two important facts. A family comes to treatment with
its history and dynamics firmly in place. To a family therapist, the established nature of the group, more than the symptoms, constitutes the
clinical problem. Family members usually live together and, at some level, depend on one another for their physical and emotional wellbeing.
Whatever transpires in the therapy session is known to all. Central principles of technique also derive from these facts. For example,
the therapist must carefully channel the catharsis of anger by one family member toward another. The person who is the object of the anger
will react to the attack, and the anger may escalate into violence and fracture relationships, with one or more member withdrawing from
therapy. For another example, free association is inappropriate in family therapy because it can encourage one person to dominate a
session. Thus, therapists must always control and direct the family interview.

Rationale for Family-Life Chronology

Frequency and Length of Treatment. Unless an emergency arises, sessions are usually held no more than once a week. Each
session, however, may require as much as 2 hours. Long sessions can include an intermission to give the therapist time to organize the
material and plan a response. A flexible schedule is necessary when geography or personal circumstances make it physically difficult for the
family to get together. The length of treatment depends both on the nature of the problem and on the therapeutic model. Therapists who
use problem-solving models exclusively may accomplish their goals in a few sessions, whereas therapists using growth-oriented models may
work with a family for years and may schedule sessions at long intervals.

Criteria for Treatment Termination

Models of Intervention

Many models of family therapy exist, none of which is superior to the others. The particular model used depends on the training received,
the context in which therapy occurs, and the personality of the therapist.

Psychodynamic-Experiential Models. Psychodynamic-experiential models emphasize individual maturation in the context of the

family system and are free from unconscious patterns of anxiety and projection rooted in the past. Therapists seek to establish an intimate bond with each family member, and sessions alternate between the therapist's exchanges with the members and the members' exchanges with one another. Clarity of communication and honestly admitted feelings are given high priority. Toward this end, family members may be encouraged to change their seats, to touch each other, and to make direct eye contact. Their use of metaphor, body language, and parapraxes helps reveal the unconscious pattern of family relationships. The therapist may also use family sculpting, in which family members physically arrange one another in tableaus depicting their personal view of relationships, past or present. The therapist both interprets the living sculpture and modifies it in a way to suggest new relationships. In addition, the therapist's subjective responses to the family are given great importance. At appropriate moments, the therapist expresses these responses to the family to form yet another feedback loop of self-observation and change.

Bowen Model. Murray Bowen called his model *family systems,* but in the family therapy field it rightfully carries the name of its originator. The hallmark of the Bowen model is persons' differentiation from their family of origin, their ability to be their true selves in the face of familial or other pressures that threaten the loss of love or social position. Problem families are assessed on two levels: the degree of their enmeshment versus the degree of their ability to differentiate and the analysis of emotional triangles in the problem for which they seek help.

An emotional triangle is defined as a three-party system (and many of these can exist within a family) arranged so that the closeness of two members expressed as either love or repetitive conflict tends to exclude a third. When the excluded third person attempts to join with one of the other two or when one of the involved parties shifts in the direction of the excluded one, emotional cross-currents are activated.

The therapist's role is, first, to stabilize or shift the "hot" triangle—the one producing the presenting symptoms—and, second, to work with the most psychologically available family members, individually if necessary, to achieve suficient personal differentiation so that the hot triangle does not recur. To preserve his or her neutrality in the family's triangles, the therapist minimizes emotional contact with family members.

Bowen also originated the *genogram,* a theoretical tool that is a historical survey of the family, going back several generations.

Structural Model. In a structural model, families are viewed as single, interrelated systems assessed in terms of significant alliances

and splits among family members, hierarchy of power (parents in charge of children), clarity and firmness of boundaries between the
generations, and family tolerance for one another. The structural model uses concurrent individual and family therapy.
General Systems Model. Based on general systems theory, a general systems model holds that families are systems and that every
action in a family produces a reaction in one or more of its members. Families have external boundaries and internal rules. Every member is
presumed to play a role (e.g., spokesperson, persecutor, victim, rescuer, symptom bearer, nurturer), which is relatively stable, but which
member fills each role may change. Some families try to scapegoat one member by blaming him or her for the family's problems (the
identified patient). If the identified patient improves, another family member may become the scapegoat. The general systems model
overlaps with some of the other models presented, particularly the Bowen and structural models.

Modifications of Techniques

Family Group Therapy. Family group therapy combines several families into a single group. Families share mutual problems and
compare their interactions with those of the other families in the group. Treatment of schizophrenia has been effective in multiple family
groups. Parents of disturbed children may also meet together to share their situations.
Social Network Therapy. In social network therapy, the social community or network of a disturbed patient meets in group sessions
with the patient. The network includes those with whom the patient comes into contact in daily life, not only the immediate family but also
relatives, friends, tradespersons, teachers, and coworkers.
Paradoxical Therapy. With the paradoxical therapy approach, which evolved from the work of Gregory Bateson, a therapist suggests
that the patient intentionally engage in the unwanted behavior (called the paradoxical injunction) and, for example, avoid a phobic object
or perform a compulsive ritual. Although paradoxical therapy and the use of paradoxical injunctions seem to be counterintuitive, the
therapy can create new insights for some patients. It is used in individual therapy as well as in family therapy.
Reframing. Reframing, also known as *positive connotation,* is a relabeling of all negatively expressed feelings or behavior as positive.
When the therapist attempts to get family members to view behavior from a new frame of reference, "This child is impossible" becomes
"This child is desperately trying to distract and protect you from what he or she perceives as an unhappy marriage." Reframing is an

important process that allows family members to view themselves in new ways that can produce change.

Goals

Family therapy has several goals: to resolve or reduce pathogenic conflict and anxiety within the matrix of interpersonal relationships; to
enhance the perception and fulfillment by family members of one another's emotional needs; to promote appropriate role relationships
between the sexes and generations; to strengthen the capacity of individual members and the family as a whole to cope with destructive
forces inside and outside the surrounding environment; and to influence family identity and values so that members are oriented toward
health and growth. The therapy ultimately aims to integrate families into the large systems of society, extended family, and community
groups and social systems, such as schools, medical facilities, and social, recreational, and welfare agencies.

COUPLES (MARITAL) THERAPY

Couples or marital therapy is a form of psychotherapy designed to psychologically modify the interaction of two persons who are in conflict
with each other over one parameter or a variety of parameters—social, emotional, sexual, or economic. In couples therapy, a trained person
establishes a therapeutic contract with a patient-couple and, through definite types of communication, attempts to alleviate the disturbance,
to reverse or change maladaptive patterns of behavior, and to encourage personality growth and development.

Marriage counseling may be considered more limited in scope than marriage therapy: Only a particular familial conflict is discussed, and
the counseling is primarily task oriented, geared to solving a specific problem, such as child rearing. Marriage therapy, by contrast,
emphasizes restructuring a couple's interaction and sometimes explores the psychodynamics of each partner. Both therapy and counseling
stress helping marital partners cope effectively with their problems. Most important is the definition of appropriate and realistic goals,
which may involve extensive reconstruction of the union or problem-solving approaches or a combination of both.

Types of Therapies

Individual Therapy. In individual therapy, the partners may consult different therapists, who do not necessarily communicate with
each other and indeed may not even know each other. The goal of treatment is to strengthen each partner's adaptive capacities. At times,
only one of the partners is in treatment; and, in such cases, it is often helpful for the person who is not in treatment to visit the therapist.

