Supportive Psychotherapy

- Canadian Psychiatry Association, Sept 2017

- Benjamin Fortin-Langelier, MD FRCPC
- Deanna Mercer, MD FRCPC
- Doug Green, MD FRCPC

Objectives

1) Describe the literature on factors linked to effectiveness in all psychotherapy interventions and be able to quickly implement strategies in their practice that have been shown to improve patient outcomes.
2) Describe the literature demonstrating that empathy improves outcomes for patients and reduces physician burnout. Describe ways to maintain and improve empathy in our lives and in clinical practice.
3) Demonstrate the steps involved in using a problem-solving approach in supportive psychotherapy.

Psychotherapy requirements in Canada

Proficiency	Working knowledge	Introductory knowledge
Cognitive Behavioural Therapy	Behavioural Therapy	Brief Dynamic Therapy
Family or Group (and WK of the other)	Family or Group (and Proficiency of the other)	Mindfulness Training
Psychodynamic Therapy	Dialectic Behaviour Therapy	Motivational Interviewing
Supportive Therapy	Interpersonal Therapies (?)	Relaxation

" As a self-regulating profession, it is essential that psychiatrists retain the leadership role in the planning, teaching, and certification of psychotherapy training of psychiatrists."

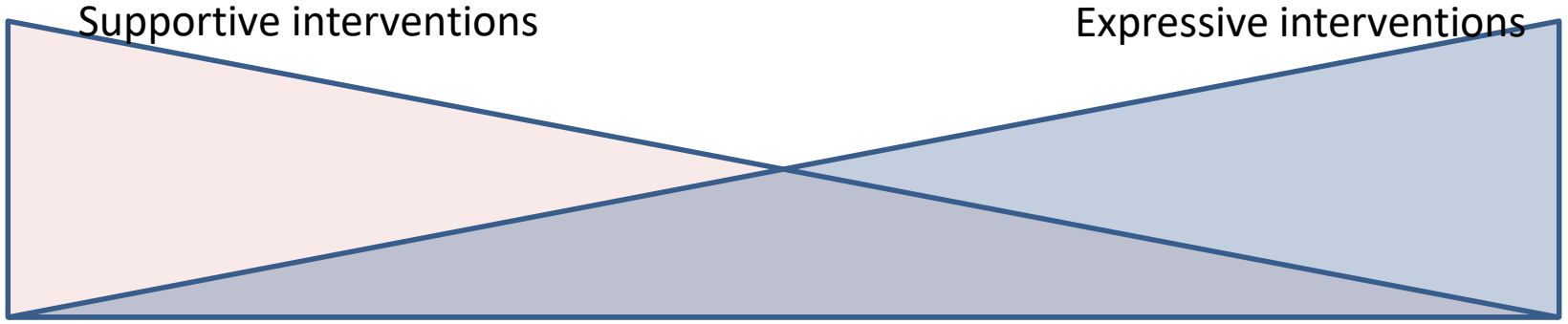
Position Statement of Canadian Psychiatric Association (Chaimovitz, 2011; 2004)

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Objectives of training in psychiatry, royal college of physicians and surgeons of Canada, 2015

What is Supportive Therapy?

Psychodynamic Supportive-Expressive Continuum



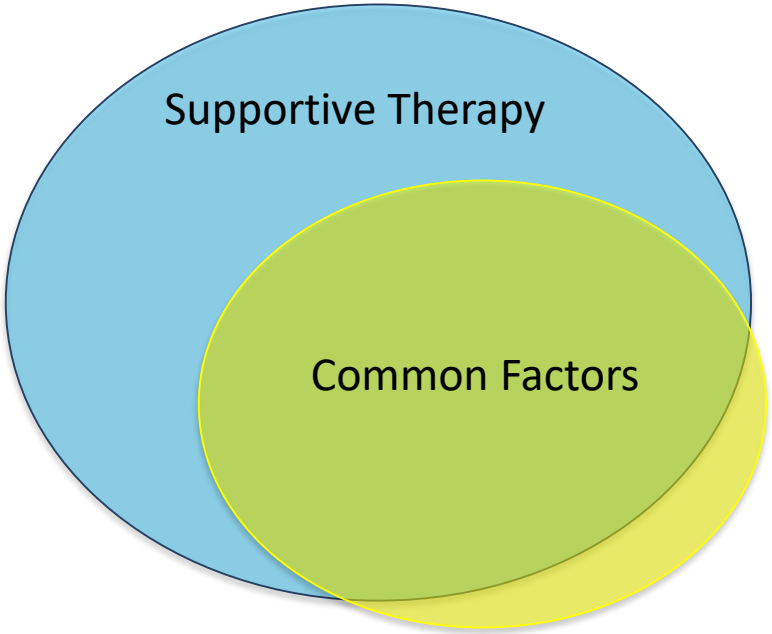
Rogerian conditions for a therapeutic relationship

- Empathy
- Unconditional Positive Regard
- Congruence / Genuineness

The curious paradox is that when I accept myself just as I am, then I can change.

Carl Rogers

Supportive Psychotherapy in Context



<u>Classic iteration of Common factors:</u>

- Therapist effect
- Therapeutic alliance
- Patient factors
- Extra-therapeutic change

<u>Lambert & Ogles (2004):</u>

- Support
- Learning
- Change

University of Ottawa's Supportive Curriculum

- 6 Lectures:
  - Emotion 101
  - Psychotherapy as a whole / Why supportive?
  - The Supportive therapy framework and clinical application
  - Listening and Empathy
  - Change strategies
  - Problem solving therapy, the basics
- 4 Therapy encounters discussed in group supervision
  - Self-reflection package (WAI-T, Listening / Change strategies)
  - Patient feedback package (HAT)

The Supportive Therapy model

Learning:

- New cognitive frame, psychoeducation
- Change in Perception of Self & the Presenting problem
- Insight, corrective emotional experience

Support:

- Forming a relationship of trust
- Encouraging the expression of thoughts and feelings
- Building hope
- Encouragement
- "Development of the therapeutic alliance"

Action:

- "Working through of emotional distress"
  - Accept and Tolerate the feelings that cannot be changed
- Risk taking/experimenting with new behaviour
  - Problem-solving
  - Encouraging healthy behaviours

Joyce 2006, Lambert and Ogles 2004

Case

- 40 year old recently separated male referred by his family physician to Shared Mental Health Team for symptoms of depression and anger
- At the time of the initial assessment he was homeless and living in his car
- Crisis services had been involved by his family physician but he was now refusing their help as he did not trust them
- Sent to ER by his family physician for SI several times but sent home as not thought to be certifiable
- Not fully trusting of his family physician as she was also looking after his wife who he was angry with

History of Presenting Illness

- Long history of neck and shoulder pain after injury at work
- WSIB involved and attempted to retrain him in non-manual work but not successful
- Eventually returned to work but reinjured himself and no source of income
- Gradually became more depressed and began to have more conflict with his wife

History of Presenting Illness (contd.)

- His wife asked him to leave because of his anger
- Began to believe she was trying to poison him
- When seen initially by family medicine his PHQ-9 was very elevated at 25 (severe depression)
- Treated with mirtazapine 45 mg with very little improvement

Impression

- When seen by psychiatry endorsing multiple depressive symptoms as well as delusions
- Threatening suicide but denied being homicidal
- No history of mania, substance abuse and organic w/u was negative
- No past psychiatric history

- Diagnosis: MDD with psychosis

Course of treatment

- Seroquel XR 50 mg was added
- Patient was initially refusing higher doses as feared sedation as was living in his car or a tent and was concerned about his safety if too sedated

What type of psychotherapy would you use?

How Effective is Supportive Therapy?

- There is agreement that supportive therapy is better than waitlist.
- How does it compare to other therapies?
  - Meta-analysis of comparative outcomes studies of psychotherapy for Depression in adults (Cujipers, *et al.,* 2008)
  - N=53 studies
    - CBT (n=38)
    - Supportive (non-directive supportive) (n=20)
    - Behavioral activation (n=15)
    - Psychodynamic therapy (n=10)
    - Problem-Solving therapy (n=7)
    - Interpersonal psychotherapy (n=6)
    - Social skill training (n=5)

- All therapies are effective
- Supportive less effective*: d=-0.13**

How Effective is Supportive Therapy?

- Meta-analysis of Non Directive Supportive Psychotherapy (NDSP):
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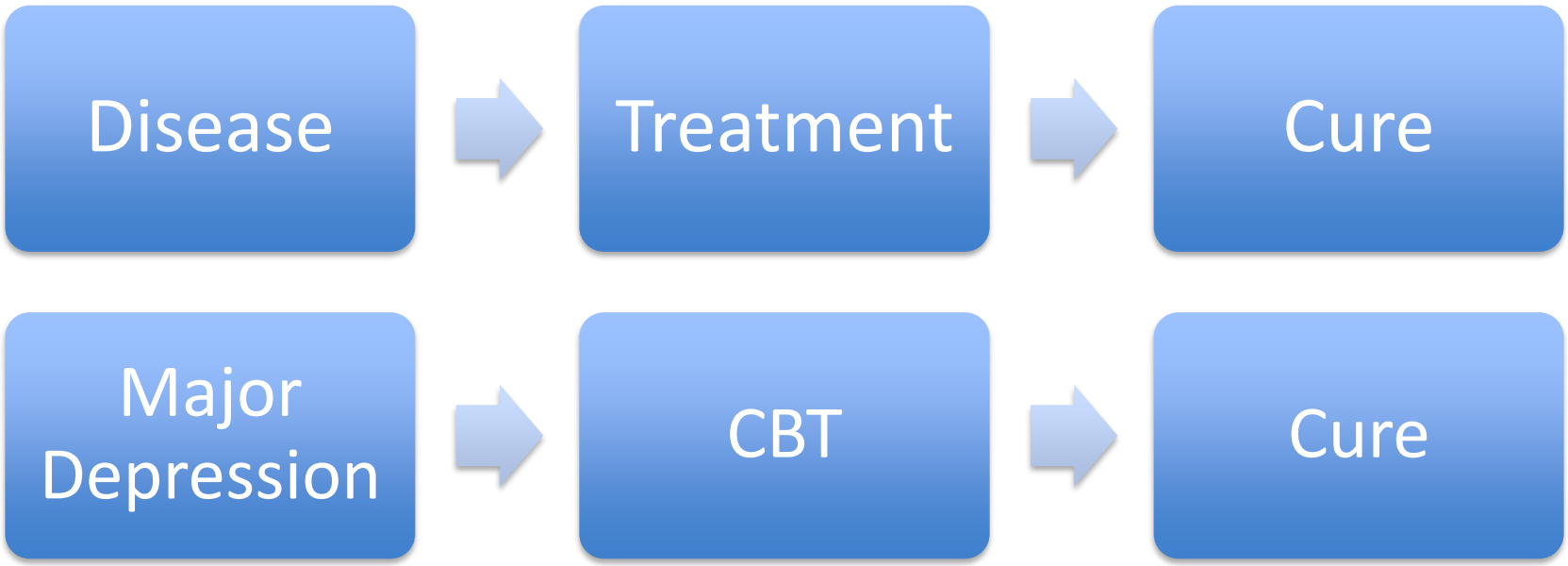
- NDSP vs Waitlist, g=0.58 (95% CI 0.45-0.72)
- NDSP vs other therapies, g=-0.20 (95% CI -0.32 to -0.08)
- Control for researcher allegiance:
  - Allegiance to alternate therapy (n=19) g= -0.35 ***
  - No allegiance (n=11) g= -0.01 (not sig)

Cujipers, 2011

Medical Model of Psychotherapy



Establishing Efficacy of Treatment

HIV+ & Depressive Sx
N=101

IPT N=24	CBT N=27	Supportive N=24	Support & IMI N=24

Intent-to-Treat Sample:				
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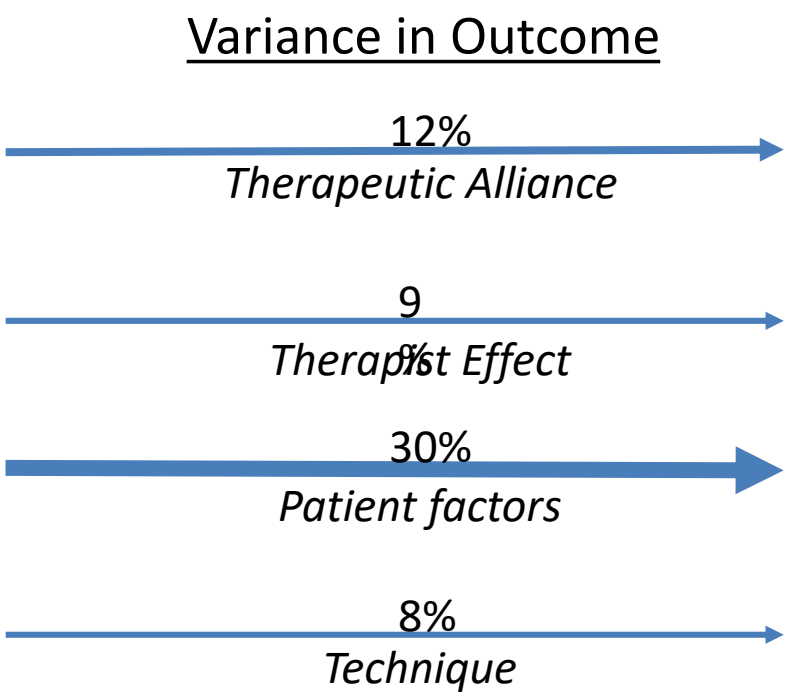
BDI Wk 16 =	14.0 (12.1)	19.8 (10.7)	20.3 (11.0)	11.7 (8.5)
ANCOVA $F_{3.95}$ =4.26; P=.007;SWI>CBT&SP, IPT>SP				

Markowtiz, et al., 1998

Common Factors

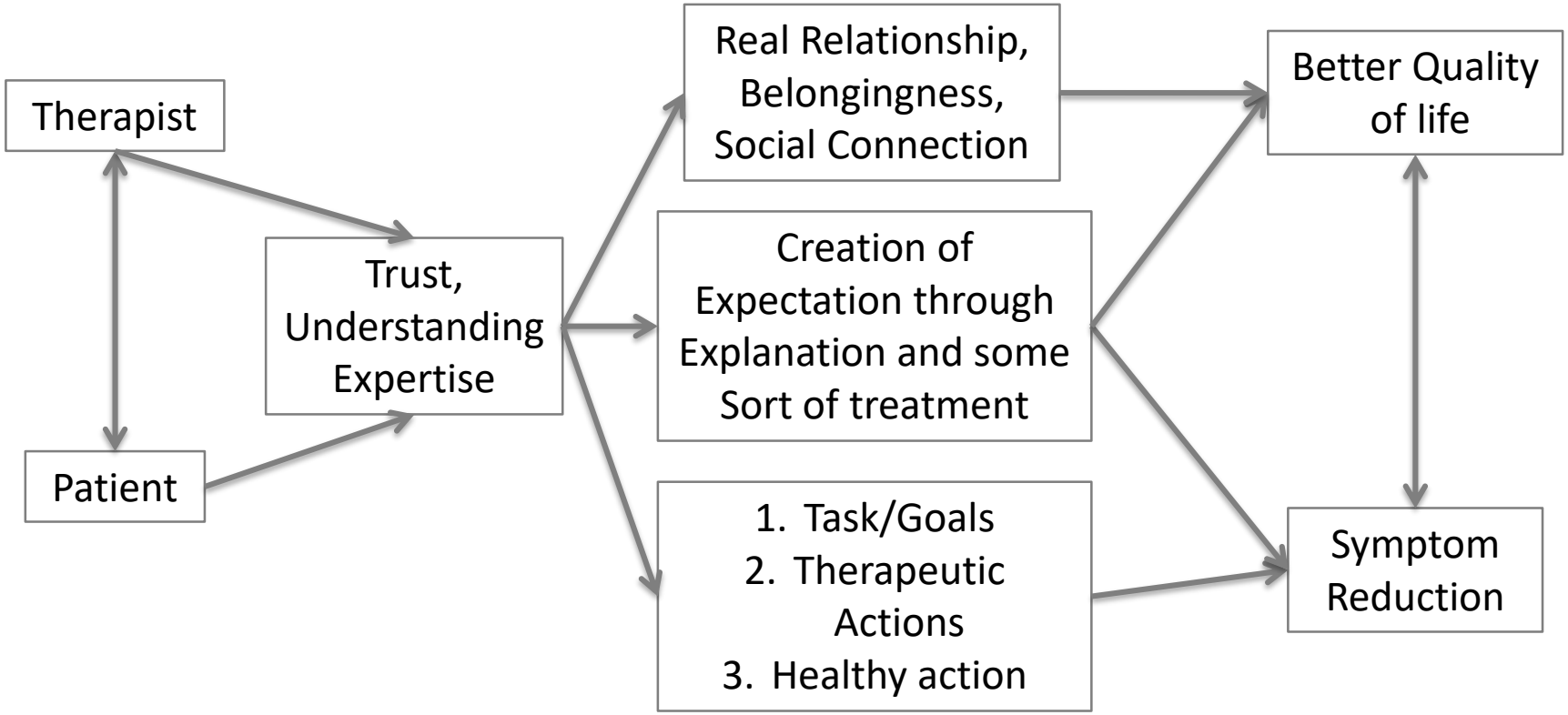


100 patients psychotherapy for depression

33% remission
66% Response

Baldwin, &, Imel 2013; Norcross, 2011

Contextual Model of Psychotherapy



Adapted from Fig 2.2. Wampold, & Imel, 2015

Therapeutic Alliance (Bordin, 1979)

- Operationalized as:
  - Agreement on Goals of therapy
  - Agreement on Tasks of therapy (Steps taken to meet goals)
  - Quality of the Bond between patient and therapist
- Measures of Alliance:
  - Patient, therapist, observer rated.
- 12% of variance in outcome, small to medium effect size

Therapeutic Alliance

- Working Alliance Inventory. Horvath. 12 items 7 point likert scale

- *My therapist* and I agree about the things I will need to do in therapy to help improve my situation. (Task)
- *My therapist* likes me. (Bond)
- I have doubts about what we are trying to accomplish in therapy. (Goals – Reverse coded)

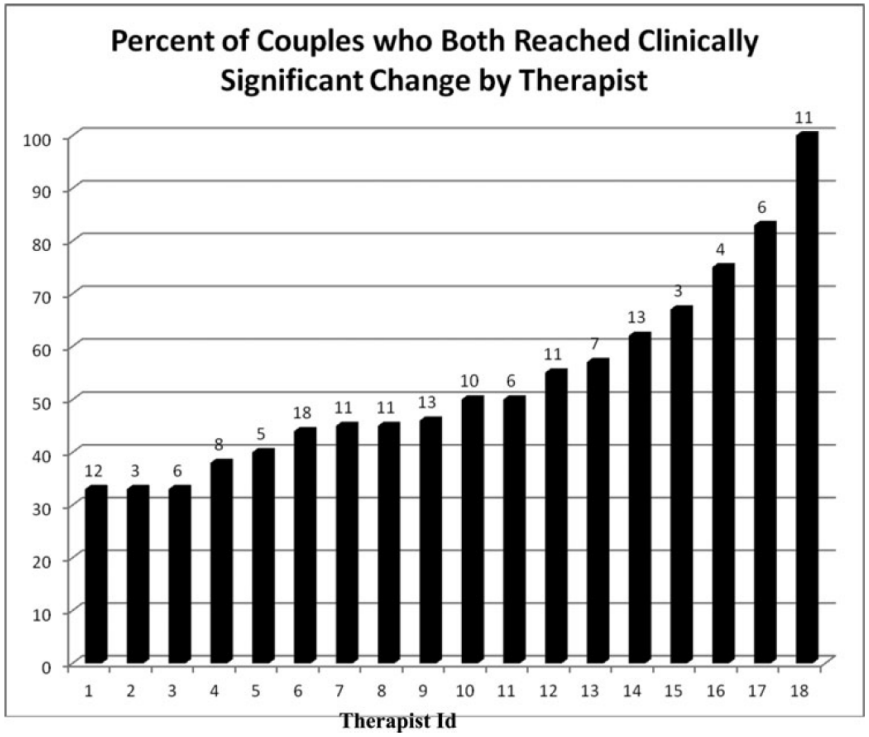
- Scores on WAI correlate with change in pre-post outcome measure.

The Therapeutic Alliance

APA Div 12 Task Force	What Works	What Does not Work
High	Alliance / Cohesion	Confrontation
High	Empathy	Negative Processes
Medium	Congruence	Assumptions
Medium	Positive Regard	Therapist-centricity
Medium	Managing Countertransference	Rigidity
Medium	Repair ruptures	Procrustean bed (one size fits all)

Norcross, & Wampold, 2011

Therapist Effect



Therapist effect accounts for 8% of variance in outcome

- 20% of therapists tend to do better
- 60% are average
- 20% tend to have less good outcome

- Difference more significant with complex and more severe patients

Barkham, *et al.,* 2017; Owen, et al., 2013

Routine Outcome Monitoring (ROM)

- Multiple tool of ROM:
  - Outcome Questionnaire 45 (OQ-45, by Michael Lambert)
  - Partners for Change Outcome Management System: International Center for Clinical Excellence (PCOMS ICCE)
  - Treatment Outcome Package (TOP, by Kraus, Boswell, Wright, Castonguay, & Pincus)
- Specific example (US community clinic):
  - 5 Therapists, Patients: n=201, Dx: Mood d/0 (74%) Anxiety (21%)
  - RCT: 1. TAU, 2. Feedback to Th (OQ-45), 3. Feedback to pt & th

	TAU ($n=64$)			T feedback ($n=70$)			P-T feedback ($n=67$)		
Variable	Pre-	Post-	Δ	Pre-	Post-	Δ	Pre-	Post-	Δ
M	83.72	69.33	14.39	88.84	69.41	19.43	84.71	62.49	22.22
SD	21.74	23.42	16.61	22.70	24.56	21.01	21.77	25.82	19.98
d			.63			.82			.92

(Boswell, *et al.,* 2015; Hawkins, *et al.,* 2004)

Routine Outcome Monitoring

- Meta-analysis (individual psychotherapy):
  - N=6 151 patients, using OQ-45
  - 5-10% of patients get worse during therapy.
  - ROM reduces the number of non-responders and increases overall effectiveness
- Outcome Questionnaire – 45
- PHQ-9
- GAD-7
- WSAS (Work and Social Adjustment Scale)

(Shimokawa, et al., 2010; Reece, et al., 2010)

Implementing ROM

- Calgary Counselling Center
- Implementation of Routine Outcome Monitoring (OQ-45) and Consultation.
- 7 years of data. 5 128 patients, 153 psychotherapists.
- Overall outcome improvement: *d = 0.035 per year (p = .003)*
- Improvement within therapists: *d = 0.034 per year (p= .042)*
- Caveat:
  - Routine Outcome Monitoring without built-in opportunity to reflect and use feedback, had not led to those results
  - 2004-2008: voluntary use of ROM (~60% use)
  - 2008. Mandatory -> 40% of staff resigned in 4 months.