The visiting partner may give the therapist data about the patient that may otherwise be overlooked; overt or covert anxiety in the visiting

partner as a result of change in the patient can be identified and dealt with; irrational beliefs about treatment events can be corrected; and
conscious or unconscious attempts by the partner to sabotage the patient's treatment can be examined.
Individual Couples Therapy. In individual couples therapy, each partner is in therapy, which is either concurrent, with the same
therapist, or collaborative, with each partner seeing a different therapist.
Conjoint Therapy. In conjoint therapy, the most common treatment method in couples therapy, either one or two therapists treat the
partners in joint sessions. Co-therapy with therapists of both sexes prevents a particular patient from feeling ganged up on when confronted
by two members of the opposite sex.
Four-Way Session. In a four-way session, each partner is seen by a different therapist, with regular joint sessions in which all four
persons participate. A variation of the four-way session is the roundtable interview, developed by William Masters and Virginia Johnson for
the rapid treatment of sexually dysfunctional couples. Two patients and two opposite-sex therapists meet regularly.
Group Psychotherapy. Group therapy for couples allows a variety of group dynamics to affect the participants. Groups usually
consist of three to four couples and one or two therapists. The couples identify with one another and recognize that others have similar
problems; each gains support and empathy from fellow group members of the same or

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is the psychosocial treatment that has received the most empirical support for patients with borderline
personality disorder. Put simply, the overarching goal of DBT is to help create a life worth living for patients who often su er tremendously
from chronic and pervasive problems across many areas of their lives. DBT is a type of psychotherapy that was originally developed for
chronically self-injurious patients with borderline personality disorder and parasuicidal behavior. In recent years, its use has extended to
other forms of mental illness. The method is eclectic, drawing on concepts derived from supportive, cognitive, and behavioral therapies.
Some elements can be traced to Franz Alexander's view of therapy as a corrective emotional experience and other elements from certain
Eastern philosophical schools (e.g., Zen).
Patients are seen weekly, with the goal of improving interpersonal skills and decreasing self-destructive behavior using techniques
involving advice, metaphor, storytelling, and confrontation, among others. Patients with borderline personality disorder especially are
helped to deal with the ambivalent feelings that are characteristic of the disorder. Marsha Linehan, Ph.D., developed the treatment method,
based on her theory that such patients cannot identify emotional experiences and cannot tolerate frustration or rejection. As with other
behavioral approaches, DBT assumes all behavior (including thoughts and feelings) is learned and that patients with borderline personality
disorder behave in ways that reinforce or even reward their behavior, regardless of how maladaptive it is.

FUNCTIONS OF DBT

As described by its originator, there are ve essential "functions" in treatment: (1) to enhance and expand the patient's repertoire of skillful
behavioral patterns; (2) to improve patient motivation to change by reducing reinforcement of maladaptive behavior, including
dysfunctional cognition and emotion; (3) to ensure that new behavioral patterns generalize from the therapeutic to the natural environment;
(4) to structure the environment so that e ective behaviors, rather than dysfunctional behaviors, are reinforced; and (5) to enhance the
motivation and capabilities of the therapist so that e ective treatment is rendered. Figure 28.5-1 illustrates how DBT breaks the cycle of
problem behavior being used to avoid emotional distress.

FIGURE 28.5-1

How dialectical behavior therapy (DBT) works.

The four modes of treatment in DBT are as follows: (1) group skills training, (2) individual therapy, (3) phone consultations, and (4)
consultation team. These are described below. Other ancillary treatments used are pharmacotherapy and hospitalization, when needed.

Group Skills Training

In group format, patients learn speci c behavioral, emotional, cognitive, and interpersonal skills. Unlike traditional group therapy,
observations about others in the group are discouraged. Rather, a didactic approach, using speci c exercises taken from a skills training
manual, is used, many of which are geared toward control emotional dysregulation and impulsive behavior.

Individual Therapy

Sessions in DBT are held weekly, generally for 50 to 60 minutes, in which skills learned during group training are reviewed and life events
from the previous week are examined. Particular attention is paid to episodes of pathological behavioral patterns that could have been
corrected if learned skills had been put into e ect. Patients are encouraged to record their thoughts, feelings, and behaviors on diary cards,
which are analyzed in the session.

Telephone Consultation

Therapists are available for phone consultation 24 hours per day. Patients are encouraged to call when they feel themselves heading toward
some crisis that might lead to injurious behavior to themselves or others. Calls are intended to be brief and usually last about 10 minutes.

Consultation Team

Therapists meet in weekly meetings to review their work with their patients. By doing so, they provide support for one another and
maintain motivation in their work. The meetings enable them to compare techniques used and to validate those that are most e ective
(Table 28.5-1).

Table 28.5-1

Consultation Team Agreements in Dialectical Behavior Therapy

RESULTS

Several studies evaluating the e ect of DBT for patients with borderline personality disorder found that such therapy was positive. Patients
had a low dropout rate from treatment; the incidence of parasuicidal behaviors declined; self-report of angry a ect decreased; and social
adjustment and work performance improved. The method is now being applied to other disorders, including substance abuse, eating
disorders, schizophrenia, and posttraumatic stress disorder.

28.6 Biofeedback

Biofeedback involves the recording and display of small changes in the physiological levels of the feedback parameter. The display can be
visual, such as a big meter or a bar of lights, or auditory. Patients are instructed to change the levels of the parameter, using the feedback
from the display as a guide. Biofeedback is based on the idea that the autonomic nervous system can come under voluntary control through

operant conditioning. Biofeedback can be used by itself or in combination with relaxation. For example, patients with urinary incontinence use biofeedback alone to regain control over the pelvic musculature. Biofeedback is also used in the rehabilitation of neurological disorders.

The benefits of biofeedback may be augmented by the relaxation that patients are trained to facilitate.

THEORY

Neal Miller demonstrated the medical potential of biofeedback by showing that the normally involuntary autonomic nervous system can be operantly conditioned by use of appropriate feedback. By means of instruments, patients acquire information about the status of involuntary biological functions, such as skin temperature and electrical conductivity, muscle tension, blood pressure, heart rate, and brain wave activity.

Patients then learn to regulate one or more of these biological states that affect symptoms. For example, a person can learn to raise the temperature of his or her hands to reduce the frequency of migraines, palpitations, or angina pectoris. Presumably, patients lower the sympathetic activation and voluntarily self-regulate arterial smooth muscle vasoconstrictive tendencies.

METHODS

Instrumentation

The feedback instrument used depends on the patient and the specific problem. The most effective instruments are the electromyogram (EMG), which measures the electrical potentials of muscle fibers; the electroencephalogram (EEG), which measures alpha waves that occur in relaxed states; the galvanic skin response (GSR) gauge, which shows decreased skin conductivity during a relaxed state; and the thermistor, which measures skin temperature (which drops during tension because of peripheral vasoconstriction). Patients are attached to one of the instruments that measures a physiological function and translates the measurement into an audible or visual signal that patients use to gauge their responses. For example, in the treatment of bruxism, an EMG is attached to the masseter muscle. The EMG emits a high tone when the muscle is contracted and a low tone when at rest. Patients can learn to alter the tone to indicate relaxation. Patients receive feedback about the masseter muscle, the tone reinforces the learning, and the condition ameliorates—all of these events interacting synergistically.