Goldberg, et al., 2016

Repairing Alliance Rupture

- Impact on outcome

Correlation Between Rupture-Repair and Outcome

Study	Treatment	Patient diagnostic criteria	*N*	Outcome measure	*r*	95% CI		*z* value	*p* value
						LL	UL		
Stiles et al. (2004)	CBT and PI	Depression	79	BDI, GSI, IIP, SAS, Self-esteem	.19	−.04	.39	1.64	.10
Stevens et al. (2007)	BRT, CBT, and STDP	Cluster C or PDNOS	44	GAS, GSI, IIP, TC, WISPI	.26	−.03	.50	1.77	.08
Strauss et al. (2006)	CT for PDs	AVPD and OCPD	25	BDI, SCID II, WISPI	.39	.03	.66	2.12	.03

Note. CBT = Cognitive Behavior Therapy; PI = Psychodynamic-Interpersonal; BRT = Brief Relational Therapy; STDP= Short-Term Dynamic Psychotherapy; CT= Cognitive Therapy; PDNOS= personality disorder, not otherwise specified; AVPD = avoidant personality disorder; OCPD= obsessive-compulsive personality disorder.

Repairing Alliance Rupture

- Ruptures:
  - Disagreement on Tasks or Goals
  - Strain in the therapist-patient bond
  - Empathic failures
- Repairs:
  - Repeating therapeutic rationale
  - Changing tasks or goals
  - Clarifying misunderstandings at surface level
  - Exploring relational themes associated with the rupture
  - Linking the alliance rupture to common pattern in a patient's life
  - New relational experience

Safran, Murray, & Eubanks-Carter, 2011

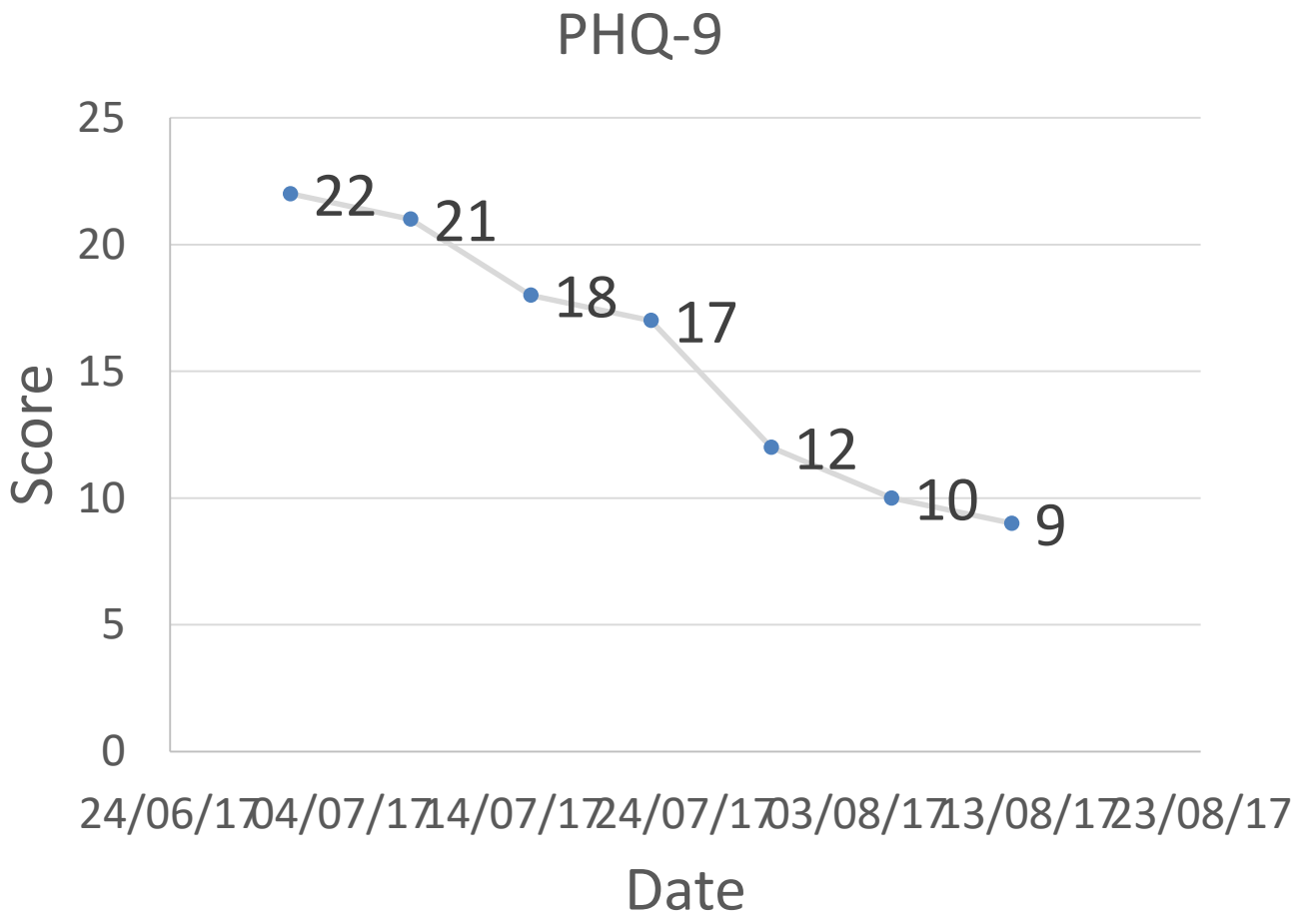
Identifying Alliance Rupture

- Routine Monitoring with Working Alliance Inventory or other measure, or…
- Helpful Aspect of Therapy Questionnaire
  - Did anything particularly helpful happen in this session?
  - Did anything happen during this session, which might have been hindering?

Experiential exercise

- Discussing progression of patient
- Give a handout of a graph progress of PHQ-9 to the patient and start a conversation.

- You have been seeing Joe for MDD for 8 weeks.
- How would you approach a discussion on the progression of his rating of depressive symptoms?


PHQ-9
25
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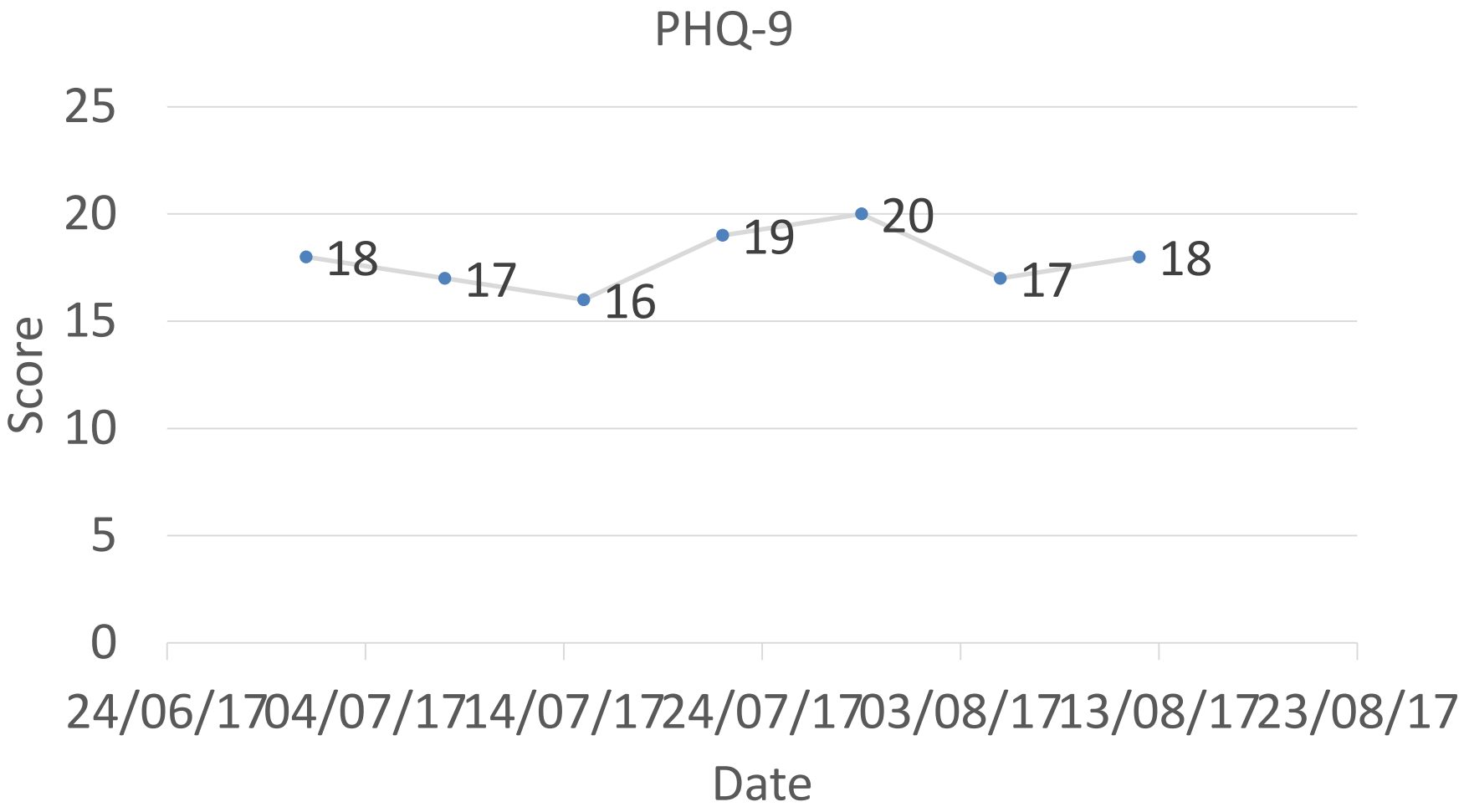
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Date

Supportive Psychotherapy in Context

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- 2019

Supportive Psychotherapy - Didactic

Lectures	Dates
Supportive in Context (Dr. F-L)	Oct 9
Empathy Intro (Dr. Mercer)	
Emotion 101 (Dr. Green)	
Visual Thinking Strategies – National Gallery	Oct 23
Listening Strategies (Dr. Mercer)	
Change Strategies (Dr. F-L.)	Oct 30
Problem Solving Therapy (Dr. Green)	
Supervision 4x 2hours	Jan-Apr 2019

Supportive Psychotherapy - Clinical

PGY level	Clinical/Evaluation
	Clinical
PGY-1	Use of supportive therapy techniques in clinical encounters throughout BCT/PGY1 No formal Supportive therapy case Completing Group Supervision package and discussing case in group supervision
	Evaluation
PGY-1	**ITER – Post supervision** -Capacity to use empathy in clinical work / Using self-reflection in Group Supervision

Psychotherapy requirements in Canada

Proficiency
Cognitive Behavioral Therapy
Family or Group (and WK of the other)
Psychodynamic Therapy
Supportive Therapy

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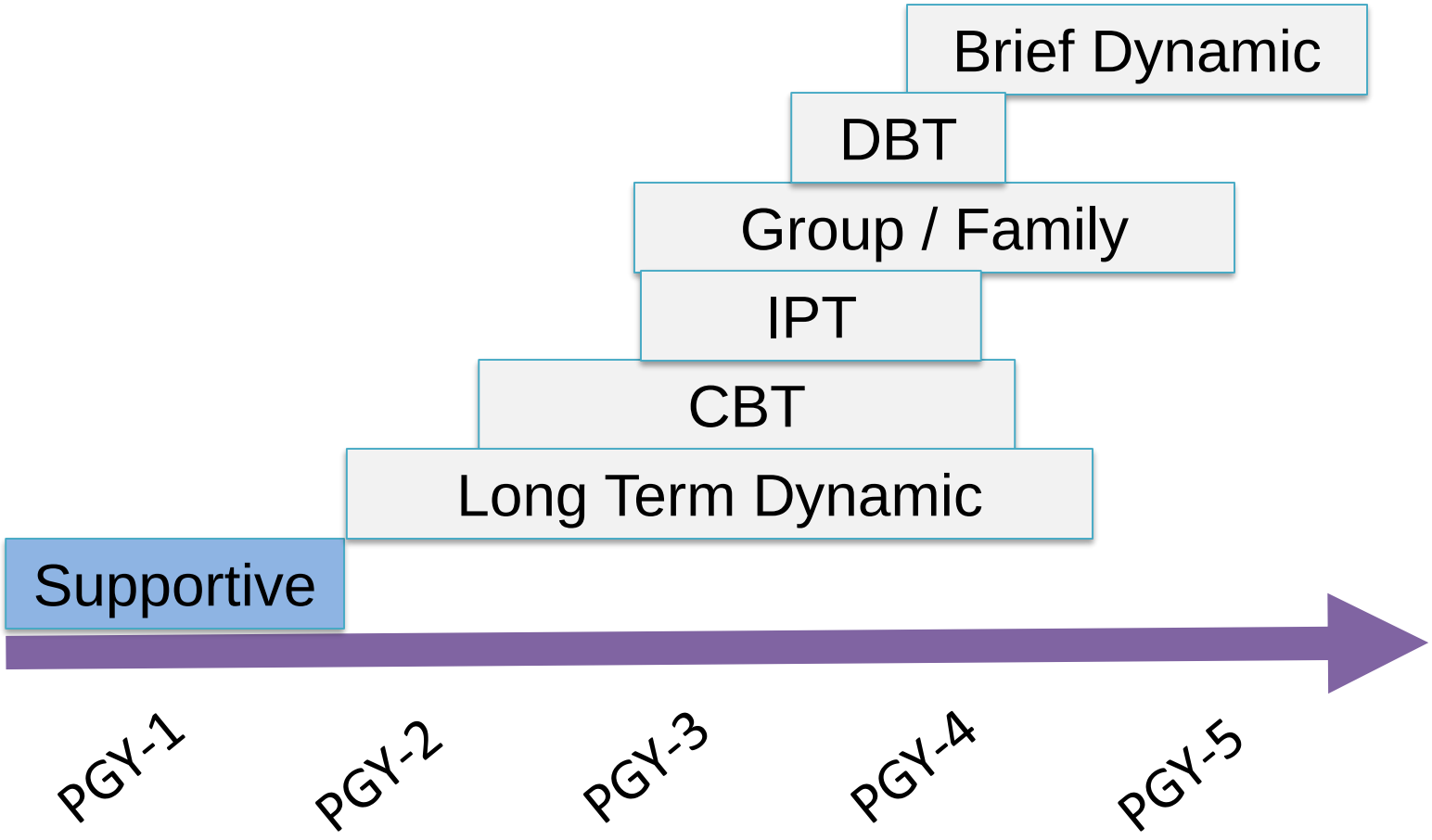
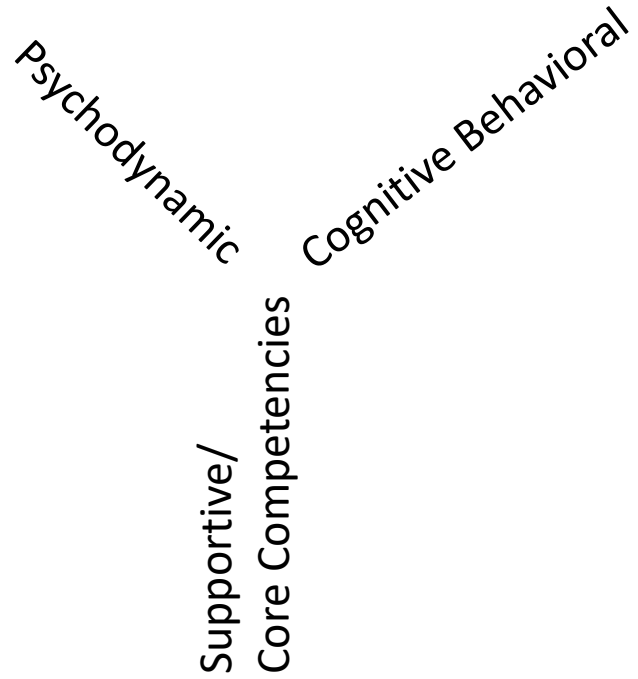
Objectives of training in psychiatry, royal college of physicians and surgeons of Canada, 2015

Psychotherapy Training

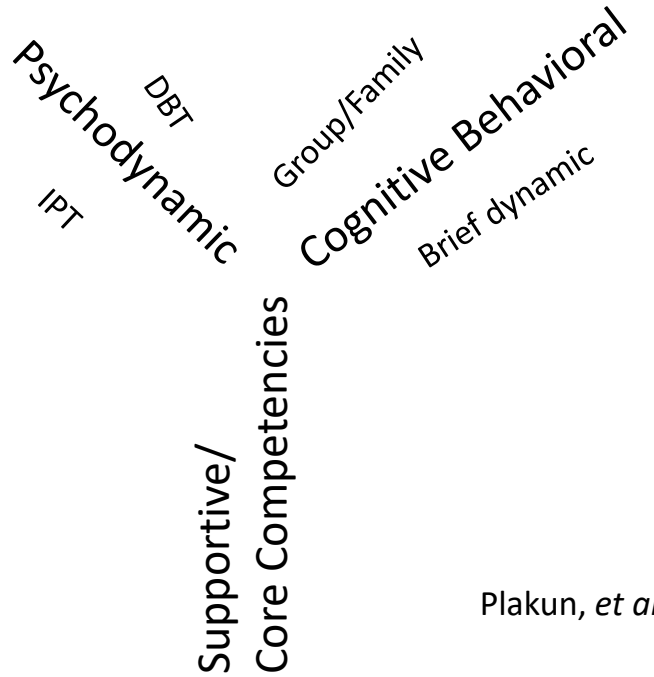


Supportive Therapy in Context

- The Y-Model



- University of Ottawa



Plakun, *et al.,* 2009

Session 3 Objectives

- At the end of this session participants will be able to describe:

1. Factors common to all psychotherapies (Common factors)
2. Research support for psychotherapy in general and for supportive psychotherapy specifically
3. Relationship of supportive psychotherapy to other therapies

Pre Quiz

1.Therapeutic Alliance is operationalized as?

a. A **Theory of Mind** / Capacity to mentalize
b. Capacity to put oneself as if in another person shoes, without ever loosing the **as if** condition
c. Quality of **Bond**, Agreement on **Tasks**, Agreement on **Goals**
d. A relationship that provides a **Corrective Emotional Experience**

Pre Quiz

2. What is true regarding supportive psychotherapy?
    a. Supportive psychotherapy is a distinct well defined of psychotherapy
    b. Supportive psychotherapy is better understood as steaming from Humanistic / Existential schools of psychotherapy
    c. Supportive psychotherapy is better understood as one end of the dynamic psychotherapy spectrum
    d. Supportive psychotherapy is often intended to fail in clinical trials

Pre Quiz

3. Is this a Specific or a Common Factor in psychotherapy?

a. Monitoring patient progress allows identification of non-responders
b. Correcting cognitive distortion leads to reduction in symptoms
c. Insight into defensive mechanism allows for growth and reduction in symptoms
d. Greater impairment correlates with poorer outcome
e. Stronger alliance correlates with stronger outcome
f. Unconditional positive regard allows patient to use their own strengths in solving difficulties
g. Higher empathy and genuineness is associated with better outcome

What is Psychotherapy?

- 1900's. Psychodynamics. Focus on "outside of awareness" factors that influence current mental state. (Freud, Adler, Jung)
- 1920's. Behaviorism. Conditioning and extinction of behavioral and emotional response. (Pavlov, Watson, Skinner)
- 1950's. Humanism. Assumption that human seek growth and actualization. (Rogers, Frankl, Perls)

What is Psychotherapy?

- Psychotherapy is a primarily interpersonal treatment that is
- A) Based on psychological principles
- B) Involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint
- C) Is intended by the therapist to be remedial for the client disorder, problem or complaint
- D) Is adapted or individualized for the particular client and his or her disorder, problem, or complaint.

Effectiveness of psychotherapy

- Eysenck 1952: *Psychotherapy no more effective and possibly less effective than no therapy.*
- Meta-analysis (Smith & Glass 1977)
- 75% of patients better than mean of non treated

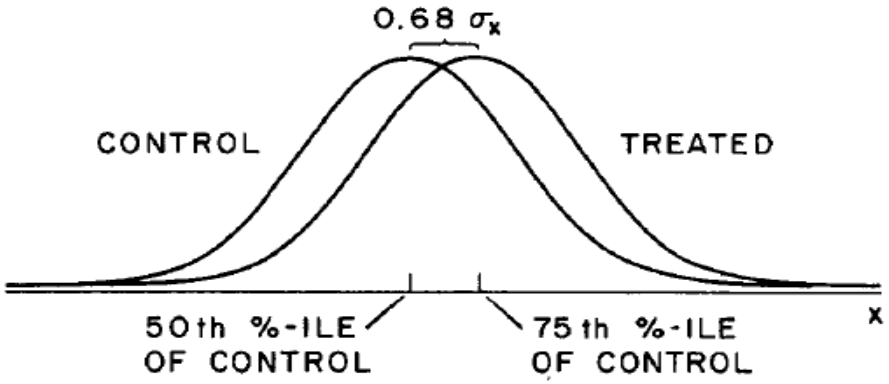


Figure 1. Effect of therapy on any outcome. (Data based on 375 studies; 833 data points.)

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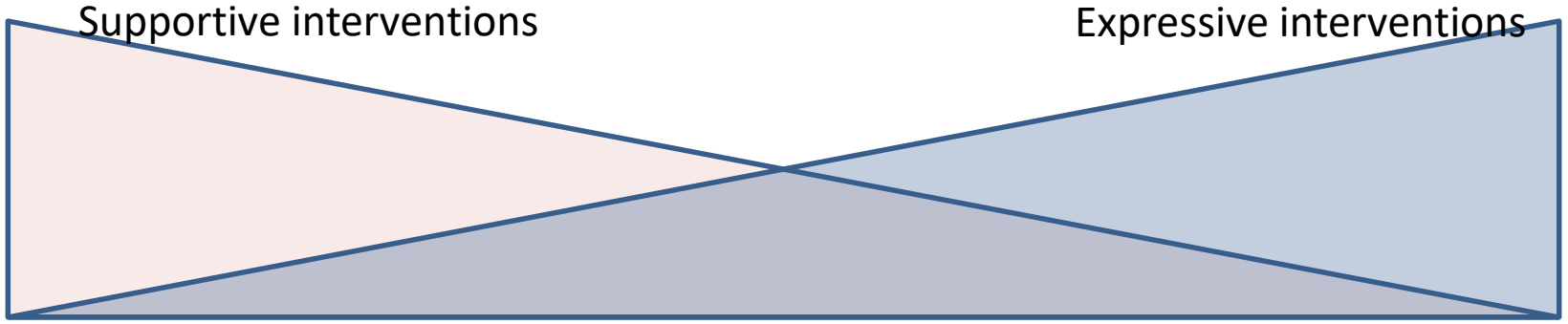

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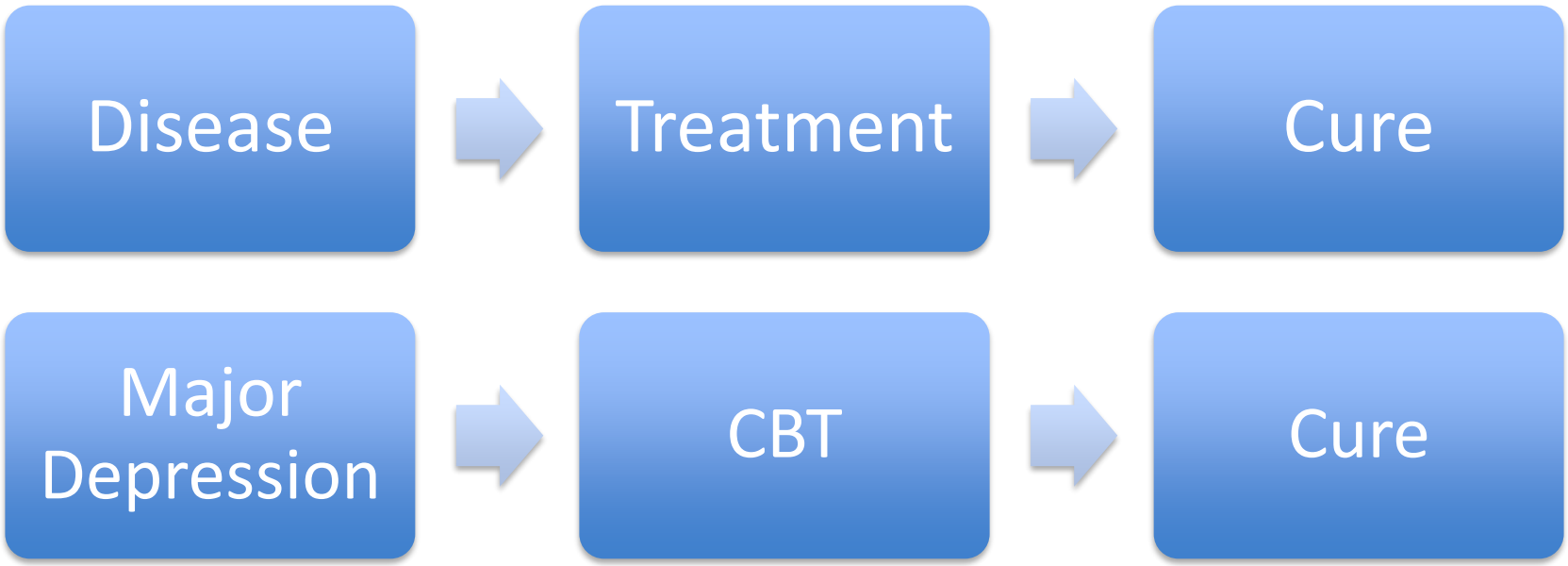

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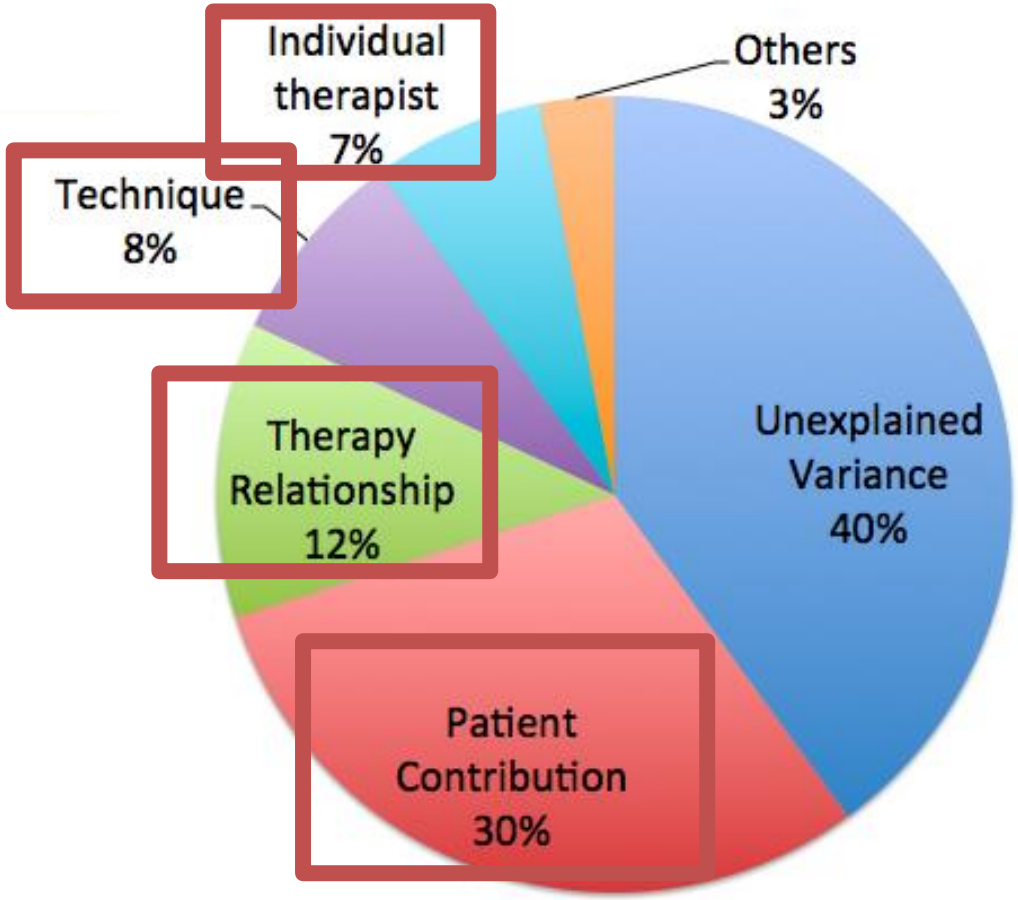
Markowtiz, et al., 1998

Specific vs Common factors



Total Outcome Variance in Psychotherapy

Norcross 2011

Therapeutic Alliance

Operationalized as:

- Quality of *Bond*
    - *My therapist and I trust one another*
- Agreement on *Goals*
    - *We agree on what is important for me to work on*
- Agreement on *Tasks*
    - *My therapist and I agree about the things I will need to do in therapy to improve my situation*

Horvath's Working Alliance inventory

Alliance and Outcome

- Alliance consistently shows a modest (*d:*0,26) but positive relation to outcome.
- Mutual relationship between Outcome and Alliance
- Alliance Rupture can explain why treatment stops working, or why some patient worsen.

Norcross 2011, Tasca 2012

The Therapeutic Alliance

APA Div 12 Task Force	What Works	What Does not Work
High	Alliance / Cohesion	Confrontation
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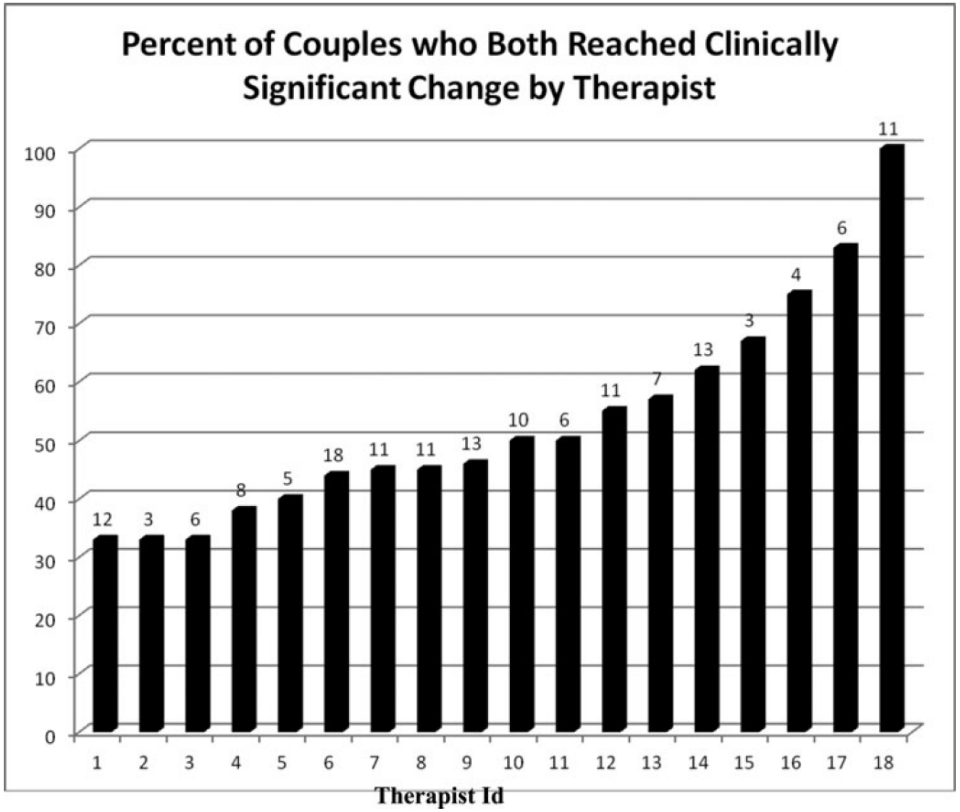


Barkham, *et al.,* 2017; Owen, et al., 2013

Therapist Factor & Outcome

- Some Therapist do consistently better than others
  - Interpersonal Skills
    - Empathy, Positive Regard-> (+) (Medium Effect Size *r:.31*)
    - Inability to identify alliance rupture, hostile/dominant -> (-)
- Number of hours of clinical work / week
  - Self-Care
- Experience / Clinical Expertise, Commitment
  - Training in multiple modalities and finding a good personal fit.

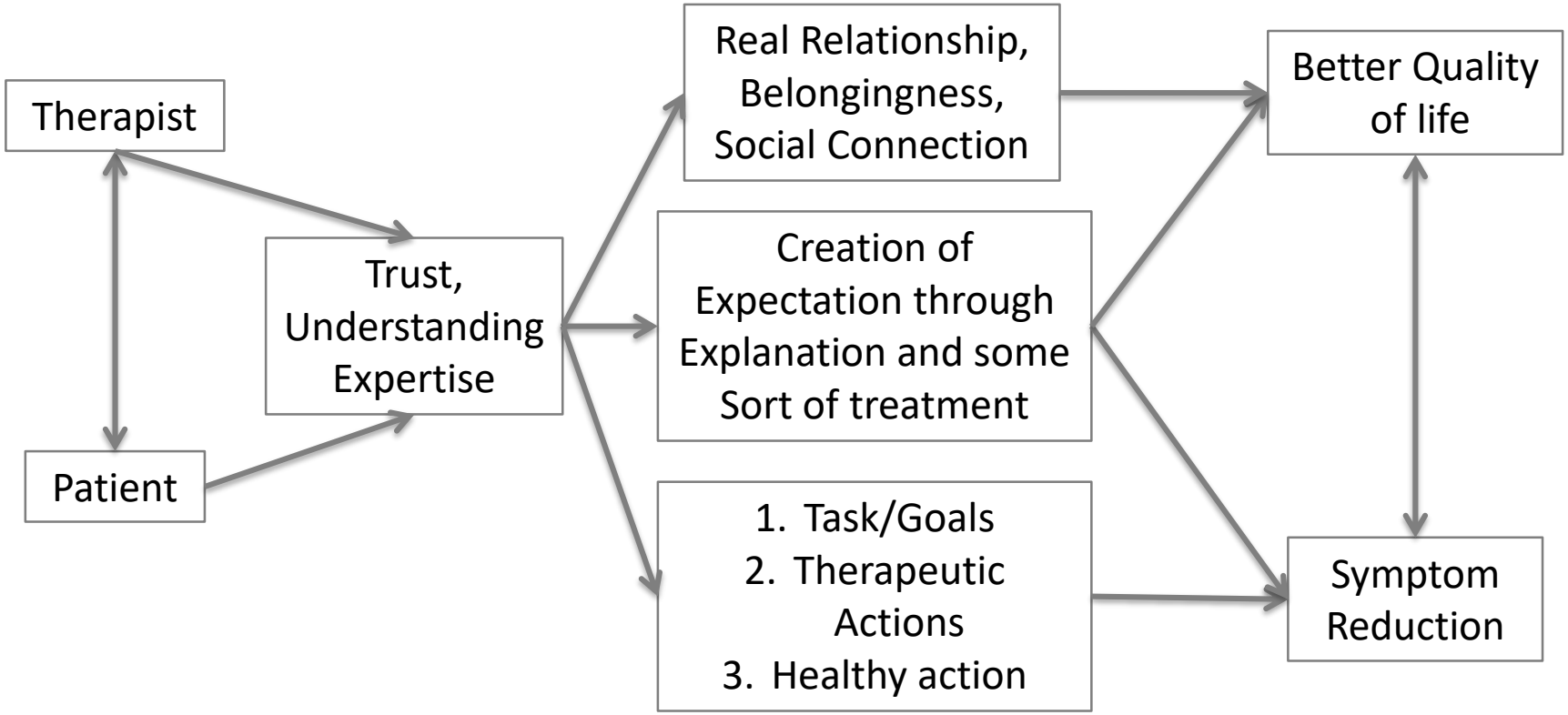
Kraus 2011, Elliott 2011

Patient Factors & Outcome

- Attachment Style (+)
  - Secure Patients (and Therapist) have better outcome
  - Dismissive-Avoidant and Preoccupied-Anxious benefit from complementary approach
- Functional Impairment & Baseline Severity (-)
  - Greater initial impairment in Social functioning correlates with smaller gain.
  - Warrant Longer term tx and intensified process

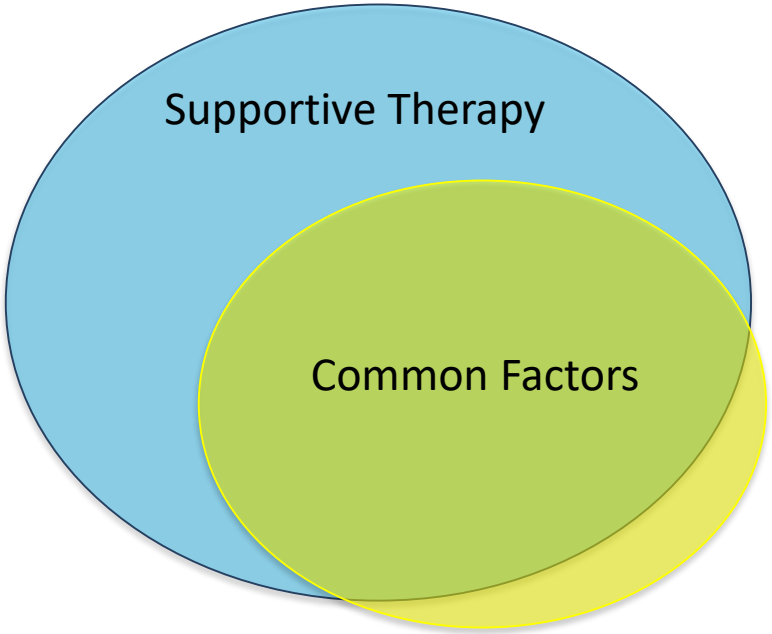
Castonguay & Beutler 2006

Contextual Model of Psychotherapy



Adapted from Fig 2.2. Wampold, & Imel, 2015

Supportive Psychotherapy in Context



<u>Classic iteration of Common factors:</u>

- Therapist effect
- Therapeutic alliance
- Patient factors
- Extra-therapeutic change

<u>Lambert & Ogles (2004):</u>

- Support
- Learning
- Change

Key Activities

The Supportive Therapy model

Learning:

- New cognitive frame, psychoeducation
- Change in Perception of Self & the Presenting problem
- Insight, corrective emotional experience

Support:

- Forming a relationship of trust
- Encouraging the expression of thoughts and feelings
- Building hope
- Encouragement
- "Development of the therapeutic alliance"

Action:

- "Working through of emotional distress"
  - Accept and Tolerate the feelings that cannot be changed
- Risk taking/experimenting with new behaviour
  - Problem-solving
  - Encouraging healthy behaviours

Joyce 2006, Lambert and Ogles 2004

Post Quiz

1.Therapeutic Alliance is operationalized as?

a. Quality of **Bond**, Agreement on **Tasks**, Agreement on **Goals**

b. A **Theory of Mind** / Capacity to mentalize

c. Capacity to put oneself as if in another person shoes, without ever loosing the **as if** condition

d. A relationship that provides a **Corrective Emotional Experience**

Post Quiz

2. What is true regarding supportive psychotherapy?

a. Supportive psychotherapy is a distinct well defined of psychotherapy

b. Supportive psychotherapy is better understood as steaming from Humanistic / Existential schools of psychotherapy

c. Supportive psychotherapy is better understood as one end of the dynamic psychotherapy spectrum

d. Supportive psychotherapy is often intended to fail in clinical trials

Post Quiz

3. Is this a Specific or a Common Factor in psychotherapy?
    a. Monitoring patient progress allows identification of non-responders (C)
    b. Correcting cognitive distortion Leads to reduction in symptoms (S)
    c. Insight into defensive mechanism allows for growth and reduction of suffering and reduction in symptoms (S)
    d. Greater impairment correlates with poorer outcome (C)
    e. Stronger alliance correlates with stronger outcome (C)
    f. Unconditional positive regard allows patient to use their own strengths in solving difficulties. (S/C)
    g. Higher empathy and genuineness is associated with better outcome. (C)

Post Quiz

- 4. Which of these has the strongest correlation with outcome in psychotherapy?
  a. Strength of therapeutic alliance evaluated on the Working Alliance Inventory (WAI)
  b. The individual therapist
  c. Use of a specific evidence-based protocol
  d. The individual patient

Supportive Therapy Tasks & Common Factor

- Maintaining Therapist Skill via Self-Reflection: WAI-T

- Monitoring Alliance through patient feedback: HAT
  - Experiential exercise.

Repairing Alliance Rupture

- Impact on outcome

Correlation Between Rupture-Repair and Outcome

Study	Treatment	Patient diagnostic criteria	*N*	Outcome measure	*r*	95% CI		*z* value	*p* value
						LL	UL		
Stiles et al. (2004)	CBT and PI	Depression	79	BDI, GSI, IIP, SAS, Self-esteem	.19	−.04	.39	1.64	.10
Stevens et al. (2007)	BRT, CBT, and STDP	Cluster C or PDNOS	44	GAS, GSI, IIP, TC, WISPI	.26	−.03	.50	1.77	.08
Strauss et al. (2006)	CT for PDs	AVPD and OCPD	25	BDI, SCID II, WISPI	.39	.03	.66	2.12	.03

Note. CBT = Cognitive Behavior Therapy; PI = Psychodynamic-Interpersonal; BRT = Brief Relational Therapy; STDP= Short-Term Dynamic Psychotherapy; CT= Cognitive Therapy; PDNOS= personality disorder, not otherwise specified; AVPD = avoidant personality disorder; OCPD= obsessive-compulsive personality disorder.

Repairing Alliance Rupture

- Ruptures:
  - Disagreement on Tasks or Goals
  - Strain in the therapist-patient bond
  - Empathic failures
- Repairs:
  - Repeating therapeutic rationale
  - Changing tasks or goals
  - Clarifying misunderstandings at surface level
  - Exploring relational themes associated with the rupture
  - Linking the alliance rupture to common pattern in a patient's life
  - New relational experience

Safran, Murray, & Eubanks-Carter, 2011

Supportive Psychotherapy: session 2 and 3

- Deanna Mercer MD FRCPC
- Doug Green MD FRCPC
- Sarah Brandigampola

- 2016

Thanks to:

- Dr Ben Fortin Langelier
- Dr Jeanne Talbot

Intro

- Experiences with counseling/psychotherapy
- Counseling Self Estimate Inventory

Objectives

- Be able to engage a patient in supportive psychotherapy, using techniques to facilitate therapeutic alliance, with an emphasis on empathy (Session 1,2, 4)
- Describe the role of emotions in mental health and mental illness (Session 3: Emotions 101)
- Be able to use specific supportive techniques to foster change and the transition from mental illness to mental health (Session 5,6)

Session 1 Objectives

- At the end of this session participants will be able to describe:

1. factors common to all psychotherapies (Common factors)
2. the research support for psychotherapy in general and for supportive psychotherapy specifically
3. the relationship of supportive psychotherapy to other therapies
4. the tasks of phase 1: support
5. the process of building empathy

Pre Quiz

1.Therapeutic Alliance is operationalized as?

a. A **Theory of Mind** / Capacity to mentalize
b. Capacity to put oneself as if in another person shoes, without ever loosing the **as if** condition
c. Quality of **Bond**, Agreement on **Tasks**, Agreement on **Goals**
d. A relationship that provides a **Corrective Emotional Experience**

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Objectives

- Try to answer: What makes psychotherapy works?
- Define *Specific* vs *Common* therapeutic factors
- Define Supportive psychotherapy as it relates to common factor

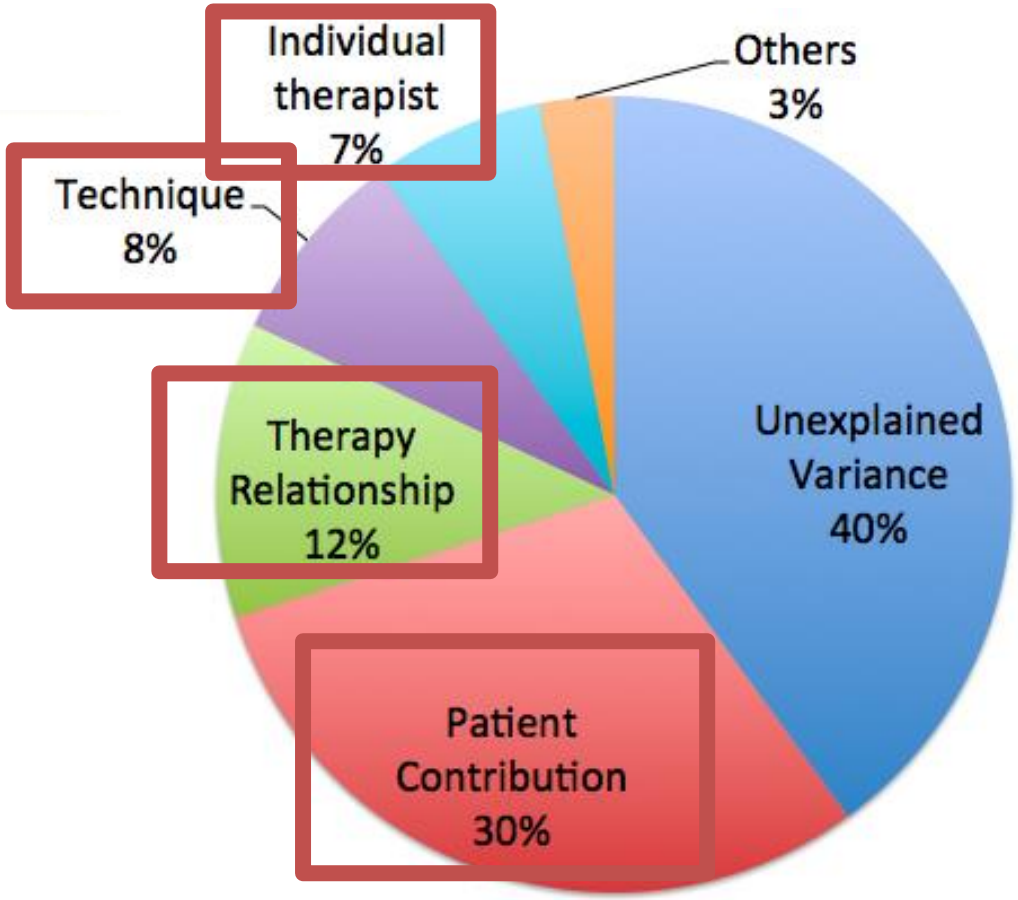
What is Psychotherapy? (Wampold & Imel 2015)

- Psychotherapy is a primarily interpersonal treatment that is
- A) Based on psychological principles
- B) Involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint
- C) Is intended by the therapist to be remedial for the client disorder, problem or complaint
- D) Is adapted or individualized for the particular client and his or her disorder, problem, or complaint.