Many less-specific clinical applications (e.g., treating insomnia, dysmenorrhea, and speech problems; improving athletic performance; treating volitional disorders; achieving altered states of consciousness; managing stress; and supplementing psychotherapy for treating anxiety associated with somatic symptom and related disorders) use a model in which frontalis muscle EMG biofeedback is combined with

thermal biofeedback and verbal instructions in progressive relaxation. Table 28.6-1 outlines some important clinical applications of
biofeedback and shows that a wide variety of biofeedback modalities have been used to treat numerous conditions.

Table 28.6-1

Biofeedback Applications

Relaxation Therapy

Muscle relaxation is used as a component of treatment programs (e.g., systematic desensitization) or as treatment in its own right (relaxation
therapy). Relaxation is characterized by (1) immobility of the body, (2) control over the focus of attention, (3) low muscle tone, and (4)
cultivation of a specific frame of mind, described as contemplative, nonjudgmental, detached, or mindful.

Progressive relaxation was developed by Edmund Jacobson in 1929. Jacobson observed that when an individual lies "relaxed," in the
ordinary sense, the following clinical signs reveal the presence of residual tension: respiration is slightly irregular in time or force; the pulse
rate, although often normal, is in some instances moderately increased as compared with later tests; voluntary or local re□ex activities are
revealed in such slight marks as wrinkling of the forehead, frowning, movements of the eyeballs frequent or rapid winking, restless shifting
of the head, a limb, or even a finger; and finally, the mind continues to be active, and once started, worry or oppressive emotion will persist.

It is amazing that a faint degree of tension can be responsible for all of this.

Learning relaxation, therefore, involves cultivating a muscle sense. To develop the muscle sense further, patients are taught to isolate and
contract speci□c muscles or muscle groups, one at a time. For example, patients □ex the forearm while the therapist holds it back to observe
tenseness in the biceps muscle. (Jacobson used the word "tenseness" rather than "tension" to emphasize the patient's role in tensing the
muscles.) Once this sensation is reported, Jacobson would say, "This is your doing! What we wish is the reverse of this—simply not doing."

Patients are repeatedly reminded that relaxation involves no e□ort. In fact "making an e□ort is being tense and therefore is not to relax." As
the session progresses, patients are instructed to let go further and further, even past the point when the body part seems perfectly relaxed.

Patients would work in this fashion with di□erent muscle groups, often over more than 50 sessions. For example, an entire session might
be devoted to relaxing the biceps muscle. Another feature of Jacobson's method was that instructions were given tersely so they would not
interfere with a patient's focus on muscle sensations; suggestions commonly used today (e.g., "*Your arm is becoming limp*") were avoided.

Patients were also frequently left alone, while the therapist attended to other patients.
In psychiatry, relaxation therapy is mainly used as a component of multifaceted broad-spectrum programs. Its use in desensitization was
mentioned previously. Relaxing breathing exercises are often helpful for patients with panic disorder, especially when considered to be
related to hyperventilation. In the treatment of patients with anxiety disorders, relaxation can serve as an occasion-setting stimulus (i.e., as a
context of safety in which other specific intervention can be confidently tried).
Later Adaptation of Progressive Muscular Relaxation
Joseph Wolpe chose progressive relaxation as a response incompatible with anxiety when designing his systematic desensitization treatment
(discussed below). For this purpose, Jacobson's original method was too lengthy to be practical. Wolpe abbreviated the program to 20
minutes during the first six sessions (devoting the remainder of these sessions to other things, such as behavioral analysis). In a later
modification of progressive relaxation, patients completed work with all the principal muscle groups in one session. The specific muscle
groups and instructions for this type of progressive relaxation are listed in Table 28.6-2. Once patients have mastered this procedure
(typically after three sessions), these groups are combined into larger groups. Finally, patients practice relaxation by recall (i.e., without
tensing the muscles).
Table 28.6-2
Outline of Initial Progressive Relaxation Session, All Muscle Groups
Autogenic Training
Autogenic training is a method of self-suggestion that originated in Germany. It involves the patients directing their attention to specific
bodily areas and hearing themselves think certain phrases reflecting a relaxed state. In the original German version, patients progressed
through six themes over many sessions. The six areas are listed in Table 28.6-3 along with representative autogenic phrases. Autogenic
relaxation is an American modification of autogenic training, in which all six areas are covered in one session.
Table 28.6-3
Sample Autogenic Phrases
Applied Tension
Applied tension is a technique that is the opposite of relaxation; applied tension can be used to counteract the fainting response. The
treatment extends over four sessions. In the first session, patients learn to tense the muscles of the arms, legs, and torso for 10 to 15 seconds
(as if they were bodybuilders). The tension is maintained long enough for a sensation of warmth to develop in the face. The patients then

release the tension, but do not progress to a state of relaxation. The maneuver is repeated five times at half-minute intervals. This method
can be augmented with feedback of the patient's blood pressure during the muscle contraction; increased blood pressure suggests that
appropriate muscle tension was achieved. The patients continue to practice the technique five times a day. An adverse effect of treatment
that sometimes develops is headache. In this case, the intensity of the muscle contraction and the frequency of treatment are reduced.
Patients with blood and injury phobia show a unique, biphasic response when exposed to a phobic stimulus. The first phase is associated
with increased heart rate and blood pressure. In the second phase, however, blood pressure suddenly falls and the patient faints. To treat the
problem, patients are shown a series of slides that are provocative (e.g., mutilated bodies). They are coached in identifying early warning
signs of fainting, such as queasiness, cold sweats, or dizziness, and in applying the learned muscle tension response quickly, contingent on
these warning signs. Patients can also perform applied tension while donating blood or watching a surgical operation. The technique of
isometric tension raises blood pressure, which prevents fainting.

Applied Relaxation

Applied relaxation involves eliciting a relaxation response in the stressful situation itself. The previous discussion showed that this is not
advisable right away because of the possible ironic effects of relaxation. Therefore, patients should first practice relaxation in nonstressful
circumstances. The method developed by Lars-Göran Öst and coworkers in Sweden has been proven eficacious for panic disorder and
generalized anxiety disorder. Establishing the relaxation response in the patient's natural environment consists of seven phases of one to two
sessions each: progressive relaxation, release-only relaxation, cue-controlled relaxation, differential relaxation, rapid relaxation, application
training, and maintenance.

RESULTS

Biofeedback, progressive relaxation, and applied tension have been shown to be effective treatment methods for a broad range of disorders.
They form one basis of behavioral medicine in which the patient changes (or learns how to change) behavior that contributes to illness.
They form a basis on which many complementary and alternative medical procedures are effective (e.g., yoga and Reiki) in which relaxation
is an important component. Relaxation also informs more mainstream treatments, such as hypnosis.