Effectiveness of psychotherapy

- Eysenck 1952: *Psychotherapy no more effective and possibly less effective than no therapy.*
- Meta-analysis (Smith & Glass 1977)
- 75% of patients better than mean of non treated

Specific vs Common factors



Total Outcome Variance in Psychotherapy

Norcross 2011

Therapeutic Alliance

Operationalized as:

- Quality of *Bond*
    - *My therapist and I trust one another*
- Agreement on *Goals*
    - *We agree on what is important for me to work on*
- Agreement on *Tasks*
    - *My therapist and I agree about the things I will need to do in therapy to improve my situation*

Horvath's Working Alliance inventory

Alliance and Outcome Norcross 2011, Tasca 2012

- Alliance consistently shows a modest (*d:*0,26) but positive relation to outcome.
- Mutual relationship between Outcome and Alliance
- Alliance Rupture can explain why treatment stops working, or why some patient worsen.

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Kraus 2011, Elliott 2011

Patient Factors & Outcome

- Reactance / Resistance Level (-)
- Motivation for change / Stages of Change (+)
  - If interventions are tailored to patient's stage
- Expectations / Preferences (+)
  - If they are met
- Religion and Spirituality (+)
  - When Spirituality elements (Matching the patient's belief) are integrated to therapy

Castonguay & Beutler 2006

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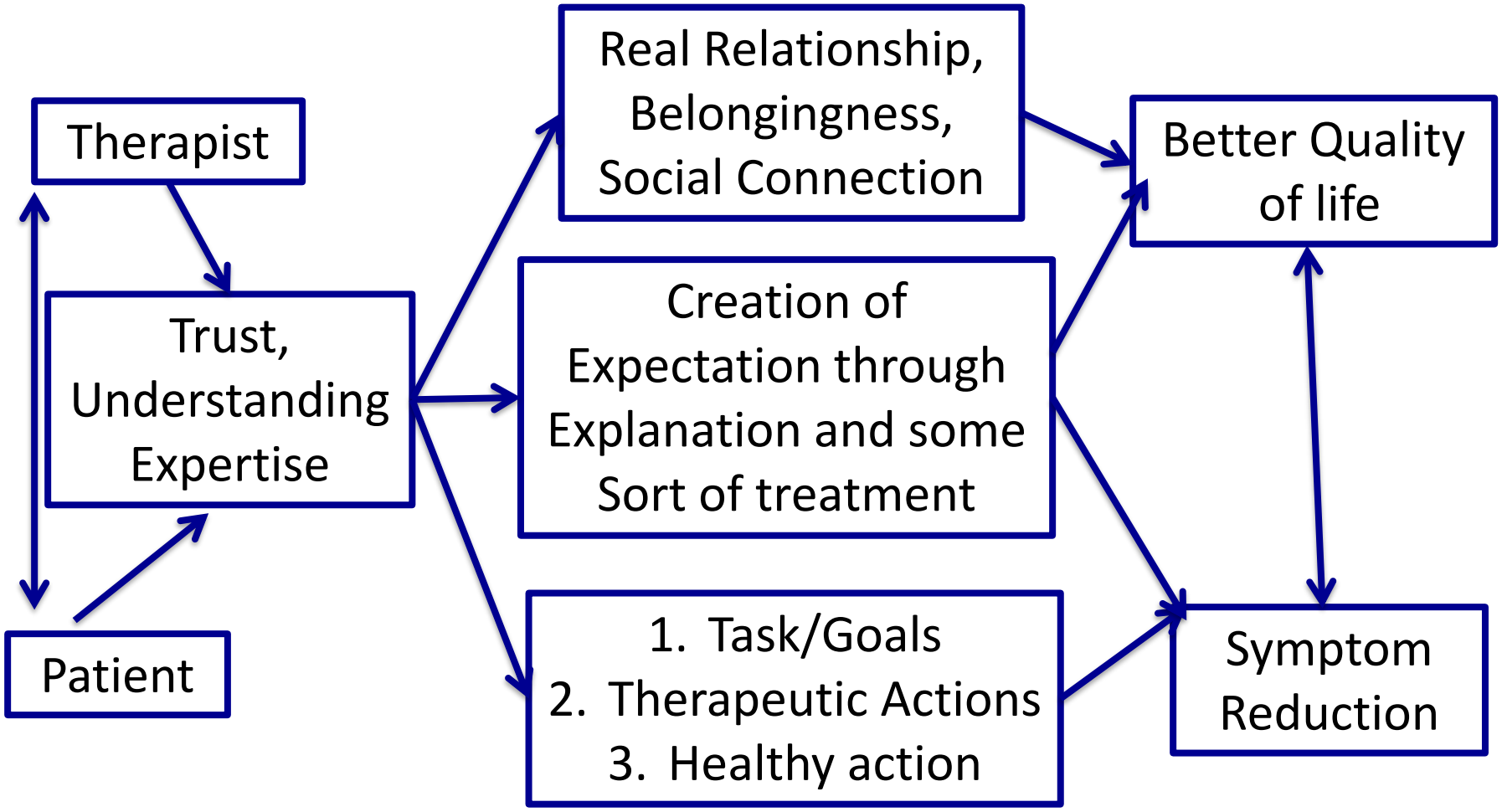
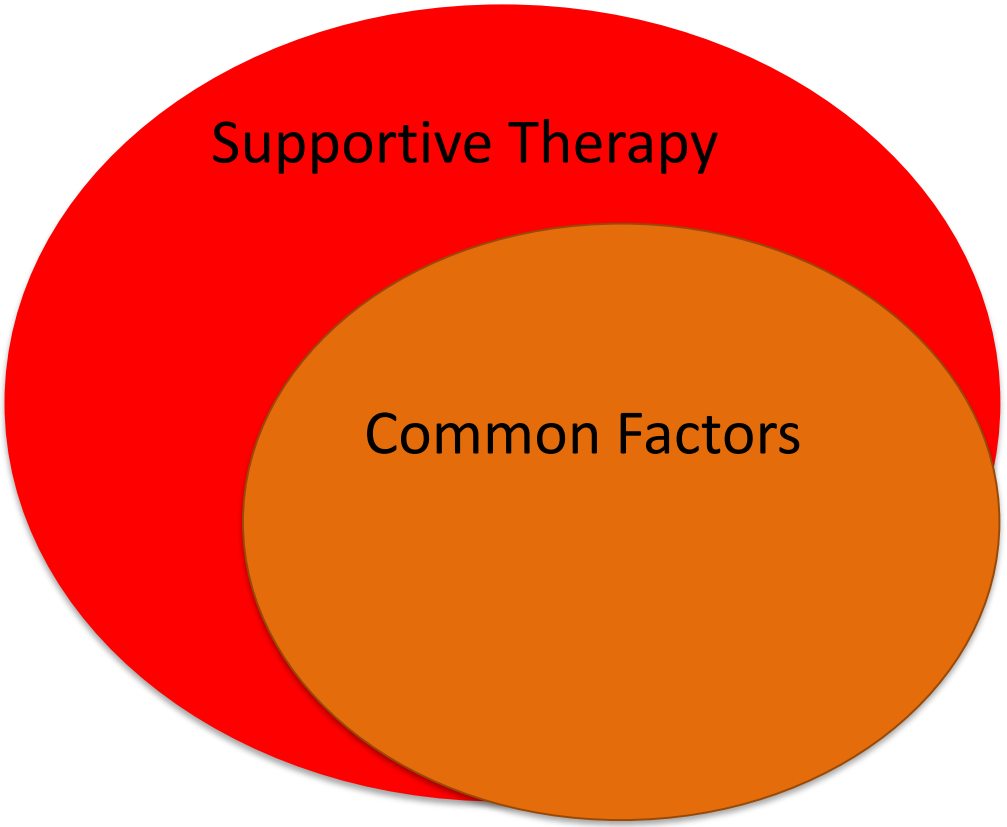


Supportive in Context



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SUPPORTIVE PSYCHOTHERAPY

Session 3

Case Ms TM

- 43 year old married woman. 3 children ages 5-9. Professional, on disability
- PC: OPD f/u post hospital admission. Diagnosis: MDD with anxious distress
- Hx:
  - MDE in University
  - GAD. OCP traits. Very organized, perfectionistic, lots of lists, uncomfortable with spending money, keeps family organized, uncomfortable with expressing emotion. Psychotherapy for anxiety (CBT, psychodynamic focus) for 3 years prior to admission.

TM

- MDE following decision to separate from husband. Despite wanting to separate struggled with demands of single parenting. Overwhelming anxiety ➔ insomnia➔depression. Off work
- Multiple brief trials of meds: Pristiq, Effexor. Trazodone oxazepam, zopiclone, lorazepam, clonazepam tried but not effective.
- Read an article that said insomnia was incurable ➔overwhelmed and made a suicide attempt.
- 2 week admission. Ddx: MDD with anxious distress, possible psychosis because significant disorganization of thought process.
- D/C meds Seroquel 150 HS, Remeron 15 HS, Lorazepam 1 HS, Olanzapine 10HS.

Case TM

- OPD
  - Very reluctant to continue meds for fear of addiction, weight gain and ongoing agitation. Complaints of severe insomnia, but husband says is sleeping well. Not able to read. Alexithymic. Complains of being bored, but all suggestions, including PHP are rejected. Not active in care of children, but no concerns about children's safety, husband says she is a great mom. Mild disorganization of thought form, noted at each OPD visit.

Case TM

- Further trials of meds: Effexor XR, Risperidone, Trazodone, Clonazepam, Oxazepam, Seroquel, Olanzapine, Lurasidone, Remeron,
- Insistent re: return to work but did not show up (or call to let them know that she was not coming in) for first day of work – completely out of keeping with premorbid behaviour.

Supportive Psychotherapy Interventions

- Progress monitoring PHQ 9, OQ 45
- Clarify goals – involved and effective parent for children, return to work
- Clarify tasks – major disagreement/ therapy rupture– patient wanted this to be accomplished without medication, clinician did not feel this could be accomplished without medication. Apologized that I couldn't do what she wanted and indicated I felt meds were needed and pt OK with this. Second potential rupture at admission following second suicide attempt.
- Therapeutic alliance- paying attention to validation – "how difficult it is to see your whole life fall apart before your eyes and not be able to put the brakes on the slide in your usual manner – which is to just work harder"
- Reframing – things have fallen apart because you have had a depression, possibly with psychosis, not because you are not strong
- Reassurance / encouragement – based on good premorbid functioning and neuropsych report fairly good chance of a successful return to work if able to take small steps
- Advice – Needs to temporarily suspend decisions about relationship because of mental health issues. Techniques suggested – DBT "pushing away"
- Psychoeducation – need for behavioural activation, small steps, noting mood responsiveness, role of exercise for mood stabilization, improving sleep

Where we are now….

- 18 months later
- Effexor XR 112.5, Seroquel 300 HS, Clonazepam 0.25 HS
- Back to work full time and doing very well at work

Supportive Psychotherapy: Why Bother !??!

1. Training in supportive psychotherapy required by Royal College of Psychiatrists (UK), ACGME (US), Royal College of Physicians and Surgeons (Can)

1. “Many psychiatrists see patients briefly for management of psychopharmacologic treatment. Remarkably, often patients are efficient about the medication issues and quickly attempt to involve the “medicating” psychiatrist in a conversation about his or her life, so supportive psychotherapy is part of the package whether intended or not”

- Pinsker 1997

What is supportive psychotherapy

- Bedi 2010
- Evolving concept with many differences of opinion
- No single universally accepted definition
- No single theoretical background: psychoanalysis, Rogerian counseling, cognitive, behavioural, systemic, interpersonal, ego psychology, attachment theory
- Recognition that in every interaction with a patient is a psychotherapeutic process that can help or hinder the treatment of the patient.

Supportive Psychotherapy

- 5 key tasks Battaglia 2007
  - Adopt a conversational style
  - Nurture positive transference
  - Reduce anxiety
  - Enhance self esteem
  - Strengthen coping mechanisms

- Supportive psychotherapy reinforces a patient's ability to cope with stressors through a number of key activities including:
  - Listening attentively
  - Encouraging expression of thoughts and feelings
  - Increasing understanding of the individual's situation and alternatives
  - Increasing self esteem and resilience
  - Working to instill a sense of hope
  - University of Toronto 2014

Stressors

- Stressors
  - Anything that challenges an individual and interrupts normal functioning and the individual's ability to work toward their goals
  - Includes life stressors such as work, relationship problems and physical and mental illness

Key Activities

Key Activities

Learning:

- developing a new cognitive frame, psychoeducation
- facilitating change in self perception and perception of the presenting problem
- Insight, cognitive learning, corrective emotional experience

Support

- Forming a relationship of trust
- Encouraging the expression of thoughts and feelings
- Building hope
- Encouragement
- "development of the therapeutic alliance"

Action

- "Working through of emotional distress" - assisting the individual to accept and tolerate the feelings associated with a situation that cannot be changed
- Risk taking/experimenting with new behaviour
  - problem-solving
  - Encouraging healthy behaviours,

Joyce 2006, Lambert and Ogles 2004

Definitions

- Supportive Psychotherapy
  - Full therapy with support, learning and action activities
- Support (Phase/Pillar/activites)
  - Forming a relationship of trust etc
- Supportive approach vs expressive approach in psychodynamic psychotherapy
  - Use of interpretation sparingly

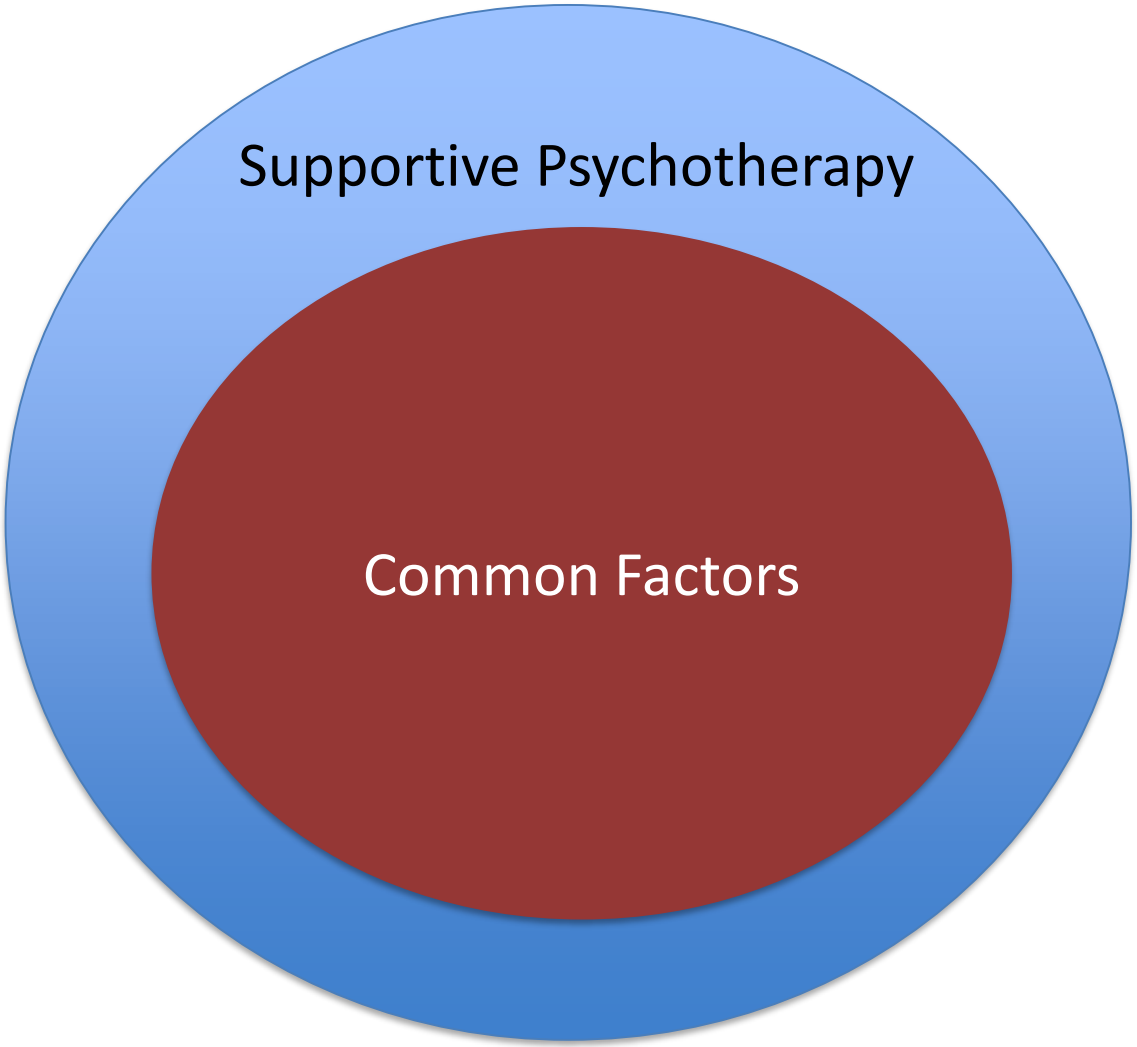
Supportive vs Expressive Psychodynamic Psychotherapy

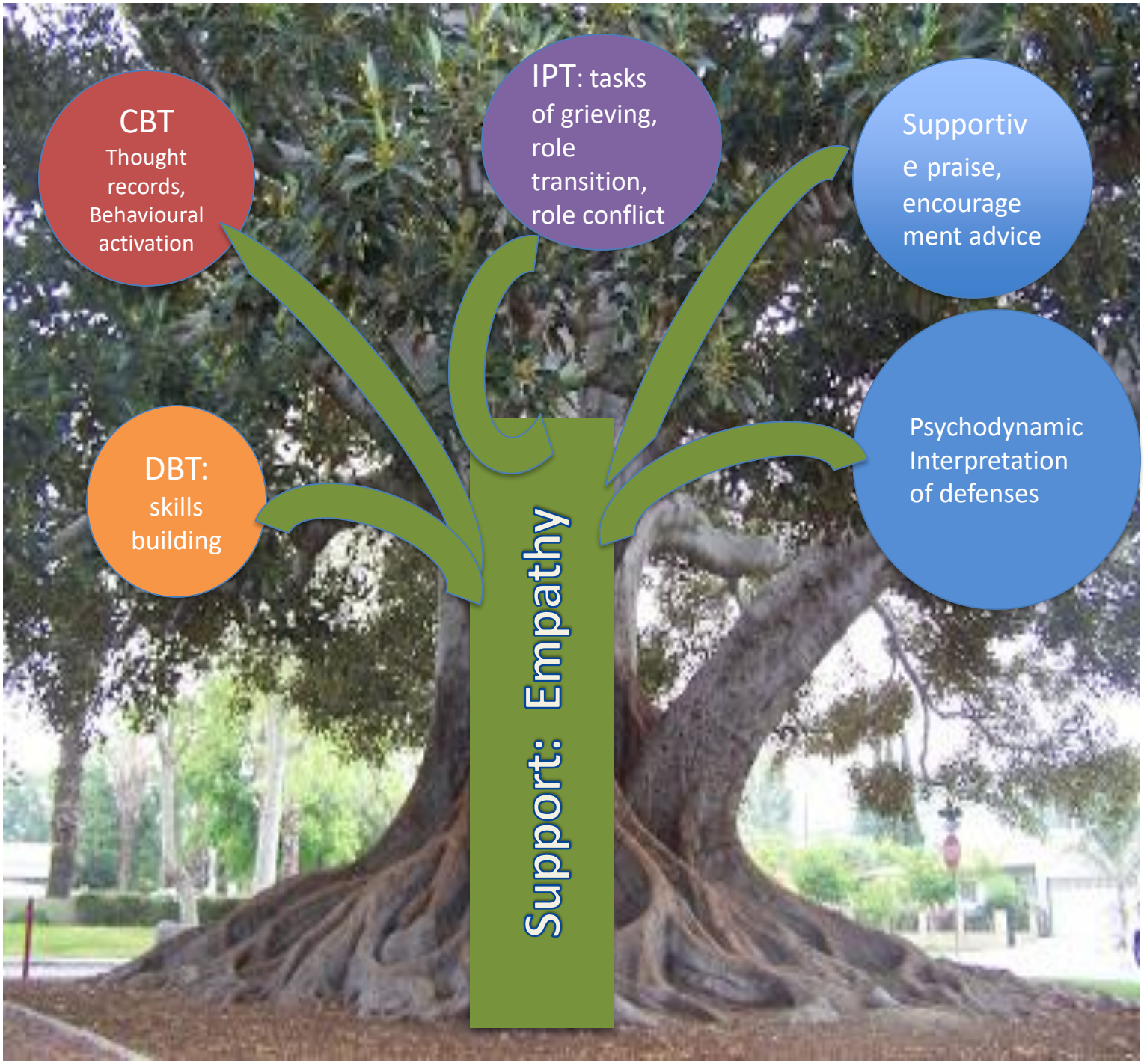
Supportive psychotherapy
Goals:
- Symptom relief
- Behaviour change

Expressive/Insight directed psychotherapy
Goals:
- Personality change
- Resolution of unconscious conflict

Therapy activities
- Analysis of the relationship between therapist and patient
- Acquisition of insight about previously unrecognized feelings, thoughts, needs, conflicts

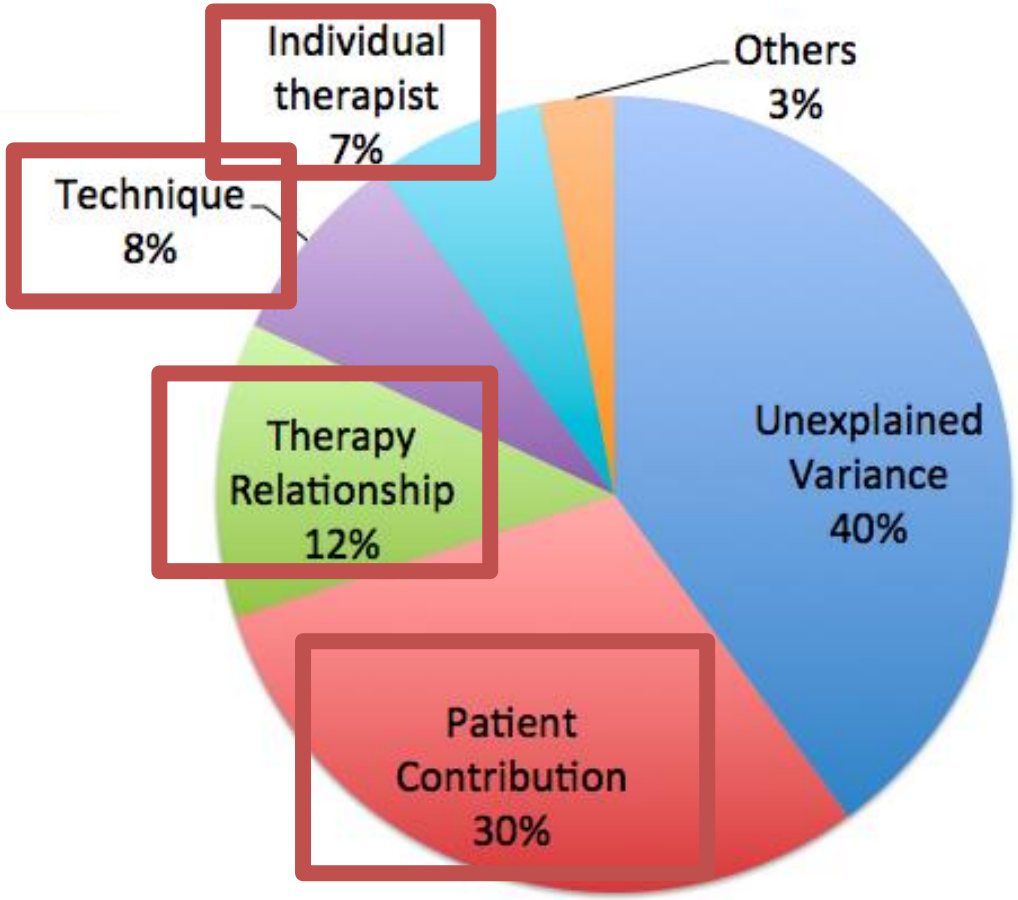
Supportive Psychotherapy = Common Factors?




CBT
Thought records, Behavioural activation
IPT: tasks of grieving, role transition, role conflict
Supportive praise, encouragement advice
DBT: skills building
Psychodynamic Interpretation of defenses
Support: Empathy

PHASE 1: SUPPORT

Specific vs Common factors



Total Outcome Variance in Psychotherapy

Norcross 2011

Therapeutic Alliance

Collaborative alliance between patient and therapist, depends on three factors

1. Patient –therapist agreement on goals
2. Patient – therapist agreement on tasks that each person is to perform
3. Strength of attachment

- Bordin

Strength of Attachment

- Forming a relationship of trust
    - Patient trusts the therapist and feels safe
- Encouraging the expression of thoughts and feelings
- Building hope
- Providing encouragement

Unconditional Positive Regard

- "in therapy is a quality of the therapist's experience towards the client"
- Unconditional
  - "no conditions of acceptance…it is the opposite pole from a selective, evaluating attitude.."
- Positive
  - One offers "warm acceptance…a prizing of the person…a caring for the client"
- Regard
  - One regards "each aspect of the client's experience as being part of that client…caring for the client as a separate person, with permission to have his or her own feelings, his/her own experiences"
- Rogers 1959

Unconditional Positive Regard

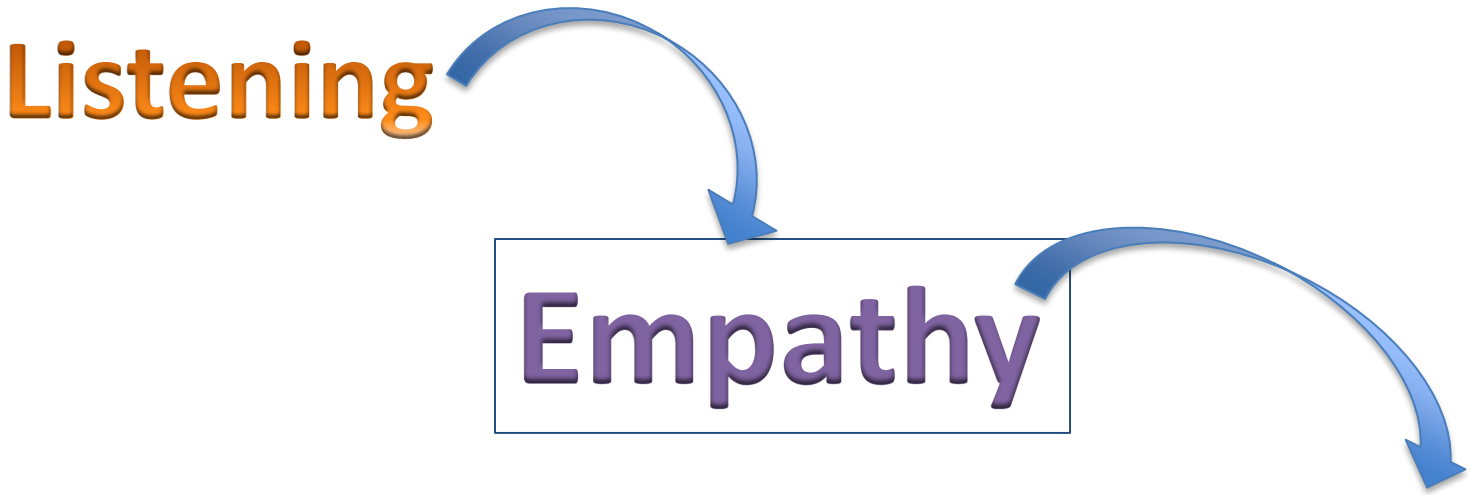
- not an all or nothing condition…for the effective therapist probably occurs sometimes and not at other times and to varying degrees”
- Rogers 1959
- Unconditional positive regards for the person, not necessarily their behaviours
- Lorne Korman

Video

- Carl Rogers and Gloria Counseling Part 2

https://www.youtube.com/watch?v=m30jsZx_Ngs

Empathy



Support

- Forming a relationship of trust
- Encouraging the expression of thoughts and feelings
- Building hope
- Encouragement
- “development of the therapeutic alliance”

Empathy

- Empathy: “to perceive the internal frame of reference of another, with accuracy… *as if* one were the other person, but without ever losing the as if condition”

Carl Rogers 1961

Empathy

- Capacity to:
  - Enter into the mind of another person
  - Imagine the experience of that person
  - Comprehend their current state of mind
  - Understand the context in which that state of mind (including thoughts, emotions, urges) arose

  Beitman, Yue 2008

Empathy

- Empathy: verb vs noun – it is something that we do, not something that we have
- Involves both a cognitive understanding and an emotional understanding
- Emotional/felt empathy
  - Biological underpinnings of empathy - mirror neuron system /premotor cortex
  - mirror neurons produce a “mirror” of what we are seeing /hearing in another individual
  - This information is then felt in our bodies – we resonate physiologically with others – then fed back to the middle prefrontal cortex ➔compare what we are feeling with our own “maps” of our emotional world➔ perception of the internal frame of reference of the other person
  - Siegel 2010, Rizzolatti, Craighero, 2004

Empathy

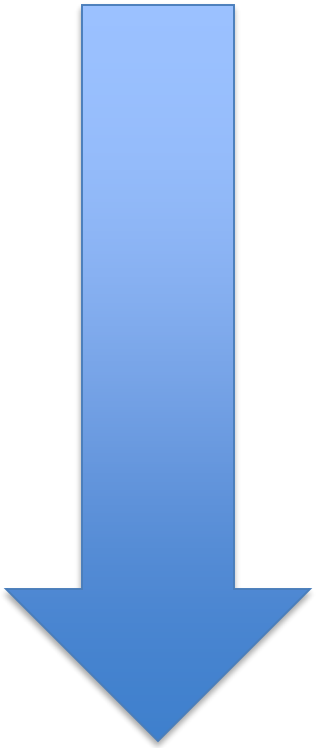
- Cognitive; building a picture of the context in which the individual finds themselves
- the ability to empathize has a genetic/biological basis, and is heavily influenced by our environment/learning - which can either increase or decrease empathy
- the more we work to build empathy with our individual patients the greater capacity we have for empathy

Building Blocks for empathy

- knowledge of an individuals symptoms and specific context
- awareness of our own reactions to our patients
- ability to let go of emotional experiences / “reset “ mirror neurons from one patient to the next
- the ability to let go of another person’s pain and suffering in order to take care of one’s self

Factors impacting on our ability to empathize

Cognitive empathy : familiarity with and acceptance of an individual's symptoms, and their context



- Individuals who resemble people in our own lives who we genuinely care about,
- individuals who have circumstances similar to ours (where we are accepting of those symptoms/contexts)
- individuals where we have had some experience with their symptoms/context
- individuals who have symptoms/contexts that we do not understand or approve of. "Empathy Blind Spot"

Factors interfering with empathy

- Emotional component of empathy: Factors that interfere with our ability to tune into our bodies
  - Fatigue, hunger,
  - “mirror neuron burnout”: seeing too many patients in a row without breaks, seeing a single patient who is experiencing a lot of distress,
  - distractions during a session/appointment
  - Inability to accurately detect and label our own emotions

Dealing with Empathy "Blind Spots"

- Acknowledging that we all have these
- Understanding the impact:
  - reduced therapeutic alliance
  - Empathy/understanding required to facilitate learning and change
- Blind Spot "clues"
  - Lack of concern for the individual
  - Persistent irritation, anger (transient irritation may be accurate empathy – ie the patient is irritated and you are picking up on that)

Dealing with Empathic Blind Spots

- Obtaining more information about the symptoms/context that the individual is experiencing
- Practices that help to facilitate empathy towards ourselves and others – psychotherapy, mindfulness
- Awareness of factors that that transiently impair empathy, building routines that limit these factors
  - getting adequate sleep, nutrition, scheduling breaks between patients
- Participating in activities that help to restore empathy
  - rest, spending time with friends and family, exercise, mindfulness, psychotherapy

Communicating Empathy

- In order for empathy to be effective in building a supportive relationship it must be communicated to the other person
- “I am wondering if you are feeling sad, because when you are talking about your parents you have tears welling up in your eyes”

Physician Factors

- Attitudes towards psychosocial aspects of care (Jackson 1999)
  - Physician's Belief Scale: 32 items measuring attitudes towards psychosocial aspects of patient care.
  - PBS >70 : 23% of clinical encounters difficult
  - PBS <70 : 8% of clinical encounters difficult
  - Not predictive: age, sex, ethnicity, years in practice

Predictor	Odds Ratio (95% CI)
Depressive or Anxiety disorder	2.4(1.5- 3.9)
≥ 5 physical symptoms	1.9 (1.1-3.1)
Severity of Symptoms >6 (10 point scale)	1.6 (1.0-2.4)
Poorer physician psychosocial attitude score	3.9 (1.6-9.5)

Videos

- ACE study Academy on Violence and Abuse https://vimeo.com/41156294
- NFB : No place called home.
  - https://www.nfb.ca/film/no_place_called_home/

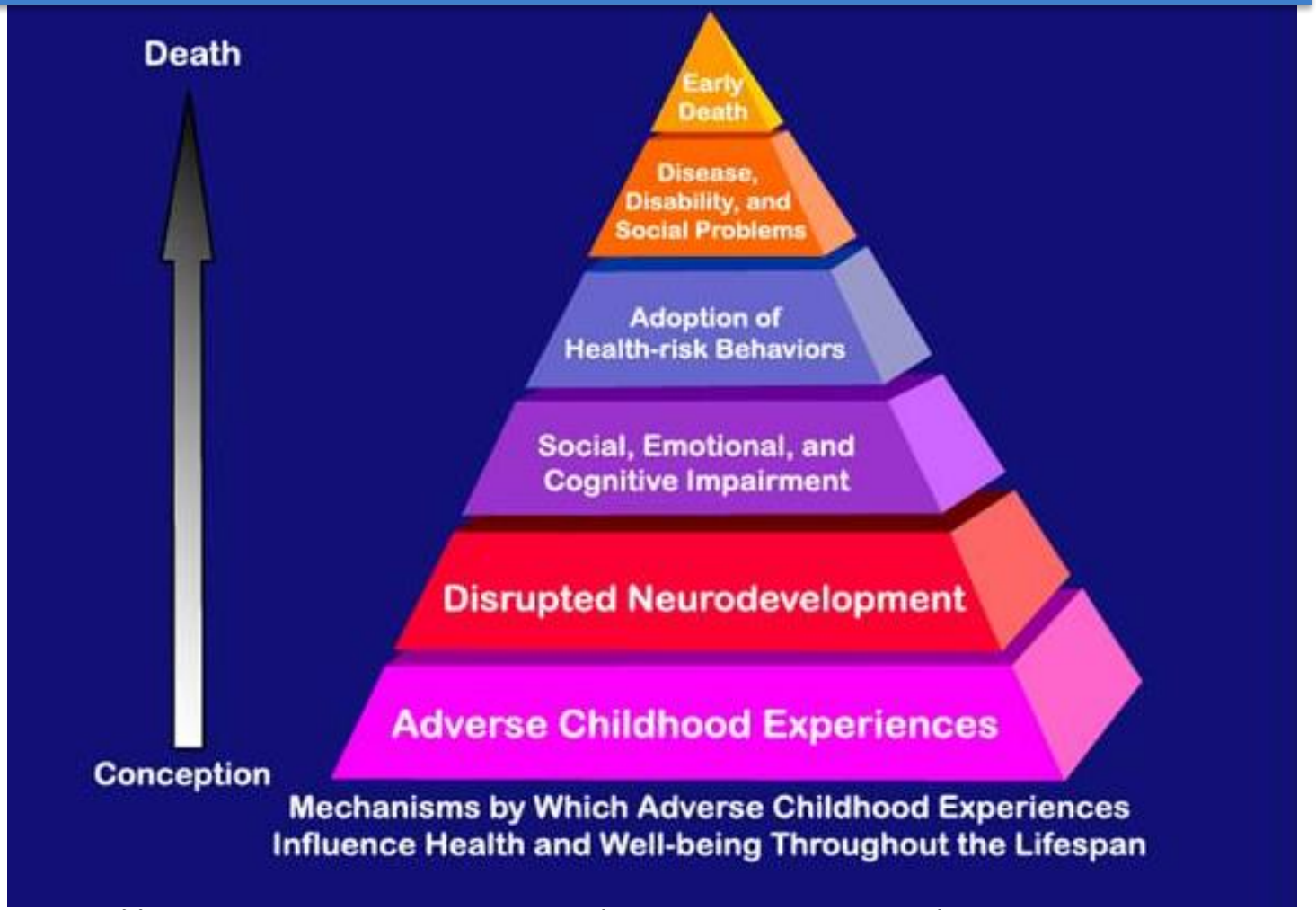
Week 2 mini quiz

- Describe the main goal of supportive psychotherapy
- Describe what is meant by a “stressor”
- Describe the three key activities in any psychotherapy (including supportive)
- Describe the key task in the support “pillar” of supportive psychotherapy
- Describe the 2 types of empathy blind spots
- List 3 factors that you have noticed interfere with your capacity to empathize with others.

ACE’s

- Adverse Childhood Events study
- ACE study Academy on Violence and Abuse https://vimeo.com/41156294

Adverse Childhood Events Study



http://www.huffingtonpost.com/jane-ellen-stevens/the-adverse-childhood-exp_7_b_1944199.html

ACES→health problems in adults

- The young brain is especially vulnerable to stress.
- prolonged stress in infancy and childhood causes increased release of **the stress hormone cortisol**
- stress hormones compromise normal brain development and the immature immune and nervous systems.
- Results in profound, **lifelong impacts on the brain and body**

What is an Adverse Childhood Experience / ACE?

Growing up experiencing any of the following conditions in the household prior to age 18:

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. Family member who is chronically depressed, mentally ill, institutionalized, or suicidal
7. Mother is treated violently
8. One or no parents
9. Physical neglect
10. Emotional neglect

Adverse Childhood Experiences (ACE's) are Common

- Regardless of the data source,
  - almost two-thirds of surveyed adults report at least one ACE, and more than one in five reported three or more ACEs.
  - study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course.
- As the number of ACEs increases so does the risk for the following:
  - Myocardial infarction
  - Asthma
  - Mental distress
  - Depression
  - Smoking
  - Disability
  - Reported income
  - Unemployment
  - Lowered educational attainment
  - Coronary heart disease
  - Stroke
  - Diabetes

Do ACES matter?

- unusually comprehensive medical history questionnaire including the ACE questions, filled out at home,
- digital scanner so that all Yes answers were picked up and re-organized by body system in a laser-printed output that typically was two or three pages long.
- Reviewing this before going into the exam room, we were able to say, “I see on the Questionnaire that ……..” Can you tell me how that has affected you later in your life?”, and we listened. Period. Later, I realized that we also implicitly Accepted.
- *Asking, Listening, and Accepting* I believe was the process underlying the discovery that in a 130,000 patient sample (2 ½ years throughput for the Department) there was a 35% reduction in outpatient visits in the subsequent year compared to their prior year, and an 11% reduction in Emergency Department visits.

- V Felitti personal communication May 2016

Addressing ACES

- Overall Goal of addressing ACES? Promoting resilience. Research is underway. Evidence suggests that even simple interventions can have a significant impact on resilience as seen in the reduction in ER and family med visits.
- Range of interventions, many involve psychotherapy/counseling
- Shifting the conversation from “what is wrong with the person” to “what happened to the person” Borstein
- Start with “asking, listening, accepting”.
- Acknowledging also helps “that must have been difficult for you. How has this experience affected you later in your life?”
- Many people who experienced ACE’s as children believe that they were somehow responsible for their parent’s difficulty or treatment of them. Gentle acnowledgment of the following helps
    1. how difficult the event was for them
    2. Children who have had these experiences almost always blame themselves
    3. No matter how many struggles you had as a child, children are never to blame for their parent’s behaviour. Parent’s have their own struggles and strength’s that they bring to parenting. Some parents have more resources and skills than others.
- Eventually…Claire Payne video

Listening

- Reference: Learning Psychotherapy 2nd ed Beitman, Yue, 25- 28
- Effective Listening
- Listening Styles
- Listening to what is not spoken
  - Incomplete speech
  - Hidden content
  - “Listening” to non verbal communication
- Summarizing
- Communicating Empathy

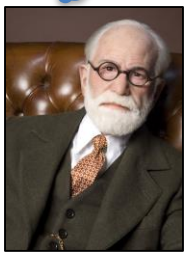
Effective Listening

- Listening intensely vs not listening at all
- Focusing attention on what the patient is saying/doing (non verbal) and therapist's own reactions (thoughts, emotions, physical experiences) to what the patient is saying and doing
- Sigmund Freud "evenly hovering attention"
  - mind floats like a butterfly from the words and experience of the patient to his own thoughts, then returns to the patient

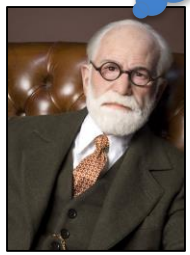
Effective Listening

Effective Listening

"so I was really upset at him, did not know what to say…" Hair is messy, tears welling up, slumped in chair, smiling



Not sure what is going on here – she is smiling but seems really sad all at the same time, I am feeling confused, I am losing interest, what time is it?



Listening Styles

- Degree of openness to what the other person is saying vs forcing the conversation into discrete problem clusters or potential solutions
- Amount of attention to non-verbal behaviour
- Amount of attention to listener's own intuitive/emotional responses

Listening styles

- Sensitivity to context –
  - how the time spent together, nature of the problem, type of relationship, the requests, the needs of the other influence listening
- Expectations:
  - individuals bring their own set of expectations about what is to be heard and seek to confirm these expectations
- ? Fixed aspects of human personality

Listening to what is not spoken

- Identifying incomplete speech and seeking details
- Listening for implied messages
- Observing mismatches between verbal and non-verbal communication

Incomplete speech

- Patient states something, but details are missing and listener is not able to “picture” what is happening and what the patient is feeling
  - “Nobody likes me”
  - “Everything I do is wrong”
  - “It’s better for me not to decide to do anything or else something bad will happen”
- How would you ask for clarification?

Hidden Content

- Listening to what is not being said directly
  - Dreams
  - Everyday communication
- Examples from page 31

“Listening” to Non-verbal Communication

- Purpose of non- verbal communication?
  - Communicating emotions
  - Regulating conversations
  - Modifying or emphasizing verbal messages
- Provides clues that someone may not be saying what they are thinking/feeling
- Forms of non verbal communication?
- Which is stronger – verbal or non verbal?

Forms of non-verbal communication

- Posture, gestures, movement
- Facial expression
- Voice – tone, pitch, volume, intensity, pauses
- Observable autonomic responses – blushing, breathing quickly
- Physical characteristics- fitness, weight, complexion
- General appearance
- Behaviour

Therapist Non-verbal Communication

- Therapist non verbal communication has a significant impact on patients
- S – face patient squarely
  - or slightly to the side
- O – open posture
  - pay attention to crossing arms or legs
- L- lean toward (or neutral or leaning back)
- E- good eye contact – fairly steady, but not staring. Be aware of cultural differences
- R appear relatively relaxed

Verbal/non verbal mismatches

- A good friend is walking down the hall towards you. You often pass each other in the hall, usually slowing down to say a few words. You start to slow down. She gives you a big smile and walks right past you. You feel hurt. How do you explain the mismatch?

Summarizing

- Communicates that you have heard the patient
  - “ok, let me make sure that I have this correct – it seems that since you and your wife have agreed to try to get back together your mood is a lot worse, you are having difficulty sleeping and you have been harming your self”
- Helps therapist to pursue further information
  - “any thoughts about what is hard for you with getting back together with your wife? ”
- Helps to conclude one area of discussion and move to the next
  - OK, now that I understand what is difficult for you currently I would like to ask you a few questions about times in the past when you have had similar difficulties

Communicating Empathy

- In order for empathy to have an impact on your patient it has to be communicated
- 2 ways of communicating empathy?
- Implicit communication
  - Paying attention to what the other person is saying
  - Making summary statements of what the person has said
  - Asking questions that make it clear you are trying to understand the person's experiences and the context of those experiences

Communicating Empathy

- Explicit communication
- Labeling thoughts, emotions, urges that the patient has not stated
  - 40 year old man who's brother recently disclosed his sexual abuse of him. Parents are not willing to "take sides" and won't provide any support until he tells them "his side of the story". He appears to be angry and hurt but hasn't stated this.
  - "You know, given this very confusing message from your parents, I am wondering if you are feeling angry and maybe hurt?"