28.7 Cognitive Therapy

A central feature of the cognitive theory of emotional disorders is its emphasis on the psychological significance of people's beliefs about

themselves, their personal world (including the people in their lives), and their future—the “cognitive triad.” When people experience
excessive, maladaptive emotional distress, it is linked to their problematic, stereotypic, biased interpretations pertinent to this cognitive triad
of self, world, and future. For example, clinically depressed patients may be prone to believe that they are incapable and helpless and to
view others as being judgmental and critical and the future as being bleak and unrewarding. Similarly, patients with anxiety disorders may
be apt to see themselves as highly vulnerable, others as more capable, and the future as likely to be characterized by personal disasters.
Although the patient’s viewpoints are flawed and dysfunctional, they nonetheless tend to be perpetuated by cognitive processes that
maintain them. Cognitive therapy is a short-term, structured therapy that uses active collaboration between patient and therapist to achieve
its therapeutic goals, which are oriented toward current problems and their resolution. Cognitive therapy is used with depression, panic
disorder, obsessive-compulsive disorder, personality disorders, and somatoform disorders. Therapy is usually conducted on an individual
basis, although group methods are sometimes helpful. A therapist may also prescribe drugs in conjunction with therapy.
The treatment of depression can serve as a paradigm of the cognitive approach. Cognitive therapy assumes that perception and
experiencing, in general, are active processes that involve both inspective and introspective data. The patient’s cognitions represent a
synthesis of internal and external stimuli. The way persons appraise a situation is generally evident in their cognitions (thoughts and visual
images). Those cognitions constitute their stream of consciousness or phenomenal field, which reflects their configuration of themselves,
their world, their past, and their future.
Alterations in the content of their underlying cognitive structures affect their affective state and behavioral pattern. Through psychological
therapy, patients can become aware of their cognitive distortions. Correction of faulty dysfunctional constructs can lead to clinical
improvement.

COGNITIVE THEORY OF DEPRESSION

According to the cognitive theory of depression, cognitive dysfunctions are the core of depression, and affective and physical changes and
other associated features of depression are consequences of cognitive dysfunctions. For example, apathy and low energy result from a
person’s expectation of failure in all areas. Similarly, paralysis of will stems from a person’s pessimism and feelings of hopelessness. From a
cognitive perspective, depression can be explained by the cognitive triad, which explains that negative thoughts are about the self, the

world, and the future.
The goal of therapy is to alleviate depression and to prevent its recurrence by helping patients to identify and test negative cognitions, to
develop alternative and more exible schemas, and to rehearse both new cognitive and behavioral responses. Changing the way a person
thinks can alleviate the psychiatric disorder.

STRATEGIES AND TECHNIQUES

Therapy is relatively short and lasts about 25 weeks. If a patient does not improve in this time, the diagnosis should be reevaluated.
Maintenance therapy can be carried out over years. As with other psychotherapies, therapists' attributes are important to successful therapy.
Therapists must exude warmth, understand the life experience of each patient, and be genuine and honest with themselves and with their
patients. They must be able to relate skillfully and interactively with their patients. Cognitive therapists set the agenda at the beginning of
each session, assign homework to be performed between sessions, and teach new skills. Therapist and patient collaborate actively (Table
28.7-1). The three components of cognitive therapy are didactic aspects, cognitive techniques, and behavioral techniques.

Table 28.7-1

Cognitive Psychotherapy

Didactic Aspects

The therapy's didactic aspects include explaining to patients the cognitive triad, schemas, and faulty logic. Therapists must tell patients that
they will formulate hypotheses together and test them over the course of the treatment. Cognitive therapy requires a full explanation of the
relation between depression and thinking, aect, and behavior, as well as the rationale for all aspects of treatment. This explanation
contrasts with psychoanalytically oriented therapies, which require little explanation.

Cognitive Techniques

The therapy's cognitive approach includes four processes: eliciting automatic thoughts, testing automatic thoughts, identifying maladaptive
underlying assumptions, and testing the validity of maladaptive assumptions.

Eliciting Automatic Thoughts. Automatic thoughts, also called *cognitive distortions,* are cognitions that intervene between external
events and a person's emotional reaction to the event. For example, the belief that "people will laugh at me when they see how badly I
bowl" is an automatic thought that occurs to someone who has been asked to go bowling and responds negatively. Another example is the
thought "She doesn't like me" when someone passes in the hall without saying "Hello." Every psychopathological disorder has its own

specific cognitive profile of distorted thought, which, if known, provides a framework for specific cognitive interventions (Table 28.7-2).

Table 28.7-2

Cognitive Profile of Psychiatric Disorders

Testing Automatic Thoughts. Acting as a teacher, a therapist helps a patient test the validity of automatic thoughts. The goal is to
encourage the patient to reject inaccurate or exaggerated automatic thoughts after careful examination. Patients often blame themselves
when things that are outside their control go awry. The therapist reviews the entire situation with the patient and helps reassign the blame
or cause of the unpleasant events. Generating alternative explanations for events is another way of undermining inaccurate and distorted
automatic thoughts.

Identifying Maladaptive Assumptions. As the patient and therapist continue to identify automatic thoughts, patterns usually
become apparent. The patterns represent rules or maladaptive general assumptions that guide a patient's life. Samples of such rules are "In
order to be happy, I must be perfect" and "If anyone doesn't like me, I'm not lovable." Such rules inevitably lead to disappointments and
failure and, ultimately, to depression (Fig. 28.7-1).

Testing the Validity of Maladaptive Assumptions. Testing the accuracy of maladaptive assumptions is similar to testing the
validity of automatic thoughts. In a particularly effective test, therapists ask patients to defend the validity of their assumptions. For
example, patients may state that they should always work up to their potential, and a therapist may ask "*Why is that so important to you?*"

Table 28.7-3 gives examples of some interventions designed to elicit, identify, test, and correct the cognitive distortions that lead to
depressive and other painful affects.

Table 28.7-3

Cognitive Errors Derived from Assumptions

A woman presented for therapy with anger control problems. She had sent a slew of hostile voicemail and e-mail messages to a
colleague, had alienated her neighbors with her complaints about noise, and had been asked to leave her bowling league after two
physical altercations with members of other teams. A careful review of the patient's thoughts and beliefs surrounding these situations
revealed a common denominator of a sense of *mistrust* and *entitlement.* In each situation, she believed that the persons who were the
objects of her anger had gone out of their way to mistreat her. Furthermore, she had an exaggerated sense of self-importance represented
by beliefs such as, "Nobody has the right to treat me that way," "I shouldn't have to deal with these people and their stupidity," and "I

have to show them they can't ever push me around." To this patient, her anger was justi□ed, as she was trying to defend herself from the
misbehavior of others. However, to the outside observer, the patient was a "loose cannon" who took o□ense at the drop of a hat and
whose behavior was outrageous and indefensible. In therapy, the patient at □rst was not open to viewing her anger problem in the
manner just described. However, as she learned to recognize the activation of her schemas of *mistrust* and *entitlement,* she became more
willing to consider ways in which she could modify her viewpoints and behaviors. This positive change was facilitated by the therapist's
empathic responses to the patient's more credible stories of mistreatment she had received from her family, whose abusive behavior gave
her the message that she should never trust anyone and that she should never put up with being mistreated again. (Courtesy of C. F.
Newman, Ph.D., and A. T. Beck, M.D.)

FIGURE 28.1

Sample automatic thought record.

Behavioral Techniques

Behavioral and cognitive techniques go hand in hand; behavioral techniques test and change maladaptive and inaccurate cognitions. The
overall purposes of such techniques are to help patients understand the inaccuracy of their cognitive assumptions and learn new strategies
and ways of dealing with issues.

Among the behavioral techniques in cognitive therapy are scheduling activities, mastery and pleasure, graded task assignments, cognitive
rehearsal, self-reliance training, role playing, and diversion techniques. One of the □rst things done in therapy is to schedule activities on an
hourly basis. Patients keep records of the activities and review them with the therapist. In addition to scheduling activities, patients are
asked to rate the amount of mastery and pleasure their activities bring them. Patients are often surprised to learn that they have much more
mastery of activities and enjoy them more than they had thought.

To simplify the situation and allow miniaccomplishments, therapists often break tasks into subtasks, as in graded task assignments, to
show patients that they can succeed. In cognitive rehearsal, patients imagine and rehearse the various steps in meeting and mastering a
challenge.