Communicating Empathy

- Level 4 validation (DBT)
  - symptoms are understandable given either biology or past learning
    - When you have a depression it is really difficult to take on everything that you could before you had the depression – that is why we have to start with small steps
    - Since the doctors missed the signs of a heart attack in your dad, it makes a lot of sense that you are still really afraid of having a heart attack and dying even though all of our tests are negative

Communicating Empathy

- Normalizing
  - Helping the individual recognize their responses as normative
    - P " When my grandmother died I didn't feel really bad. My mom was so upset but I wasn't – it made me feel really guilty"
    - T "It's not unusual - unless there is a very close relationship children often accept the death of a grandparent as a matter of course
    - Winston, Rosenthal, Pinsker 2012

Empathy “formula”

- “It seems to me that you might be feeling _____(name the emotion expressed by the patient)_____because ___(indicate the experiences and the behaviours)_____”

- A middle age woman comes to therapy to work on lack of assertiveness tells the therapist about an incident where she was able to confront her mother.
  - T “It sounds to me like you are feeling strong because you were able to tell your mom how you feel without backing down.”

“Learning” in supportive psychotherapy

- Support and action phases well described in supportive psychotherapy
- “Learning” is less well developed, but includes
  - Facilitating change in self perception – improving self esteem
  - Facilitating change in the perception of the presenting problem – problems as challenges to be solved or coped with
  - Corrective emotional experience

Corrective Emotional Experience

- “transformation of painful emotional conflicts within the therapeutic relationship”
- “Re-experiencing the old unsettled conflict but with a new ending”
- Alexander and French 1946
- Working through painful emotional conflicts by experiencing new and more adaptive feelings in the therapeutic relationship
- Bridges 2006

Corrective Emotional Experience

- An impressive body of research supports the contention that patient's in session experiencing and processing of painful, unresolved emotions, in a safe and empathic therapeutic relationship are necessary to bring about a new ending
- Bridges 2006

Corrective Emotional experience

- 3 key components
  - Emotional arousal, emotional experience, emotion expression, emotional processing
- Emotional arousal
  - Optimal emotional arousal
  - Therapists must have skills to both encourage emotional expression and to help individuals regulate intense expressions of anger, fear, shame
- Emotional experience
  - Patient's subjective, felt sense of the quality and intensity of their emotions
  - Bridges 2006

Corrective Emotional Experience

- Emotional expression
  - Verbal and non verbal expressive behaviours
- Emotional processing
  - Meaningful integration of emotion and cognition
  - Emotional insight
  - Reorganization of a patient's sense of self
  - Improved ability to respond adaptively
- Emergence of positive emotions indicates significant emotional processing and resolution
- Bridges 2006

What do you do when Listening and Empathy don't work?

- Dealing with "resistance", transference and countertransference – to be covered Oct 26
- Nov 16 VTS session at National Gallery
- Nov 23 2016: Intro to Problem Solving therapy Dr Green
- Dec 7 2015: Change Strategies, intro to supervision
- Feb 8, Mar 22, April 19 2016: Supervision

Summary

- There are Specific and Common Factors in Psychotherapy
- Specific Techniques are important but when applied properly they tend to produce similar outcomes
- Client Factors, Alliance and Therapist factors account for most of the explained variance in Psychotherapy.
- Supportive Psychotherapy skills of support/empathy support new emotional learning and set the stage for change strategies including coping strategies and problem solving strategies
- Supportive psychotherapy can be used to improve outcome in any psychiatric treatment and is an important component of all of the other psychotherapies.

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Action/Change strategies

- Supportive Psychotherapy session 4
- Oct 2016
- Deanna Mercer MD FRCPC
- Ruth Taylor MD FRCPC

Objectives

At the end of this session residents will be able to

1. describe the relationship between support, learning and change/action strategies in supportive psychotherapy
2. Describe the general strategies for change in supportive psychotherapy
3. Describe the concept of barriers to change and basic strategies to identify and help patients work through barriers to change

Week 4 quiz

1. State the overall goal of supportive psychotherapy
2. Describe the main goal of the support phase/pillar of supportive psychotherapy
3. Describe what is meant by a “corrective emotional experience”
4. State the two ways of experiencing empathy
5. Describe the relationship between listening and empathy

Quiz #3

- Which of the phases of supportive psychotherapy would these actions belong to?
  Support, Learning, Action/Change
  - Forming a trusting relationship
  - Working through emotional distress
  - Experimenting with new behaviors
  - Facilitating expression of thoughts and feelings

Quiz #3

- Which of the phases of Supportive psychotherapy would these actions belong to?
  - Forming a trusting relationship **(Support)**
  - Working through emotional distress **Learning**
  - Experimenting with new behaviors **(Action)**
  - Facilitating expression of thoughts and feelings **(Support)**

  They all result in Learning

Quiz #3

- Rank those factors from Highest to Lowest correlation with outcome in psychotherapy:
  - Therapist Factors
  - Patient Factors
  - Therapeutic Alliance
  - Extra-therapeutic change
  - Technique (Specific Factors)

  **Bonus: Which are the three so-called common factors?*

Quiz #3

- Rank the Common factors from Highest to Lowest correlation with outcome in psychotherapy:
  - Extra-therapeutic change
  - **Patient Factors***
  - **Therapeutic Alliance***
  - Technique (Specific Factors)
  - **Therapist Factors***

Quiz #3

- True or False?
  - Working Alliance is usually defined as *agreement on Goals, Tasks and Quality of Bond?*
  - Securely attached therapist and patients tend to have better outcome than insecurely attached patients and therapist?
  - Patient with Personality disorder crave for meaningful relationship and tend to form stronger alliance than patients without PD

Quiz #3

- True or False?
  - Working Alliance is usually defined as *agreement on Goals, Tasks and Quality of Bond?* **True**
  - Securely attached therapist and patients tend to have better outcome than insecurely attached patients and therapist?
    - **True**, *in insecurely attached patient and therapist, matching Th-Pt with complementary style leads to better outcome (ie: Dismissive-Anxious better than Anxious-Anxious)*
  - Patient with Personality disorder form stronger alliance than patients without PD
    - **False.** *More antagonistic, less able to trust in general.*

Week 4: Integrate your knowledge

Mr M is an 85 year old man who is admitted to internal medicine following a fall with failure to thrive and 60 lb weight loss. 4 months ago his wife had a stroke and was placed in a nursing home. MR M's only family is his wife. Mr M has a past history of depression. Workup shows advanced metastatic lung cancer.

Q1: what do you think he is feeling, thinking?

Q2: how does this make you feel?

Week 4: Integrate your knowledge

You are assigned to Mr M and have been given instructions by your senior to "talk to Mr M".

1. What is your task with Mr M?
2. What is the goal of your treatment with him?

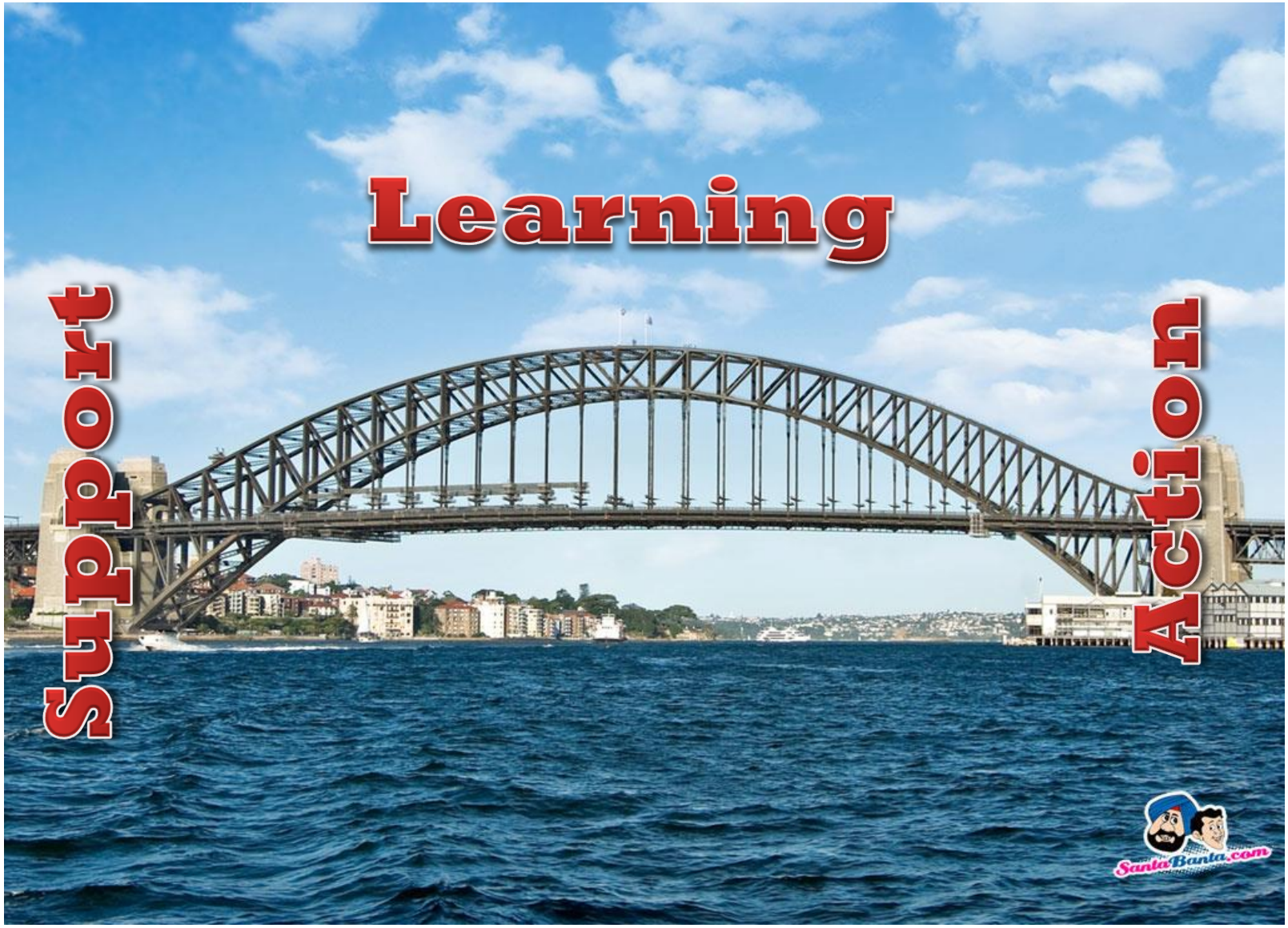
Mr M responds that since you are young and a doctor you clearly can have no idea of how he is feeling about this situation and he isn't sure that talking to you about this is will be helpful to him.

3. What are the challenges for the therapeutic/working alliance/bond?
4. What will you say to Mr M?

CHANGE STRATEGIES

Supportive psychotherapy

Supportive Psychotherapy Change Strategies



The two emotion system model

LIFE

Social/Affiliative
"Wise Mind"

emotions

thoughts

Problem Solving

Strategies to cope

Eating well
Sleeping
Meds
Avoiding drugs and alcohol
Exercise
Pleasant activities
Building Mastery

911/safety response

Anger
Fear
shame

fight
flight
freeze

Change

- What is the patient to do differently?
  - Hundreds? Millions ? solutions to problems
  - Many adaptive ways to cope with problems that can not be solved.
  - Where to find these solutions and ways of coping?
    - reading, from your supervisors, from life experiences, from other mental health colleagues.
- How do we support and encourage patients to make these changes?

Change – Coles notes!

1. Ask patient what they have done in the past with similar problems.
   - How did that work?
   - Are there any barriers to using that strategy (problem solving or coping) again?
2. What have they thought about trying
   - Easier to implement strategies that one has thought about, can imagine oneself doing
3. New strategies

Acceptance

- For many people having a therapist actively listen to and understand their experiences provides a corrective emotional experience. This helps them to accept the problems that they have and then they are able to move on to problem solving and/or coping with difficult experiences
- For others who are not able to tolerate and accept their experiences – psychotherapies (ACT, DBT, mindfulness) have been developed to help with the first step of accepting and tolerating difficult experiences

General Change Techniques

- Rationalizing/Reframing
- Advice and teaching
- Anticipatory guidance
- Psychoeducation
- Praise
- Reassurance
- Encouragement/behavioural activation
- Goal setting/SMART – covered in PST

Techniques

- RATIONALIZING & REFRAMING
  - Rationalize – give a rationale for a situation / outcome (psychoeducation)
  - Reframe – an alternative way of looking at a situation / outcome (CBT)
  - May be challenging to avoid sounding argumentative or contradictory
  - Goal is to improve self-esteem, reduce anxiety

Techniques

- RATIONALIZING & REFRAMING – E.g
  - Pt: *"My 15 yo son keeps his room such a mess. He knows it drives me up the wall. I think he does it just to spite me."*
  - Th: *"If we think of your son's keeping his room messy as a rebellion against you, it can be seen as a fairly safe way of doing something on his own without getting into trouble, and we can see that you have given him enough sense of security that he can begin to act on his own. This may be an indication that you've done things right."*

Techniques

- RATIONALIZING & REFRAMING – E.g
  - Pt: *"I was so stupid. I got a parking ticket, and I could have been back before the meter ran out. I wasn't paying attention."*
  - Th: *"Yeah. That's tough. If you figure it's bound to happen occasionally, you can think of a couple of parking tickets a year as a routine cost of having a car."*

Rationalizing and Reframing

- ROH addictions.
- 34 year old recently separated woman, 5 year old daughter. Manager with Health Canada.
- Oxycodone Use Disorder. 40 – 50 mg/d
- Admitted for severe withdrawal sx.
- Hx ‘anxious temperament”. Teased and bullied as a kid as was overweight. Pattern of emotionally and physically abusive relationships, including her marriage.
- In session reports that she is embarrassed ,“Huge step back” - can’t support herself and daughter on her own while trying to deal with her addiction and has moved back in with her parents.

Advice and Teaching

- Advice – specific suggestions
- Teaching – principles to guide decision making
- In general teaching is more effective than advice
- For advice
  - Best if can help patient figure out own solutions (e.g. use Socratic questioning – CBT)
  - When making suggestions remember to:
    1. Find out if your patient can imagine doing what you are suggesting
    2. Find out if your patient thinks the suggestion might work
    3. Trouble shoot any potential barriers

Advice and Teaching

- In general avoid giving advice when patient can make own decisions e.g. decorating choices, internet security

  - *Pt: "You know I worry about everything. Do you think it's safe to use my credit card on the internet? I read that they can steal your identity…"*
  - *Th: "Yes, I've read about that. I think the psychotherapy question is not whether I think it's a good idea but how you come to a decision when there are different opinions or when you have competing pressures."*

Advice and Teaching

- Teaching is more important than advice – educate re principles / universalities
  - *Th: You tend to put up with things until you become furious; then, for example, you scream at people. Dealing with a problem before it becomes extreme is usually a better approach.*
  - *Th: Even if you are right, people do not like to be told what to do.*

Cases

- ROH addictions
- 35 year old male. 10 year hx daily alcohol and THC use years. Recently unemployed and THC/alcohol escalated. Verbally aggressive with wife. She and 5 children have gone to a shelter. Patient has no contact with his children. Abstinent for 2 weeks. Is thinking of leaving treatment in order to find his children. He asks you to help him make this decision.
- What advice do you have for him?
- How would you use Socratic questioning to help him find his own solution to this problem.

Anticipatory Guidance

- rehearsal
- Also used a lot in CBT (part of behavioural experiments)
- Help anticipate obstacles & strategies to deal with various scenarios
- More concrete guidance needed for more impaired patients

Anticipatory Guidance

Pt: I'm seeing my internist next week about this indigestion and weakness.

Th: You know, I hope, that you should start with the most distressing symptom and not at the beginning. Are you willing to rehearse what you will say to explain your problem to the doctor?

Pt: OK… I've been feeling generally bad for 3 months, and for about 3 weeks, I've felt nauseated almost every day. It's worse after I eat.

Th: Good! And if anyone says, "Do you understand?" and you are not completely sure, say, "Would you go over it again?"

Anticipatory Guidance

- E.g. Relapse Prevention
  - Help identify high-risk situations & ways to deal with them
  - Talk about how to cope with negative emotional states
  - Talk about how to cope with interpersonal conflict
  - Talk about how to cope with social pressure
  - Identify early symptoms of relapse
  - Help develop plan of action for monitoring recurrence of symptoms and intervention

Anticipatory Guidance

- 24 year old male with BD I and alcohol use disorder. Last episode precipitated by 3 day “bender”. Has stopped using, signed up for addictions program which will start in 3 months. Returning to complete 4th year psychology program.
- Q1: When will be high risk times for relapse?
- Q2: How will you introduce this topic?
- Q3: what advice would you give him?

Naming the problem/Psychoeducation

- Enhances sense of control & reduces anxiety
- Helps individual to organize their efforts at change
  - Patient - My mother says I shouldn't lay down so much, but it feels better when I do. I read the adds every week, but the jobs don't pay enough and there's no future. I don't have much money left. It would be great if I won the lottery. There was one job that might have had something, but I would have to commute – I hate that.
  - Therapist- This has been going on for a long time. You no longer have symptoms of depression, so the current medication seems right. I think your problem is demoralization. That's a condition in which a person is convinced that her efforts won't succeed, so she does nothing. The only way out is to begin doing things, anything. Small steps can lead to small successes. It's a rehabilitation approach. It affects self esteem and confidence.

Psychoeducation

- Family Medicine
- 44 year old female. Hx alcohol dependence in full remission for 10 years. 1 year ago partner enter politics. Patient required to attend multiple social gatherings, host dinner parties. Had no free time, unable to attend AA (previously attended twice a week) and around alcohol several times a week. Started to drink daily (1 bottle of wine) and has developed severe depressive symptoms.

1. Differential diagnosis?
2. Using Choosing Wisely Canada guidelines suggest a treatment plan. Provide psychoeducation about your treatment suggestions.

Reassurance

- “this is going to get better, you are going to be OK ”
- Used a lot in medicine
- Most effective when patient believes you have heard their story and you understand them
- not just saying what patient wants to hear
- Stay within limits of your expertise

Reassurance

- 50 year old mother of 2, separated, BPD for many years. Starts DBT next week. States she is not hopeful that this treatment will work, since none have helped in the past (patient has never done DBT)
- Parents of a 22 year old man, 3 year history progressive functional decline, recent admission for psychosis in the context of daily marijuana use. On antipsychotic meds for 3 weeks and has stopped using and is a bit better. Parents are very afraid he will never get better.
- Patient with OCD and violent obsessions that involve their children. Patient is very afraid that they will hurt their children. No past history of violence/agression, despite having OCD for many years

PRaise

- Positive Reinforcement of adaptive behaviour
- Fastest way to increase adaptive behaviours
- Make sure that the positive reinforcer is actually reinforcing
  - Some people need over the top reinforcement before they believe you, others need quiet praise in order to be willing to repeat the behaviour
- How would you positively reinforce:
  - Patient with schizophrenia reports no THC use over the past month
    - 16 year old
    - 35 year old mom with 3 young children who's partner still uses

Encouragement

- “You can do it”
- Indicating that you believe in the patient and their ability to make changes builds hope
- Important to make sure you believe that the change is achievable
- Big changes require small steps – sometimes very small
- If a patient is not able to do that small task, break the task down into even smaller tasks
- Encouragement (having someone believe you can do something) is helpful when trying to get patients to engage in adaptive behaviours
  - Maintain hygiene, get exercise, interact with others, be more independent, accept caring

Encouragement

Pt: All I was able to do last week was go to a movie. I must be in bad shape.

Th: One of the worst things about depression is that it makes you unable to even imagine things being better. Everything that was ever good is new evidence of how bad you are now. That's the illness. It may be hard to believe, but medications and gradually getting back into your usual activities usually makes a difference and the depression lifts. For now going to a movie is a good first step."

Barriers to Change

- “Resistance”
- Reference Learning Psychotherapy, 2nd ed, Beitman and Yue Module 6 page 227

- What do you think ‘resistance” means?

Origins of Resistance

- Psychoanalysis
  - Forces within the patient opposed to the recollection of repressed memories

- Greenson 1967 – broader concept
  - “all those forces within the patient which oppose the procedures and processes of analysis”

3 Barriers to Change

- Patient
  - 22 year old with schizoaffective disorder and THC use disorder – afraid to quite smoking because believes his depression will get worse
- Therapist
  - Expects that patient “should” quit because they were told to do so
- Patient’s social network
  - All of the patient’s friends use and tell the patient he is not as much fun when he doesn’t use with them

Barriers to change - Patient

1. Fear of change
2. Inability to carry out the task
   - Patient would like to stop using, but is not aware of strategies that he can use to achieve this
3. Transference
   - Patients parents disapprove of his use and see it as a personal weakness. Patient assumes that therapist believes the same. When therapist insists that he stops using he gets angry because he believes the therapist sees him as “weak”.

Barriers to change - therapist

- Inappropriate or excessive expectations
  - Lack of knowledge about patient
    - Therapist not aware that patient doesn't have strategies to help him to stop using
  - Lack of knowledge about therapeutic techniques
    - Therapist unaware of strategies to increase motivation to stop using (ie motivational interviewing)
  - Countertransference
    - Therapist's brother uses THC heavily and doesn't recognize the impact it has on his depression and subsequent marital problems. Therapist is angry with her brother and responds to him with frustration. Therapist assumes patient is aware of the impact of his use on his illness and is just ignoring this information and is frustrated and impatient with her patient.

Barriers to Change- Social Network

- Criticism of patient for being in psychotherapy
  - Parents believe that if patient stopped using and got a job all his problems would be solved
- Antagonism towards changes that might disturb the equilibrium of the social network
  - Friends all use and are criticized by their parents for using too much. If patient quits using, friends are worried that there will be increased pressure on them to quit.