Patients (especially inpatients) are encouraged to become self-reliant by doing such simple things as making their own beds, doing their
own shopping, and preparing their own meals. This process is called self-reliance training. Role playing is a particularly powerful and
useful technique to elicit automatic thoughts and to learn new behaviors. Diversion techniques are useful in helping patients get through

difficult times and include physical activity, social contact, work, play, and visual imagery.
Imagery or thought stoppage can treat impulsive or obsessive behavior. For instance, patients imagine a stop sign with a police oficer
nearby or another image that evokes inhibition at the same time that they recognize an impulse or obsession that is alien to the ego.
Similarly, obesity can be treated by having patients visualize themselves as thin, athletic, trim, and well muscled, and then training them to
evoke this image whenever they have an urge to eat. Hypnosis or autogenic training can enhance such imagery. In a technique called guided
imagery, therapists encourage patients to have fantasies that can be interpreted as wish ful□llments or attempts to master disturbing a□ects
or impulses.

EFFICACY

Cognitive therapy can be used alone in the treatment of mild to moderate depressive disorders or in conjunction with antidepressant
medication for major depressive disorder. Studies have clearly shown that cognitive therapy is e□ective and in some cases is superior or
equal to medication alone. It is one of the most useful psychotherapeutic interventions currently available for depressive disorders, and it
shows promise in the treatment of other disorders.
Cognitive therapy has also been studied as a way of increasing compliance with lithium (Eskalith) prescription by patients with bipolar I
disorder and as an adjunct in treating withdrawal from heroin.

28.8 Behavior Therapy

The term *behavior* in *behavior therapy* refers to a person’s observable actions a**Behavior Therapy**

The term *behavior* in *behavior therapy* refers to a person’s observable actions and responses. Behavior therapy involves changing the
behavior of patients to reduce dysfunction and to improve quality of life. Behavior therapy includes a methodology, referred to as *behavior
analysis,* for the strategic selection of behaviors to change, and a technology to bring about behavior change, such as modifying antecedents
or consequences or giving instructions. Behavior therapy has not only in□uenced mental health care, but, under the rubric of behavioral
medicine, it has also made inroads into other medical specialties.
Behavior therapy represents clinical applications of the principles developed in learning theory. Behavioral psychology, or behaviorism,
arose in the early 20th century in reaction to the method of introspection that dominated psychology at the time. John B. Watson, the father
of behaviorism, had initially studied animal psychology. This background made it a small conceptual leap to argue that psychology should

concern itself only with publicly observable phenomena (i.e., overt behavior). According to behavioristic thinking, because mental content is
not publicly observable, it cannot be subjected to rigorous scienti c inquiry. Consequently, behaviorists developed a focus on overt
behaviors and their environmental influences.
Today, di erent behavioral schools continue to share a focus on veri able behavior. Behavioral views di er from cognitive views in
holding that physical, rather than mental, events control behavior. According to behaviorism, mental phenomena or speculations about them
are of little or no scientific interest.

HISTORY

As early as the 1920s, scattered reports about the application of learning principles to the treatment of behavioral disorders began to
appear, but they had little e ect on the mainstream of psychiatry and clinical psychology. Not until the 1960s did behavior therapy emerge
as a systematic and comprehensive approach to psychiatric (behavioral) disorders; at that time, it arose independently on three continents.
Joseph Wolpe and his colleagues in Johannesburg, South Africa, used Pavlovian techniques to produce and eliminate experimental neuroses
in cats. From this research, Wolpe developed systematic desensitization, the prototype of many current behavioral procedures for the
treatment of maladaptive anxiety produced by identi able stimuli in the environment. At about the same time, a group at the Institute of
Psychiatry of the University of London, particularly Hans Jurgen Eysenck and M. B. Shapiro, stressed the importance of an empirical,
experimental approach to understanding and treating individual patients, using controlled, single-case experimental paradigms and modern
learning theory. The third origin of behavior therapy was work inspired by the research of Harvard psychologist B. F. Skinner. Skinner's
students began to apply his operant-conditioning technology, developed in animal-conditioning laboratories, to human beings in clinical
settings.

SYSTEMATIC DESENSITIZATION

Developed by Wolpe, systematic desensitization is based on the behavioral principle of counterconditioning, whereby a person overcomes
maladaptive anxiety elicited by a situation or an object by approaching the feared situation gradually, in a psychophysiological state that
inhibits anxiety. In systematic desensitization, patients attain a state of complete relaxation and are then exposed to the stimulus that elicits
the anxiety response. The negative reaction of anxiety is inhibited by the relaxed state, a process called *reciprocal inhibition.* Rather than
using actual situations or objects that elicit fear, patients and therapists prepare a graded list or hierarchy of anxiety-provoking scenes

associated with a patient's fears. The learned relaxation state and the anxiety-provoking scenes are systematically paired in treatment. Thus,
systematic desensitization consists of three steps: relaxation training, hierarchy construction, and desensitization of the stimulus.

Relaxation Training

Relaxation produces physiological effects opposite to those of anxiety: slow heart rate, increased peripheral blood flow, and neuromuscular
stability. A variety of relaxation methods have been developed. Some, such as yoga and Zen, have been known for centuries. Most methods
use so-called progressive relaxation, developed by the psychiatrist Edmund Jacobson. Patients relax major muscle groups in a fixed order,
beginning with the small muscle groups of the feet and working cephalad or vice versa. Some clinicians use hypnosis to facilitate relaxation
or use tape-recorded exercise to allow patients to practice relaxation on their own. Mental imagery is a relaxation method in which patients
are instructed to imagine themselves in a place associated with pleasant, relaxed memories. Such images allow patients to enter a relaxed
state or experience (as Herbert Benson termed it) the *relaxation response.*
The physiological changes that take place during relaxation are the opposite of those induced by the adrenergic stress responses that are
part of many emotions. Muscle tension, respiration rate, heart rate, blood pressure, and skin conductance decrease. Finger temperature and
blood flow to the finger usually increase. Relaxation increases respiratory heart rate variability, an index of parasympathetic tone.

Hierarchy Construction

When constructing a hierarchy, clinicians determine all the conditions that elicit anxiety, and then patients create a hierarchy list of 10 to 12
scenes in order of increasing anxiety. For example, an acrophobic hierarchy may begin with a patient's imagining standing near a window
on the second floor and end with being on the roof of a 20-story building, leaning on a guard rail and looking straight down. Table 28.8-1
provides an example of a hierarchy construction for fear of water and heights.

Table 28.8-1

Hierarchy Construction (Least Anxious to Most Anxious): Fear of Water and Heights

Desensitization of the Stimulus

In the final step, called *desensitization,* patients proceed systematically through the list from the least to the most anxiety-provoking scene
while in a deeply relaxed state. The rate at which patients progress through the list is determined by their responses to the stimuli. When
patients can vividly imagine the most anxiety-provoking scene of the hierarchy with equanimity, they experience little anxiety in the
corresponding real-life situation.

Adjunctive Use of Drugs. Clinicians have used various drugs to hasten relaxation, but drugs should be used cautiously and only by
clinicians trained and experienced in potential adverse effects. Either the ultrarapidly acting barbiturate sodium methohexital (Brevital) or
diazepam (Valium) is given intravenously in subanesthetic doses. If the procedural details are followed carefully, almost all patients find the
procedure pleasant, with few unpleasant side effects. The advantages of pharmacological desensitization are that preliminary training in
relaxation can be shortened, almost all patients can relax adequately, and the treatment itself seems to proceed more rapidly than without
the drugs.

Indications. Systematic desensitization works best in cases of a clearly identifiable anxiety-provoking stimulus. Phobias, obsessions,
compulsions, and certain sexual disorders have been treated successfully with this technique.

THERAPEUTIC-GRADED EXPOSURE

Therapeutic-graded exposure is similar to systematic desensitization, except that relaxation training is not involved and treatment is usually
carried out in a real-life context. This means that the individual must be brought in contact with (i.e., be exposed to) the warning stimulus to
learn rsthand that no dangerous consequences will ensue. Exposure is graded according to a hierarchy. Patients afraid of cats, for example,
might progress from looking at a picture of a cat to holding one.

FLOODING

Flooding (sometimes called *implosion*) is similar to graded exposure in that it involves exposing the patient to the feared object in vivo;
however, there is no hierarchy. Flooding is based on the premise that escaping from an anxiety-provoking experience reinforces the anxiety
through conditioning. Thus, clinicians can extinguish the anxiety and prevent the conditioned avoidance behavior by not allowing patients to
escape the situation. Clinicians encourage patients to confront feared situations directly, without a gradual buildup, as in systematic
desensitization or graded exposure. No relaxation exercises are used, as in systematic desensitization. Patients experience fear, which
gradually subsides after a time. The success of the procedure depends on having patients remain in the fear-generating situation until they
are calm and feel a sense of mastery. Prematurely withdrawing from the situation or prematurely terminating the fantasized scene is
equivalent to an escape, which then reinforces both the conditioned anxiety and the avoidance behavior and produces the opposite of the
desired eect. In a variant, called *imaginal flooding,* the feared object or situation is confronted only in the imagination, not in real life. Many

patients refuse ooding because of the psychological discomfort involved. It is also contraindicated when intense anxiety would be
hazardous to a patient (e.g., those with heart disease or fragile psychological adaptation). The technique works best with specic phobias.

PARTICIPANT MODELING

In participant modeling, patients learn a new behavior by imitation, primarily by observation, without having to perform the behavior until
they feel ready. Just as irrational fears can be acquired by learning, they can be unlearned by observing a fearless model confront the feared
object. The technique has been useful with phobic children who are placed with other children of their own age and sex who approach the
feared object or situation. With adults, a therapist may describe the feared activity in a calm manner that a patient can identify. Or, the
therapist may act out the process of mastering the feared activity with a patient. Sometimes a hierarchy of activities is established, with the
least anxiety-provoking activity being dealt with rst. The participant-modeling technique has been used successfully with agoraphobia by
having a therapist accompany a patient into the feared situation. In a variant of the procedure, called *behavior rehearsal,* real-life problems
are acted out under a therapist's observation or direction.

The following is a self-report by a patient with a contamination phobia, who is afraid to touch objects for fear of being infected or
contaminated. She describes her reactions.

[The therapist] started touching everything very slowly. I was told to follow behind and touch everything she touched. It was like we
were spreading the contamination. She touched doorknobs, light switches, walls, pictures, and woodwork. She opened drawers in each
bedroom and touched the contents. She opened closets and touched clothes hanging on the rods. She touched the towels and sheets in the
linen closet. She went through the children's rooms, touching dolls, stuffed animals, models, Star Wars figures, Transformers, and books.

[The therapist] kept talking to me quietly and calmly all the time we went along. I had been anxious when we started, but as we
continued, my anxiety level decreased. At one point, when I had begun to think the worst was over, she pointed to the attic door and said
we were going inside. I said, "No, that's where the mice were." She told me I didn't want to have a place in my home that was o limits.

I agreed but became very anxious. It was very hard for me to go inside. I began touching the boxes too, but I was very upset. Then, she
put her hands down on the floor and wanted me to do the same. I said, "I can't. I just can't." [The therapist] said, "Yes you can."

[The therapist] spent several hours with me that day. Before she left, she made a list of things for me to do by myself. Twice a day I

was to go through the house touching everything the way she had done with me. I was to invite a friend of mine who had a pet to come
and visit and also friends of my children who had pets. (Courtesy of Rolf G. Jacobs, M.D., and William H. Pelham, M.D.)

EXPOSURE TO STIMULI PRESENTED IN VIRTUAL REALITY

Advances in computer technology have made it possible to present environmental cues in virtual reality for exposure treatment. Beneficial
effects have been reported with virtual reality exposure of patients with height phobia, fear of lying, spider phobia, and claustrophobia.
Much experimental work is being done in the field. One model uses an avatar of the patient walking through a crowded supermarket
with other avatars (including one of the therapists) as a way of conquering agoraphobia.

ASSERTIVENESS TRAINING

Assertiveness is defined as assertive behavior that enables a person to act in his or her own best interest, to stand up for herself or himself
without undue anxiety, to express honest feelings comfortably, and to exercise personal rights without denying the rights of others.
Two types of situations frequently call for assertive behaviors: (1) setting limits on pushy friends or relatives and (2) commercial
situations, such as countering a sales pitch or being persistent when returning defective merchandise. Early assertiveness training programs
tended to de□ne speci□c behaviors as assertive or nonassertive. For example, individuals were encouraged to assert themselves if somebody
got in front of them in a supermarket checkout line. Increasing attention is now given to context, that is, what would be assertive behavior
in this situation depends on circumstances.

SOCIAL SKILLS TRAINING

The negative symptoms in patients with schizophrenia constitute behavioral de□cits that go beyond dificulties with assertiveness. These
patients have inadequate expressive behaviors and inappropriate stimulus control of their social behaviors (i.e., they do not pick up social
cues). Similarly, patients with depression often experience a lack of social reinforcement because of a lack of social skills, and social skills
training has been found to be eficacious for depression. Patients with social phobia similarly often have not acquired adolescents' social
skills. In fact, their social defensive behaviors (e.g., avoiding eye contact, making brief statements, and minimizing self-disclosure) increase
the probability of the rejection that they fear.
Social skills training programs for patients with schizophrenia cover skills in the following areas: conversation, conflict management,
assertiveness, community living, friendship and dating, work and vocation, and medication management. Each of these skills has several

components. For example, assertiveness skills include making requests, refusing requests, making complaints, responding to complaints,
expressing unpleasant feelings, asking for information, making apologies, expressing fear, and refusing alcohol and street drugs. Each
component involves specific steps. For example, conflict management includes skills in negotiating, compromising, tactful disagreeing,
responding to untrue accusations, and leaving overly stressful situations. A situation in which conflict management skills might be used is
when the patient and a friend decide to go to a movie and their choice of movie differs.
Negotiating and compromising, for example, involves the following steps:
1. Explain one's viewpoint briefly.
2. Listen to the other person's viewpoint.
3. Repeat the other person's viewpoint.
4. Suggest a compromise.