Recognizing Barriers to Change

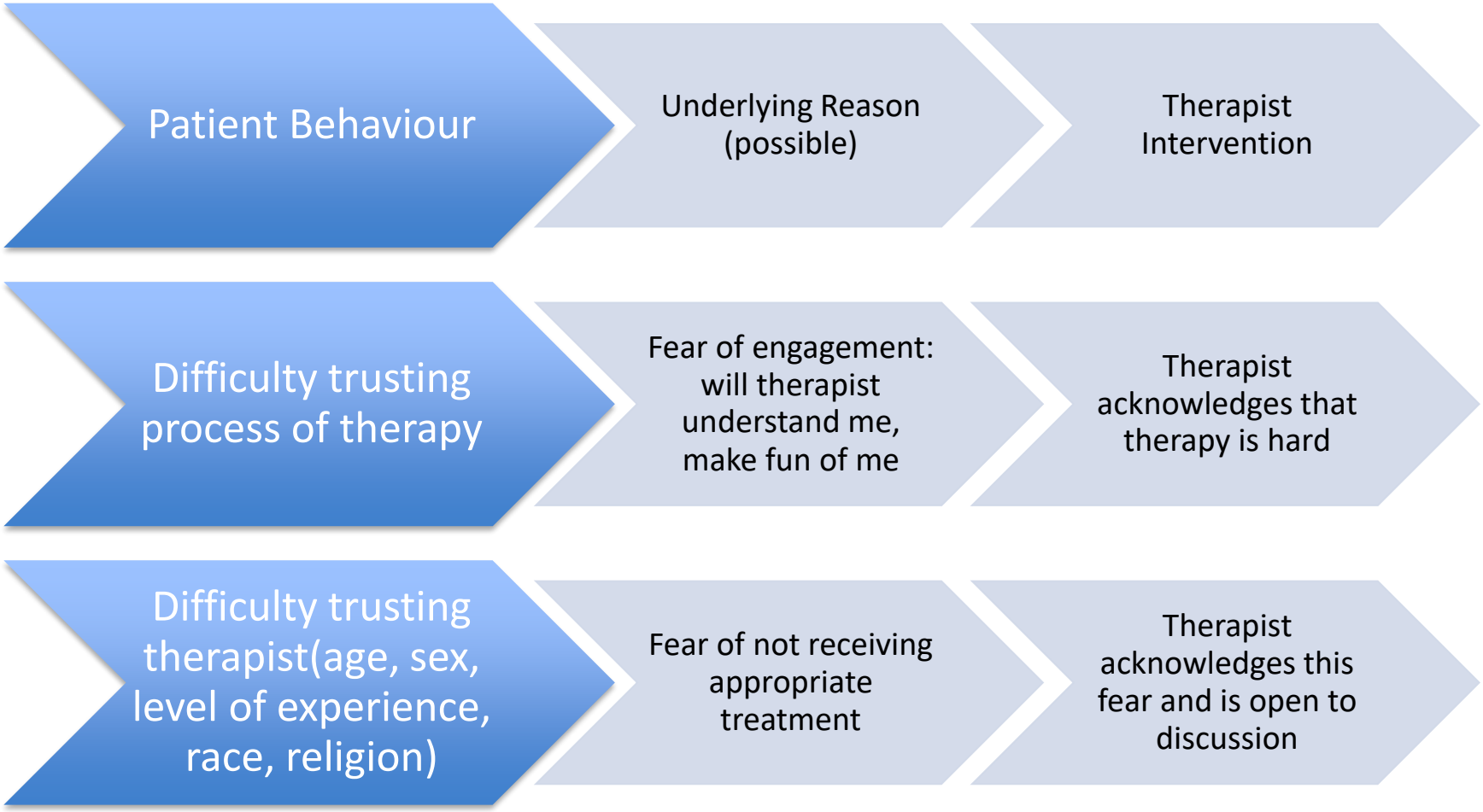
- "Patient appears to not be meeting therapist expectations for progress in therapy"

1. Clinician's emotional response
   - Discomfort: Frustration, Anxiety, Shame
2. Compare what "should" be happening at this stage of therapy to what is happening
   - Support phase
     - Engagement – establishing a good working alliance

Barriers to change: stage of treatment

- Support/Learning phase
  - Empathy and Listening
    - Engagement
    - Engagement = working/therapeutic alliance
      - Agreement on tasks and goals
      - Quality of the bond – quality of mutuality and collaboration
  - Pattern Search
    - Understanding the problem
      - Problematic patterns of thoughts, feelings, behaviour

Engagement


Patient Behaviour
Underlying Reason (possible)
Therapist Intervention
Difficulty trusting process of therapy
Fear of engagement: will therapist understand me, make fun of me
Therapist acknowledges that therapy is hard
Difficulty trusting therapist(age, sex, level of experience, race, religion)
Fear of not receiving appropriate treatment
Therapist acknowledges this fear and is open to discussion

Pattern Search

Pattern search- Tasks : identifying problematic patterns of thought, feeling and behaviour.

Failure to identify these patterns – patient lying, withholding information, talking about irrelevant information, attacking therapist

Possible reasons: fear of re-experiencing the pain associated with those patterns; fear of therapist response; fear therapist will violate confidentiality

“Change” phase

Tasks of Change phase: taking on new patterns of thoughts and behaviours

a) Patient agrees to a new way of thinking or acting, but fails to follow through. Patient won’t consider therapist’s suggestions. Patient ends therapy.

Potential reasons: Patient is not clear on what must be done to accomplish what they want. Fear: change involves doing something a new way, and patient fears that potential losses outweigh potential gains. Influences in environment resist change.

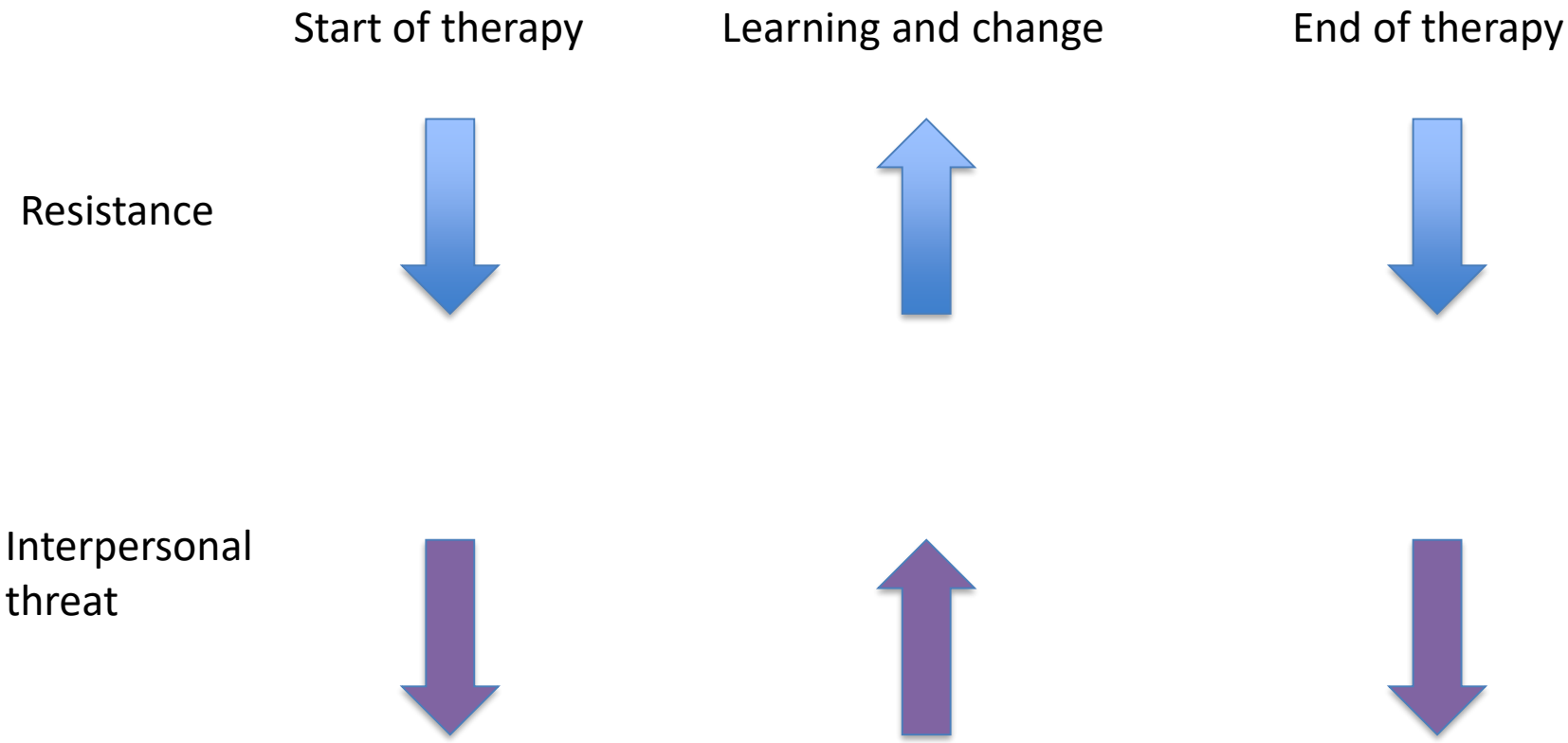
Ending Treatment

Maintaining improvement without support of the therapist

Patient has new symptoms, problems at the end of the treatment. Patient continues to call/request appointments at the end of treatment

Patient is not better; Fear of separation (fear of normal sadness at the end of a relationship); fear that they will not be able to maintain gains, handle situations on own.

Barriers to change



Orlinsky, Howard 1978

Dealing with Barriers to Change

Stumbling blocks to stepping stones

1. Identify what is happening
2. Respect the information that is presenting itself – understanding that this is important information
3. Strategies
    i. Reduce/modify the task
    ii. Gentle encouragement
    iii. Psychoeducation
    iv. Interpret the behaviour * this will be covered in depth in psychodynamic psychotherapy.
    v. Acceptance and work on other areas

Interpreting the Behaviour: Fear of Change

- Will be covered more in psychodynamic psychotherapy
- Fear of emotional pain is a common reason for people to avoid changing
  - Patient agrees to stop THC use, but reports at the next session that they continued to use. When you ask about this they avoid eye contact and explain that they are afraid that their friends won't want them around if they don't smoke with them. "they say I am not very much fun to be around if I'm not using"
- Fear often underlies anger
  - "no matter how inappropriate, nasty, sarcastic or demanding a patient's behaviour can be, therapists should remain aware that self protection is probably the reason".
  - When you try to explore the reasons why your patient didn't follow through with the agreement to stop using he gets really irritated and says.."yeah, like you know all about how to be perfect. You don't know what it is like to live my life, you should try it some time." and turns away.

Fear of Change: Therapist response
Put your O_2 on first

- Breathe
- Remind yourself that the likely underlying cause is fear
- Try to understand
  - “OK, I get you are irritated with me. I’m making this sound easy, but it really isn’t. Can you help me understand what makes this hard for you? “
- Help patient to examine the pros and cons of changing and not changing the behaviour
  - “so using helps you to feel accepted by your friends, and helps you to relax around them. Any downsides to using?
  - If you don’t use your friends my feel uncomfortable around you, might not invite you to hang out. Any upsides to not using? “

Three reasons for therapist frustration/anger

- Empathy – picking up on frustration that your client is feeling
- Countertransference – frustration based on past experiences and what is happening in the session
- Barriers to change – your client is not progressing in therapy the way that you had hoped

Summary: Change and Barriers to Change

- Change strategies need to follow support and learning phases in order to be effective
- General change strategies include helping patients change how they are thinking about their problem as well as specific suggestions about new behaviours.
- Change strategies can be grouped into strategies that help patients to i) accept and cope in the face of problems that they are not able to change and iii) problem solving strategies
- Barriers to change are common and arise from the patient, therapist and patient's social network. Identifying and understanding barriers to change allows therapists to transform stumbling blocks into stepping stones.

Action/Change strategies

- Supportive Psychotherapy session 5
- Benjamin Fortin-Langelier, MD FRCPC
- Deanna Mercer MD FRCPC
- Oct 2019

Objectives

At the end of this session residents will be able to

1. Describe the relationship between support, learning and change/action strategies in supportive psychotherapy
2. Describe the general strategies for change in supportive psychotherapy
3. Describe the concept of barriers to change and basic strategies to identify and help patients work through barriers to change

Agenda

1. Quiz
2. General Change strategies
3. Barriers to Change

Session 5 quiz

1. Empathy requires all of the following except:
   a) Affective arousal
   b) A low ACE score
   c) Emotional understanding/perspective taking
   d) Emotion regulation
   e) Empathic concern/Compassionate behavior

Session 5 quiz

2. True or False?
   a) Working Alliance is usually defined as *agreement on Goals, Tasks and Quality of Bond?*
   b) Patient with Personality disorder crave for meaningful relationship and tend to form stronger alliance than patients without PD

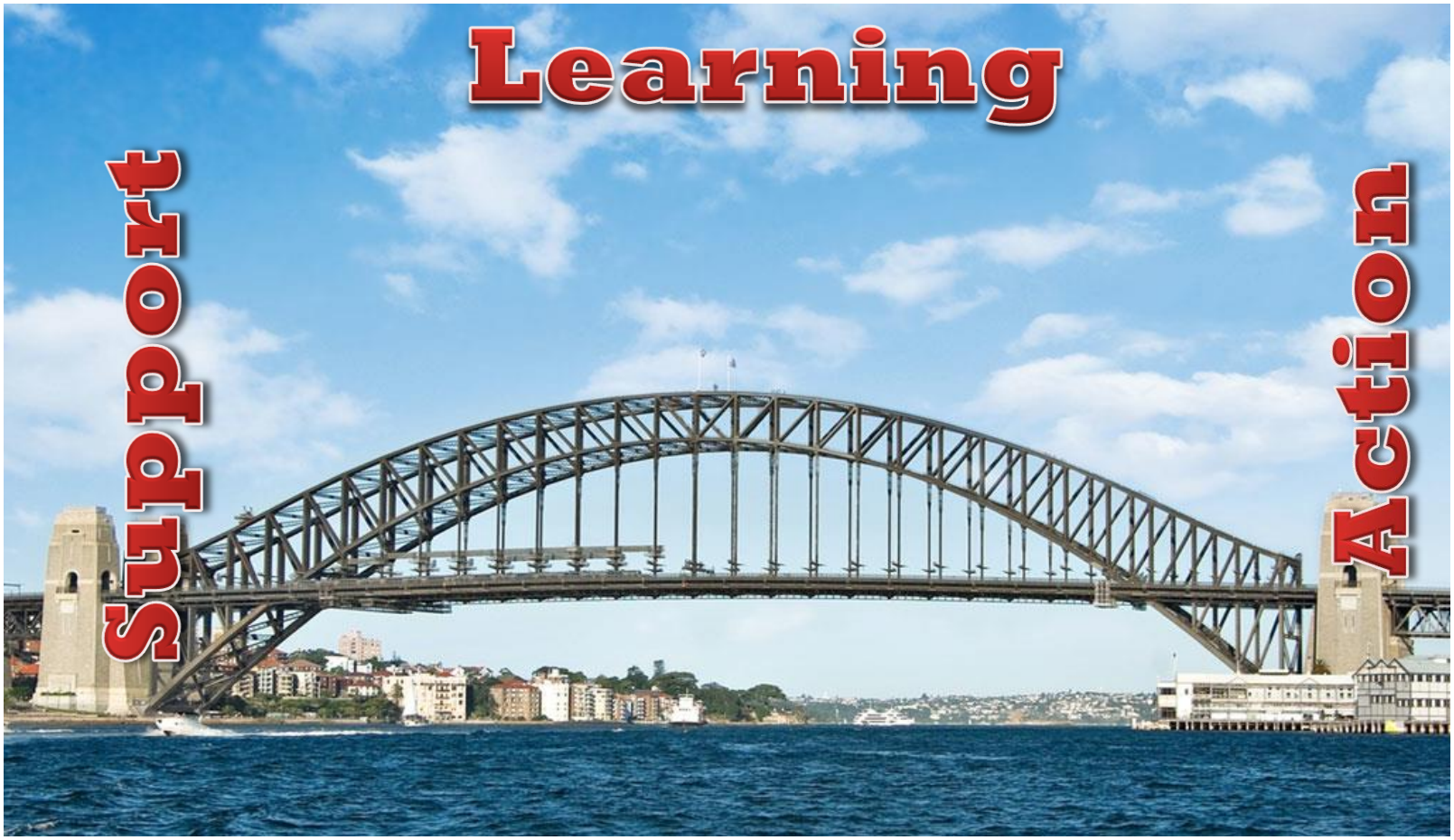
Session 5 quiz

3. Supportive therapy can provide scaffolding to learn specific psychotherapy models by fostering awareness of factors that impact therapy outcome across all forms of psychotherapy. Give an example of how supportive therapy can help increase effectiveness with regards to the following common factors:
   a) Therapeutic alliance
   b) Patient factors
   c) Therapist effect

CHANGE STRATEGIES

Supportive psychotherapy

Supportive Psychotherapy Change Strategies



General Change Techniques

- Support

1. Reframe
2. Educate & Reassure (Advice)
3. Anticipatory guidance (Prepare)
4. Praise & Encourage (Reinforce)

- Problem Solving Therapy (session 6)

Support Fosters Change

- Validation & Expression of Empathy
  - Decrease arousal allows flexibility in problem solving
- “The curious paradox is that when I accept myself just as I am, then I can change.”
  - Carl Rogers, *On Becoming A Person*

Reframe

- Giving a new perspective, and opening possibilities. (Change assigned meaning)
- Core technique of Family/Systems Therapy
- Variations in different model:
  - CBT: Identifying and correcting distortions
  - IPT: The Sick role
  - Psychodynamic: Interpretations

Reframe

- *Pt*: “You’re rejecting me and you don’t care!”
- *Th:* “I truly *believe you have the capacity to handle this crisis.* I’m worried admitting you to hospital would send the opposite message” “Let’s look at your list of distress tolerance tools and see how we can prepare you for the difficult time ahead”

Reframe

- Using theory to make sense of behavior, such as attachment:
- An unsupportive spouse may be using de-activating attachment strategies to protect link with attachment figure:
  - Wife: “He never listens, it’s like he doesn’t care”
  - Th: “Right, we talked about this. Sometimes, when Jo (husband) detects a bit of anger, things get scary and he goes into “silent mode”, trying not to rock boat, so that you can both stay safe”
- An angry teenager’s attack may be reframed as attachment protest
  - “Are you seeing me?”, “Am I important to you?”

Educate & Reassure

- Giving a diagnosis.
  - “ You have Obstructive Sleep Apnea, left untreated, it can interfere with the recovery of MDD/PTSD. It is a serious, but treatable condition. The main treatment is a CPAP machine. It can take time to tolerate the CPAP, but since this is so important we’ll make sure we can find a way to make it work.”

Educate & Reassure

- Socratic Approach to Advice
- In general avoid giving advice when patient can make own decisions e.g. decorating choices, internet security

  - *Pt: "You know I worry about everything. Do you think it's safe to use my credit card on the internet? I read that they can steal your identity…"*
  - *Th: "Yes, I've read about that. I think the psychotherapy question is not whether I think it's a good idea but how you come to a decision when there are different opinions or when you have competing pressures."*

Educate & Reassure

- Teaching is more important than advice – educate re principles / universalities
- *Th: You tend to put up with things until you become furious; then, for example, you scream at people. Dealing with a problem before it becomes extreme is usually a better approach.*
- *Th: Even if you are right, people do not like to be told what to do.*

Exercise

- One person lists a symptom / complain
- The other responds with a reframe/diagnosis

- « I feel so tired »
- « Reduced energy is a common symptom of Major Depressive Disorder »

Anticipatory Guidance

- Prepare patients for difficult times.
- Ex: Preventing perinatal depression:
  - *Th*: “You’re about to become a parent. This will be a difficult transition. You will need help and support. Who can be there to make sure you can also rest and take care of yourself to make sure your child has a healthy mother.”

Anticipatory Guidance

Pt: I'm seeing my internist next week about this indigestion and weakness.

Th: You know, I hope, that you should start with the most distressing symptom and not at the beginning. Are you willing to rehearse what you will say to explain your problem to the doctor?

Pt: OK… I've been feeling generally bad for 3 months, and for about 3 weeks, I've felt nauseated almost every day. It's worse after I eat.

Th: Good! And if anyone says, "Do you understand?" and you are not completely sure, say, "Would you go over it again?"

Anticipatory Guidance

- E.g. Relapse Prevention
  - Help identify high-risk situations & ways to deal with them
  - Talk about how to cope with negative emotional states
  - Talk about how to cope with interpersonal conflict
  - Talk about how to cope with social pressure
  - Identify early symptoms of relapse
  - Help develop plan of action for monitoring recurrence of symptoms and intervention

Activate & Reinforce

	Increase a Behavior (Reinforcement)	Decrease a Behavior (Punishment)
Add (+) Something		
Remove (-) Something		
RESULT		

Kaplan & Sadock 2009

Activate & Reinforce

- Positive Reinforcement of adaptive behaviour
- Fastest way to increase adaptive behaviours
- Make sure that the positive reinforcer is actually reinforcing
  - Some people need over the top reinforcement before they believe you, others need quiet praise in order to be willing to repeat the behaviour
- How would you positively reinforce:
  - Patient with schizophrenia reports no THC use over the past month
    - 16 year old
    - 35 year old mom with 3 young children who's partner still uses

Activate & Reinforce

- Emotions are reinforcers and punishments.
- “I feel good after spending time with friends”
  - The feeling follows the action, patients will need encouragement to take the initial risk and the joy of seeing your pride may be the only initial reinforcer.
- “I felt angry after paying my parking ticket”
  - Anger is unpleasant and aversive

Activate & Reinforce

Pt: All I was able to do last week was go to a movie. I must be in bad shape.

Th: One of the worst things about depression is that it makes you unable to even imagine things being better. Everything that was ever good is new evidence of how bad you are now. That's the illness. It may be hard to believe, but medications and gradually getting back into your usual activities usually makes a difference and the depression lifts. For now going to a movie is a good first step."

Putting into practice

- Reframe
- Educate and Reassure
- Anticipatory Guidance (Prepare)
- Activate and Reinforce

Case 1

- 24 year old male with BD I and alcohol use disorder being discharged from inpatient unit. Latest manic episode precipitated by a 3 day “bender”. He signed up for addictions program which will start in 3 weeks. Hoping to resume university courses.
- Q1: When will be high risk times for relapse?
- Q2: How will you introduce this topic?
- Q3: what advice would you give him?

Case 2

- 26 y.o. M with Schizophrenia. You meet him and his parents who are very upset of how lazy their son has become. He no longer has hallucination or delusions and should be getting ready to go back to work, but only sits on the couch all day.
- Q1. How would you be supportive to the parents and patient?

Case 3

- 34 F veteran with PTSD.
- Isolating increasingly. Leaves home once a week by fear of having a panic attack
- Pt: “I’m not a social a person, I prefer staying home”
- Q1: How do you make sense of her behavior?
- Q2: How would you approach it with the patient?

Case 4

- 44 year old female. Hx alcohol dependence in full remission for 10 years. She discloses with much shame that she has had a relapse for the past 6 months and had chosen not to mention anything in the past 2 appointments you had with her.