At his initial appointment, Phillip described very serious symptoms of obsessive-compulsive disorder (OCD). He was 23 years old and
living at home because he was no longer able to work or go to school. His days were consumed with behaviors related to checking,
repeating, and hoarding. Phillip was unable to throw away anything—he saved junk mail, used tissues and napkins, old papers and
magazines, and any kind of receipt for fear that he might lose something important. Phillip spent many hours checking his trash, his car,
and his home to be sure that he had not thrown away anything important. He also checked everything he wrote (e.g., checks, school
exams and papers, letters and e-mails) to be sure that he had not made a mistake, and he read and reread books, magazines, and articles
to be sure he understood the written material adequately. Phillip worried constantly that he had done something wrong and would
disappoint his parents. He was also depressed because he was unable to function well in life, and he had tremendous social anxiety that
had plagued him for many years, making it difficult to make and keep friends.
By the end of Phillip's second session, his therapist was beginning to get a good idea of the general nature and severity of his symptoms
and some of the maintaining factors. However, to plan the treatment in more detail and to get a better idea of how the symptoms
occurred during his daily life, she asked Phillip to keep daily records over the next week using a form that she had prepared for him. The
form had a place for recording the amount of time he spent doing rituals each morning, afternoon, and evening, as well as another place
to record more details about at least one episode of rituals each day (e.g., what was happening before, during, and after the rituals; see

Daily Monitoring of Rituals

AVERSION THERAPY

When a noxious stimulus (punishment) is presented immediately after a speci�c behavioral response, theoretically, the response is
eventually inhibited and extinguished. Many types of noxious stimuli are used: electric shocks, substances that induce vomiting, corporal
punishment, and social disapproval. The negative stimulus is paired with the behavior, which is thereby suppressed. The unwanted behavior
may disappear after a series of such sequences. Aversion therapy has been used for alcohol abuse, paraphilias, and other behaviors with
impulsive or compulsive qualities, but this therapy is controversial for many reasons. For example, punishment does not always lead to the
expected decreased response and can sometimes be positively reinforcing. Aversion therapy has been used with good effect in some cultures
in the treatment of opioid addicts

FIGURE 28.8-1

Treatment of addicts at Tham Krabok Monastery in Thailand results in a 70 percent success rate, according to its records. The 10-day free
treatment begins with a vow to Buddha never to use narcotics again. Then, patients are given an herbal medicine that makes them vomit
immediately. (From White PT, Raymer S. The poppy—for good and evil. *National Geographic.* 1985;167:187, with permission.)

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Saccadic eye movements are rapid oscillations of the eyes that occur when a person tracks an object that is moved back and forth across the
line of vision. A few studies have demonstrated that inducing saccades while a person is imagining or thinking about an anxiety-producing
event can yield a positive thought or image that results in decreased anxiety. Eye movement desensitization and reprocessing has been used
in posttraumatic stress disorders and phobias.

POSITIVE REINFORCEMENT

When a behavioral response is followed by a generally rewarding event, such as food, avoidance of pain, or praise, it tends to be
strengthened and to occur more frequently than before the reward. This principle has been applied in a variety of situations. On inpatient
hospital wards, patients with mental disorders receive a reward for performing a desired behavior, such as tokens that they can use to
purchase luxury items or certain privileges. The process, known as *token economy,* has successfully altered behavior. Table 28.8-3 gives a
summary of some clinical applications of behavior therapy.

Table 28.8-3

Some Common Clinical Applications of Behavior Therapy

Charles was a 70-year-old retired business executive. Throughout his life, his work consumed him. Although he married and had a

family, his job was his primary focus. He went to the office early and came home late. He enjoyed what he did—it was stimulating and
made him feel important and useful. But as he got older, his performance was not what it used to be, and he decided it was time to
retire. However, his mood was pretty low when he no longer had a job. He did not have the energy to get more involved in his church or
to develop other hobbies, so he sat around all day, without any social contacts. His wife and best friend encouraged him to go talk to
someone. The therapist suggested that they try behavioral activation. Charles was somewhat skeptical, as it seemed too simple, but he
needed to do something. The therapist spent some time with Charles talking about the kinds of activities that used to make him feel good
and some of the things he used to enjoy. They then put together a list of things he might be able do—even if he did not feel much like it
—just to see what would happen. The list included looking for volunteer work where he could use his job skills, spending more time
with his wife in some of the activities they once had enjoyed (e.g., watching movies, taking walks), and rejuvenating an old hobby from
his college days—shing. Charles initially agreed to do some easy activities—go to one movie a week, take one walk a week, and contact
his church activity leader about possible volunteer activities. He was surprised to nd that even these "baby steps" helped him feel better.
He had the chance to talk with other people and began to see that even in retirement, he could find useful and fun things to do. (Courtesy
of M. A. Stanley, Ph.D., and D. C. Beidel, Ph.D.)

RESULTS

Behavior therapy has been used successfully for a variety of disorders (Table 28.8-3) and can be easily taught (Table 28.8-4). It requires less
time than other therapies and is less expensive to administer. Although useful for circumscribed behavioral symptoms, the method cannot be
used to treat global areas of dysfunction (e.g., neurotic conflicts, personality disorders). Controversy continues between behaviorists and
psychoanalysts, which is epitomized by Eysenck's statement: "Learning theory regards neurotic symptoms as simply learned habits; there is
no neurosis underlying the symptoms, but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis."
Analytically oriented theorists have criticized behavior therapy by noting that simple symptom removal can lead to symptom substitution:
When symptoms are not viewed as consequences of inner conflicts and the core cause of the symptoms

Psychotherapy and various techniques

Candidate Name		Assessor Name	
Date of Assessment		Assessor Position	

MULTIPLE CHOICE QUESTIONS

Course Code: PSYC06

I. ANSWER ALL THE QUESTIONS

1) Which of the following is not an antidepressant drug?

a) Tricyclic antidepressants.

b) Monoamine oxidase inhibitors (MAOIs).

c) Selective serotonin reuptake inhibitors (SSRIs).

d) Antinoamine tritase rehibitor (ATRs).

Check your answer

2) Anxiolytic drugs are used to treat:

a) The symptoms of depression and mood disorder.

b) The symptoms of anxiety and stress.

c) The symptoms of psychosis and schizophrenia.

d) None of the above.

Check your answer

3) What is a major side effect of Prozac?

a) Loss of sexual desire.

b) Loss of hair.

c) Weight loss.

d) Weight gain.

Check your answer

4) antipsychotics do which of the following?

a) Alleviate Major positive symptoms (such as thought disorder and hallucinations).

b) Alleviate Major negative symptoms (such as social withdrawal).

c) Reducing the burden of institutional care.

d) All of the above.

Check your answer

5) Beck's Cognitive therapy for depression requires the individual to:

a) Make an objective assessment of their beliefs.

b) Keep a dream diary.

c) Keep a mood diary.

d) Set attainable life goals.

Check your answer

6) Behaviour analysis is based upon the principles of:

a) Classical conditioning.

b) Operant conditioning.

c) Dream analysis.

d) All of the above.

Check your answer

7) Behaviour modification is a type of:

a) Behaviour therapy.

b) Cognitive behavioural therapy.

c) Humanistic therapy.

d) Client centred therapy.

Check your answer

8) Drugs called Benzodiazepines are used to treat:

a) Depression.

b) Anxiety disorders.

c) Schizophrenia.

d) Mood disorders

Check your answer

9) Client centred therapy is a type of:

a) Humanistic therapy.

b) Psychodynamic therapy.

c) Cognitive therapy.

d) Behavioural therapy.

Check your answer

10) Which of the following might be considered as the central tenets of Client-Centred Therapy:

a) Empathy.

b) Unconditional positive regard.

c) Congruence.

d) All of the above.

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Psychotherapy and various techniques

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UNIVERSITY REG NO - U14MB313

6/10

MULTIPLE CHOICE QUESTIONS

Course Code: PSYC06

I. **ANSWER ALL THE QUESTIONS**

1) Which of the following is not an antidepressant drug?

a) Tricyclic antidepressants.

b) Monoamine oxidase inhibitors (MAOIs).

c) Selective serotonin reuptake inhibitors (SSRIs).

d) Antinoamine tritase rehibitor (ATRs).

Check your answer

2) Anxiolytic drugs are used to treat:

a) The symptoms of depression and mood disorder.

b) The symptoms of anxiety and stress.

c) The symptoms of psychosis and schizophrenia.

d) None of the above.

Check your answer

3) What is a major side effect of Prozac?

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Psychotherapy and various techniques

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7/10

MULTIPLE CHOICE QUESTIONS

Course Code: PSYC06

I. ANSWER ALL THE QUESTIONS

1) Which of the following is not an antidepressant drug?

a) Tricyclic antidepressants.

b) Monoamine oxidase inhibitors (MAOIs).

c) Selective serotonin reuptake inhibitors (SSRIs).

d) Antinoamine tritase rehibitor (ATRs).

Check your answer

2) Anxiolytic drugs are used to treat:

a) The symptoms of depression and mood disorder.

b) The symptoms of anxiety and stress.

c) The symptoms of psychosis and schizophrenia.

d) None of the above.

Check your answer

3) What is a major side effect of Prozac?

a) Loss of sexual desire.

b) Loss of hair.

c) Weight loss.

d) Weight gain.

Check your answer

4) antipsychotics do which of the following?

a) Alleviate Major positive symptoms (such as thought disorder and hallucinations).

b) Alleviate Major negative symptoms (such as social withdrawal).

c) Reducing the burden of institutional care.

d) All of the above.

Check your answer

5) Beck's Cognitive therapy for depression requires the individual to:

a) Make an objective assessment of their beliefs.

b) Keep a dream diary.

c) Keep a mood diary.

d) Set attainable life goals.

Check your answer

6) Behaviour analysis is based upon the principles of:

a) Classical conditioning.

b) Operant conditioning.

c) Dream analysis.

d) All of the above.

Check your answer

7) Behaviour modification is a type of:

a) Behaviour therapy.

b) Cognitive behavioural therapy.

c) Humanistic therapy.

d) Client centred therapy.

Check your answer

8) Drugs called Benzodiazepines are used to treat:

a) Depression.

b) Anxiety disorders.

c) Schizophrenia.

d) Mood disorders

Check your answer

9) Client centred therapy is a type of:

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- a) Humanistic therapy.
- b) Psychodynamic therapy.
- c) Cognitive therapy.
- d) Behavioural therapy.

Check your answer

10) Which of the following might be considered as the central tenets of Client-Centred Therapy:

- a) Empathy.
- b) Unconditional positive regard.
- c) Congruence.
- d) All of the above.

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SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCE

VALUE ADDED COURSE STUDENT DETAILS

PSYCHOTHERAPY TECHNIQUES FOR FINAL YEAR STUDENTS

S.No	Register No	Students List	Department	Signature
1	U14MB311	SHALINI. T. C.	Psychiatry	
2	U14MB312	SHANMUGA RAJA. A	Psychiatry	
3	U14MB313	SHANMUHA PRIYA. S	Psychiatry	
4	U14MB314	SHAREEFA AKHTAR.S	Psychiatry	
5	U14MB315	SHEMBIYAN. R.M.	Psychiatry	
6	U14MB321	SOWWMYA. S	Psychiatry	
7	U14MB322	SOWMYAMANJA MADHA.I	Psychiatry	
8	U14MB323	SREEDEVI. B	Psychiatry	
9	U14MB324	SREEPADMA PURUJITH. S.S.	Psychiatry	
10	U14MB325	SRI JAYALAKSHMI. A	Psychiatry	
11	U14MB326	SRITATA. S	Psychiatry	
12	U14MB327	SRRUTHII. N.M.	Psychiatry	

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13	U14MB328	SUBRAMANI. B	Psychiatry	B Subramani
14	U14MB329	SUDARSHNA. K	Psychiatry	Sudarshna
15	U14MB330	SUKIRTHA. K	Psychiatry	Sukirtha

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Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research

(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that SREEDEVI. B has actively participated in the Value Added Course on **Psychotherapy and various techniques** held during January - June 2018 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. ARUN SEETHARAMAN

RESOURCE PERSON

Dr. ARUN SEETHARAMAN, MD.,
Reg. No: 91440
Associate Professor, Psychiatry
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Osudu, Kudapakkam, Puducherry 605 502.

Dr. V.R.SRIDHAR

COORDINATOR

Dr. V. R. SRIDHAR, MD.,D.P.M.,
Reg. No: 30995
Professor & HOD, Psychiatry
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Kudapakkam, Puducherry-605 502.

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SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Sri Lakshmi Narayana Institute of Medical Sciences

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CERTIFICATE OF MERIT

This is to certify that SRRUTHII. N.M. has actively participated in the Value Added Course on **Psychotherapy and various techniques** held during January – June 2018 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

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RESOURCE PERSON

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Dr. V.R.SRIDHAR
COORDINATOR

Dr. V. R. SRIDHAR, MD.,D.P.M.,
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SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Student Feedback Form

Course Name: **PSYCHOTHERAPY TECHNIQUES**
Subject Code: **PSYC06**

Name of Student: ____ Roll No.: _______________

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					
2	Course contents met with your expectations					
3	Lecturer sequence was well planned					
4	Lectures were clear and easy to understand					
5	Teaching aids were effective					
6	Instructors encourage interaction and were helpful					
7	The level of the course					
8	Overall rating of the course	1	2	3	4	5

**** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory***

Suggestions if any:

Signature

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Student Feedback Form

Course Name: **PSYCOTHERAPY & TECHNIQUES**

Subject Code: **PSYC06**

Name of Student: SIVARAJ · S Roll No.: U14MB318

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear				✓	
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned				✓	
4	Lectures were clear and easy to understand				✓	
5	Teaching aids were effective				✓	
6	Instructors encourage interaction and were helpful				✓	
7	The level of the course					
8	Overall rating of the course	1	2	3	(4)	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

Signature

Date: 30|6|18

Student Feedback Form

Course Name: **PSYCOTHERAPY & TECHNIQUES**

Subject Code: **PSYC06**

Name of Student: SHALINI ·T· C Roll No.: U14MB311

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					
2	Course contents met with your expectations					
3	Lecturer sequence was well planned					
4	Lectures were clear and easy to understand					
5	Teaching aids were effective					
6	Instructors encourage interaction and were helpful					
7	The level of the course					
8	Overall rating of the course	1	2	3	4	5

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

Shalini
Signature

Date: 30 · 6 · 2018

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

Date: 30-06-2018

From

Dr.V.R.Sridhar
Professor and Head,
Department of Psychiatry,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research,
Chennai.

Through Proper Channel

To

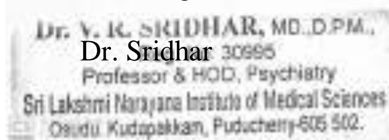
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Completion of value-added course: Psychotherapy and various techniques

Dear Sir,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **Psychotherapy and various techniques**. We solicit your kind action to send certificates for the participants, that is attached with this letter. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards,



Dr. Sridhar

Encl: Certificates

Photographs

SRI LAKSHMI NARAYANA INSTITUE OF HIGHER EDUCATON AND RESEARCH

PSYC06 -Psychotherapy and various techniques JAN –JUN 2018