Agenda

- ✓ Quiz
- ✓ General Change strategies
3. Barriers to Change

Barriers to Change - Where

- Patient
  - 22 year old with schizoaffective disorder and THC use disorder – afraid to quite smoking because he believes his depression will get worse
- Therapist
  - Expects that patient “should” quit because they were told to do so
- Patient’s social network
  - All of the patient’s friends use and tell the patient he is not as much fun when he doesn’t use with them

Barriers to change - Patient

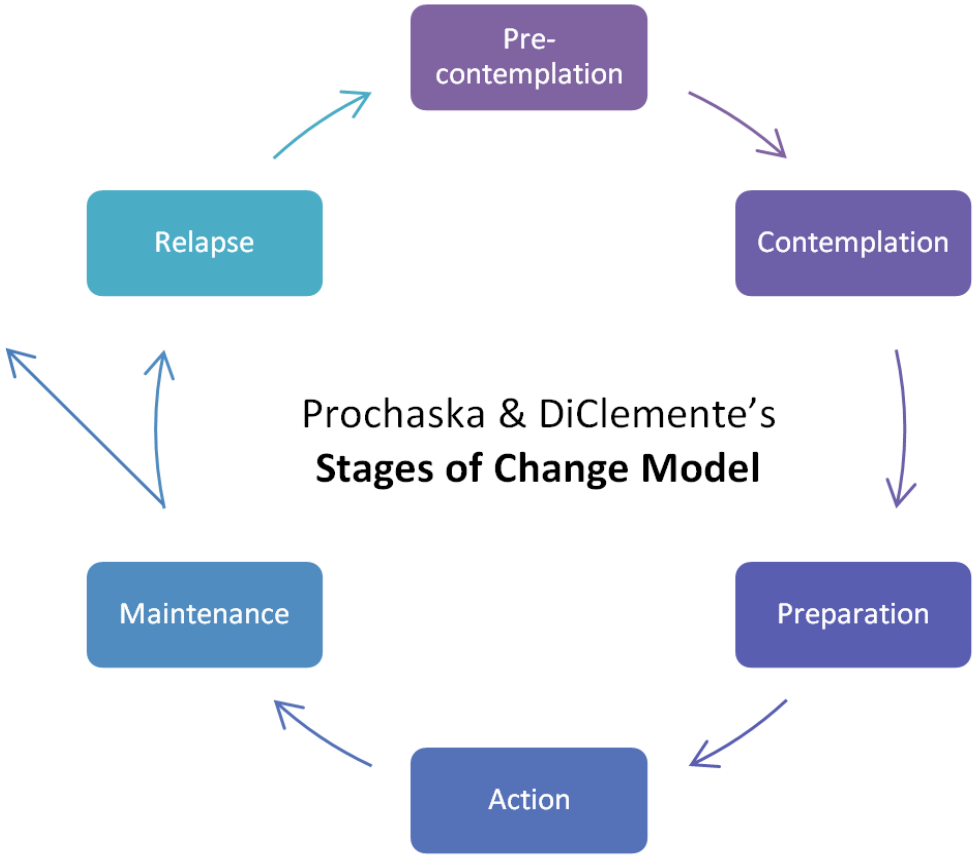
1. Inability to carry out the task
   - Patient would like to stop using, but is not aware of strategies that he can use to achieve this
2. Transference / Psychodynamics
   1. Negative reaction to therapist/therapy
   2. Fear based reaction

Barriers to change - Patient

1. Readiness for change

Motivation=

Desire to change x Belief that change is possible



Barriers to change - Therapist

- Inappropriate or excessive expectations
  - Lack of knowledge about patient
    - Therapist not aware that patient doesn't have strategies to help him to stop using
  - Lack of knowledge about therapeutic techniques
    - Therapist unaware of strategies to increase motivation to stop using (ie motivational interviewing)
  - Countertransference – Negative relational stance
  - Assumption of incapacity of patient to change

Barriers to Change- Systemic factors

- Criticism of patient for being in psychotherapy
  - Parents believe that if patient stopped using and got a job all his problems would be solved
- Antagonism towards changes that might disturb the equilibrium of the social network
  - Friends all use and are criticized by their parents for using too much. If patient quits using, friends are worried that there will be increased pressure on them to quit.

Recognizing Barriers to Change

- "Patient appears not to be meeting therapist expectations for progress in therapy"

Key cues

1. Clinician's emotional response
   - Discomfort: Frustration, Anxiety, Shame
2. Compare what "should" be happening at this stage of therapy to what is happening
   - Support phase
     - Engagement – establishing a good working alliance

Barriers to change - When

- For each stage of treatment:
  - How would a barrier manifest?
  - What could you do about it?
- Engagement, Establishing alliance
- Change phase
- Ending

Dealing with Barriers to Change

Stumbling blocks to stepping stones

1. Identify what is happening
2. Respect the information that is presenting itself – understanding that this is important information
3. Strategies
    i. Reduce/modify the task
    ii. Gentle encouragement
    iii. Psychoeducation
    iv. Interpret the behaviour * this will be covered in depth in psychodynamic psychotherapy.
    v. Acceptance and work on other areas
    vi. Re-explain rational for tasks

Interpreting the Behaviour

- Fear
  - Fear of change
    - Loss, Risk, and Emotional pain in general
  - Fear expressed though aggression
- Negative relational pattern

Barriers: Therapist response
Put your O_2 on first

- Breathe
- Remind yourself that the likely underlying cause is fear
- Try to understand
  - “OK, I get you are irritated with me. I’m making this sound easy, but it really isn’t. Can you help me understand what makes this hard for you? “
- Help patient to examine the pros and cons of changing and not changing the behaviour
  - “so using helps you to feel accepted by your friends, and helps you to relax around them. Any downsides to using?
  - If you don’t use your friends my feel uncomfortable around you, might not invite you to hang out. Any upsides to not using? “

Three reasons for therapist frustration/anger

- Empathy – picking up on frustration that your client is feeling
- Countertransference – frustration based on past experiences and what is happening in the session
- Barriers to change – your client is not progressing in therapy the way that you had hoped

Summary: Change and Barriers to Change

- Change strategies that follow support result in more effective learning.
- General change strategies include helping patients change how they are thinking about their problem as well as specific suggestions about new behaviours.
- Change strategies can be grouped into strategies:
  - To accept and cope problems that can't be changed
  - To problem solve
- Barriers to change are common and arise from the patient, therapist and patient's social network. Identifying and understanding barriers to change allows therapists to transform stumbling blocks.

Supervision Package

- 4 sessions
- 1 case per session
- Group discussion (3 smaller group)
- Fill:
  - Case description
  - Listening + Change strategy sheet
  - WAI-T
- Ask Patient to fill HAT

Problem-solving Therapy in Primary Care

D Green MD

Case

- 65 year old married woman on dialysis presents with severe depressive symptoms and passive suicidal ideation expressing feelings of hopelessness and helplessness about her situation and a sense of being “overwhelmed”
- Had been treated with various antidepressants but had never had any type of psychotherapy
- Main stressors related to health issues, relationship issues, problems with her home environment and lack of support

The Need for Psychosocial Treatments in Primary Care

- Mental disorders, especially depression, are common in primary care
- Most cases are first identified in primary care and majority of treatment takes place there
- Treatment often consists of medications, reassurance and some form of brief counselling

The Need for Psychosocial Treatments in Primary Care (contd.)

- Over one-third remain symptomatic 6 months to 5 years after diagnosis
- Although medications are often first line treatment many patients do not adhere to treatment
- Remission rates low especially with initial medication and often may require a non-medication approach

Rationale for problem-solving approach

- Research has shown that minor life events or problems are strongly associated with psychological symptoms, especially depression
- The degree of impact of a stressor in part moderated by personal coping abilities including the ability to problem solve

Rationale for problem-solving treatment

- The patients' symptoms are caused by their everyday problems
- If the problems can be resolved, the symptoms will improve
- Problems can be resolved using the technique of problem-solving

We cannot solve our problems with the same thinking we used when we created them (Albert Einstein)

Goals of problem-solving treatment

- For patients to understand the link between their symptoms and their problems
- To define the patient's current problems
- To teach a problem-solving technique that attempts to resolve problems in a structured way
- To provide patients with a positive experience of problem-solving

Evidence for PST

- Since its introduction researchers have found PST to be an evidence-based treatment for **depression**
- A 2009 meta-analysis (Bell and D'Zurilla) concluded that PST can be an effective treatment for depression
- Although not found to be more effective than alternative psychosocial therapies it was more effective than supportive therapy control group

Evidence for PST

- Also studied in generalized anxiety disorder, obesity, recurrent headaches, cancer, diabetes and offenders
- All studies showed benefit from treatment with PST as a stand alone treatment or as part of a more comprehensive treatment approach
- A 2007 meta-analysis (Malouff et al) conducted across 32 studies with a total of 2,895 participants with a variety of mental and physical health problems provides strong quantitative evidence of its efficacy.

PST in primary care

- In randomized controlled trials, when delivered by appropriately trained FPs to patients experiencing major depression, PST has been shown to be more effective than placebo and equally as effective as antidepressant medication (both tricyclics and SSRIs)

Mechanism of action

1. Patient improves because they achieve problem resolution or
2. They improve because of a sense of empowerment gained from PST skill development or
3. Both of the above factors

Which patients may benefit?

- Patient experiencing a symptom related to life difficulties, including relationship, financial or employment problems, which are seen by the patient in a realistic way
- Frequently patient feel overwhelmed and confused by these difficulties
- Can be used in patients who are on antidepressant medication (although there may not be an additive benefit)

Major Problem-Solving Dimensions

1. Problem orientation
2. Problem-solving skills

Problem orientation

- Serves a motivational function in dealing with problems
- Reflects a general awareness of problem, as well as his or her own problem-solving ability (e.g. Threat vs. challenge appraisal, self-efficacy beliefs, outcome expectancies)
- 2 categories
  1. **Positive problem orientation**
  2. **Negative problem orientation**

There are solutions even to the hardest problems

“Positive Problem Orientation”

1. Appraise a problem as a “challenge”
2. Believe that problems are solvable
3. Believe in one’s personal ability to solve problems successfully
4. Believe that successful problem solving takes time, effort and persistence
5. Commit to solving problems rather than avoiding them


City Hall
"No problem is too big or too small."
OH, NO, YOUR PROBLEM ISN'T TOO BIG OR TOO SMALL - IT'S JUST TOO DIFFICULT.
Search: 122682274
Balco

“Negative problem orientation”

1. View a problem as a significant threat to psychological, social or health wellbeing
2. Doubt one’s ability to solve problems successfully
3. Become emotionally upset when confronted with problems in living (i.e. low frustration and uncertainty tolerance)

Major Problem-Solving Dimensions

1. Problem orientation
2. Problem-solving skills

Problem-solving skills

- Activities by which a person attempts to understand problems in everyday living and to find effective “solutions” or ways of coping with them
- Involves 4 major skills:
  1. Problem definition and formulation
  2. Generation of alternative solutions
  3. Decision making, and
  4. Solution implementation and verification

Three problem-solving styles

1. Rational style
2. Impulsivity/ carelessness style
3. Avoidance style

Rational style

- Constructive problem-solving style that involves the rational, deliberate and systematic application of the 4 major problem-solving skills
- Does not include solution implementation skills

"I think we should immediately launch this program before our rational thinking sets in."

Impulsivity/carelessness style

- Attempts at problem-solving are narrow, impulsive, careless, hurried and incomplete
- Typically considers only a few alternatives and often impulsively goes with the first idea that comes to mind
- Monitors solution outcomes carelessly and inadequately

"Of course I'm doing something about the problem — I'm avoiding it!"

Avoidance style

- Style characterized by procrastination, passivity or inaction and dependency
- Waits for problems to resolve themselves and attempts to shift the responsibility for solving his or her problems to other people

Multitasking

- According to cognitive psychologist Marvin Levine the conscious mind engages in three important activities during problem solving:
  a) It takes in information from the environment
  b) “displays” the information when needed (retrieves the information from our memory banks)
  c) Manipulates the information that is remembered and attempts to comprehend it

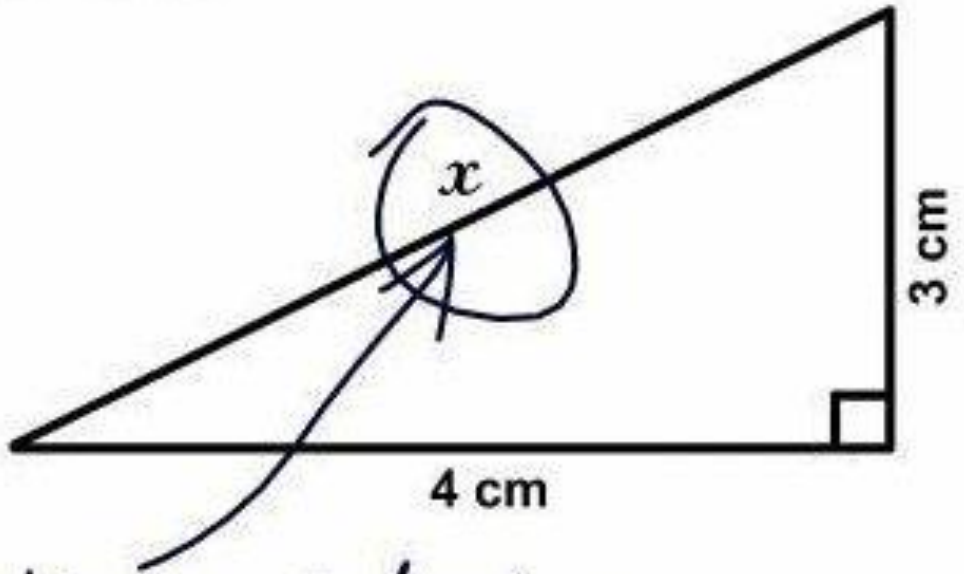
Multitasking

- However the capacity of the conscious mind is limited in that it cannot perform all three activities at the same time, especially when the quantity and complexity of the information is substantial

Ways to promote problem-solving multitasking

1. **Externalization**
   - Write ideas down, draw diagrams to show relationships, make lists
2. **Visualization**
   - Use imagination to visualize the problematic situation and rehearse solution alternatives
3. **Simplification**
   - Focus on only the most relevant information
   - Break down complex problems into more manageable smaller problems
   - Translate complex, vague and abstract concepts into more simple, specific and concrete terms

3. Find x.



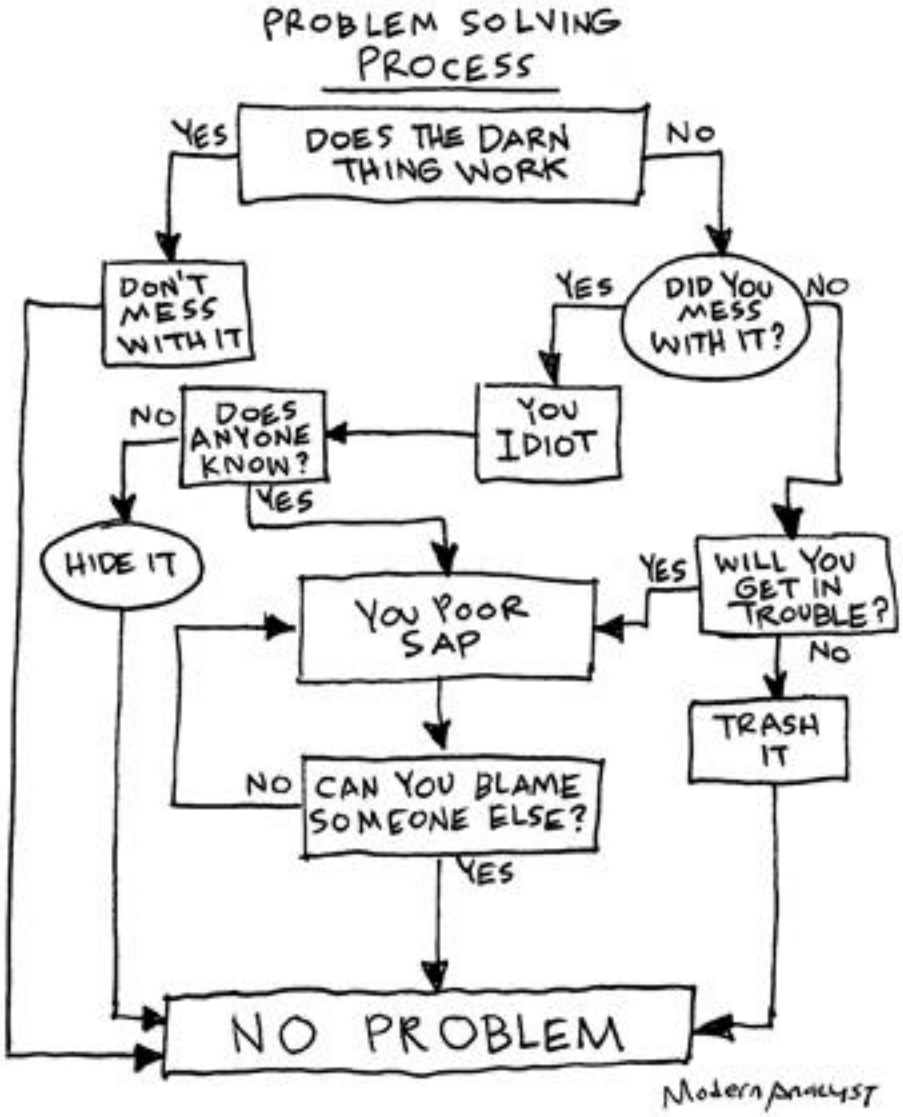
Here it is

Assessment in PST

- Therapist identifies:
  - Major life events
  - Current daily problems
  - Emotional stress responses
  - Problem-orientation deficits
  - Problem-solving style deficits
  - Solution implementation skills deficits

PST treatment

1. Increase positive orientation
2. Reduce negative orientation
3. Improve rational problem-solving skills
4. Reduce or prevent impulsive/careless problem solving
5. Minimize tendency to avoid problem solving
6. May also involve other CBT methods(e.g. social skills training, exposure methods) to teach effective solution implementation skills


PROBLEM SOLVING PROCESS
DOES THE DARN THING WORK
YES
NO
DON'T MESS WITH IT
DID YOU MESS WITH IT?
YES
NO
YOU IDIOT
DOES ANYONE KNOW?
NO
YES
HIDE IT
YOU POOR SAP
WILL YOU GET IN TROUBLE?
YES
NO
TRASH IT
CAN YOU BLAME SOMEONE ELSE?
NO
YES
NO PROBLEM
Modern Analyst

The Problem Solving Loop

1. Identify the problem.

2. Explore information and create ideas.

3. Select the best idea

4. Build and test the idea.

5. Evaluate the results.

ADAPT

- **A**ttitude
- **D**efine
- **A**lternatives
- **P**redict
- **T**ry out

Attitude

- To determine the patient's attitude about a problem ask him or her to describe to you their:
  - **Thoughts** - before, during, and after the problem occurred
  - **Feelings** - before, during, and after the problem occurred
  - **Behaviour** – what he or she did to cope
  - **Degree of satisfaction** with how he or she coped

➢ Assess whether they have overall a **positive** vs. a **negative** orientation to the problem

Barriers to adopting a positive orientation

1. Poor self-confidence
2. Negative thinking
3. Negative emotional reactions

Overcoming negative thinking: Healthy thinking rules

1. How we think about a situation often affects how we feel about it (ABC model)
2. Nothing is 100% perfect – problems are a normal part of life
3. All humans make mistakes
4. Every minute spent thinking negative thoughts takes away from the pleasure of focusing on positive aspects of life
5. It takes two to have a bad relationship (30% rule)
6. Forget winning – learning lasts longer- think of problems as challenges not threats

ADAPT

- Attitude
- **D**efine
- Alternatives
- Predict
- Try out

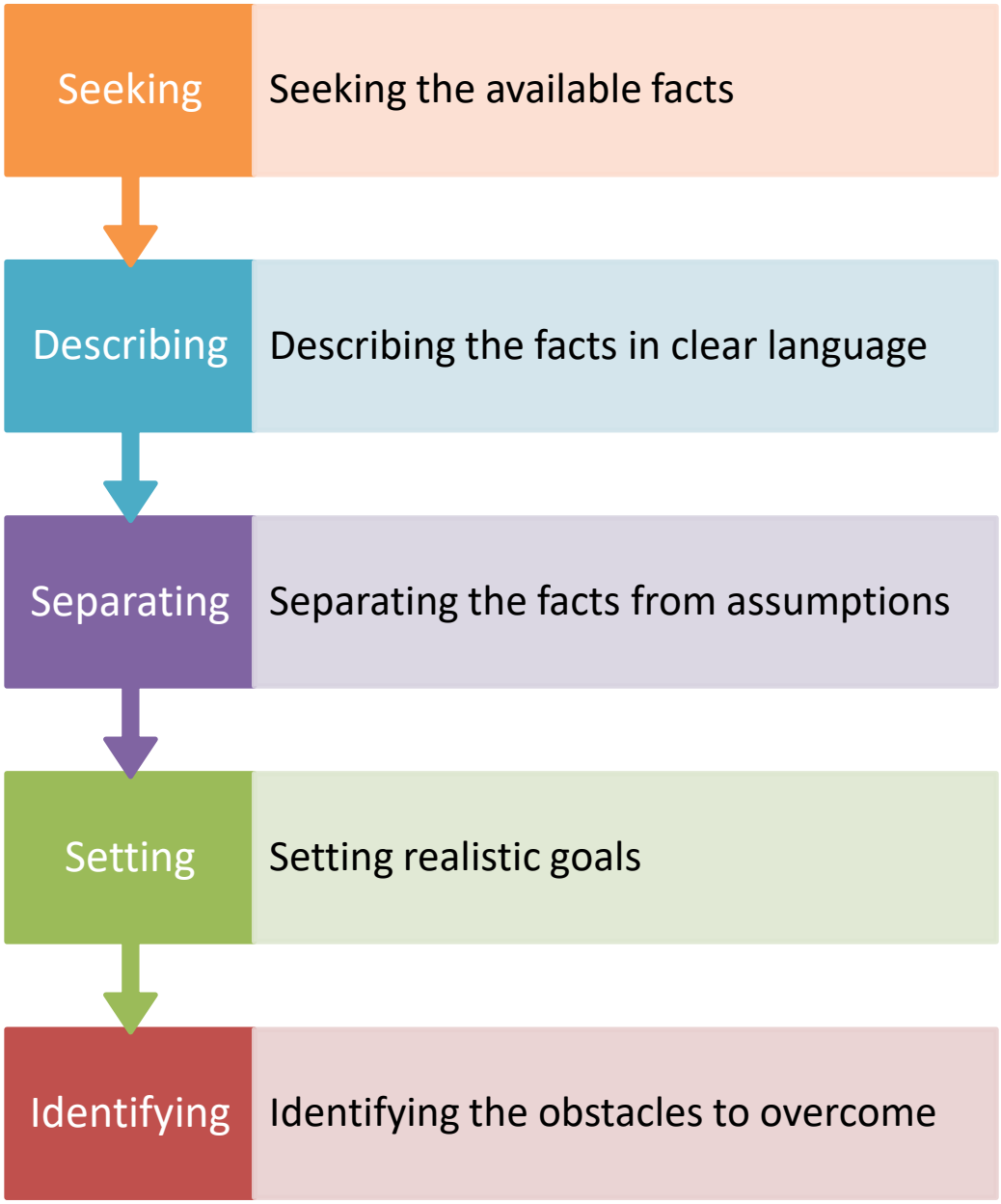
“It isn’t that they can’t see the solution. It’s that they can’t see the problem”.

- G.K. Chesterson

“A problem well-defined is a problem half-solved.”

-John Dewey

5 steps in defining a problem



Seeking the available facts

- Who is involved?
- What happened (or did not happen) that bothers you?
- Where did it happen?
- When did it happen?
- Why did it happen?
- How did you respond to the situation? (i.e., actions, thoughts and feelings)j

Setting realistic goals

Need to identify goals that are attainable

If goal seems too large follow the simplification principle and break the problem into smaller ones, keeping the final destination in mind

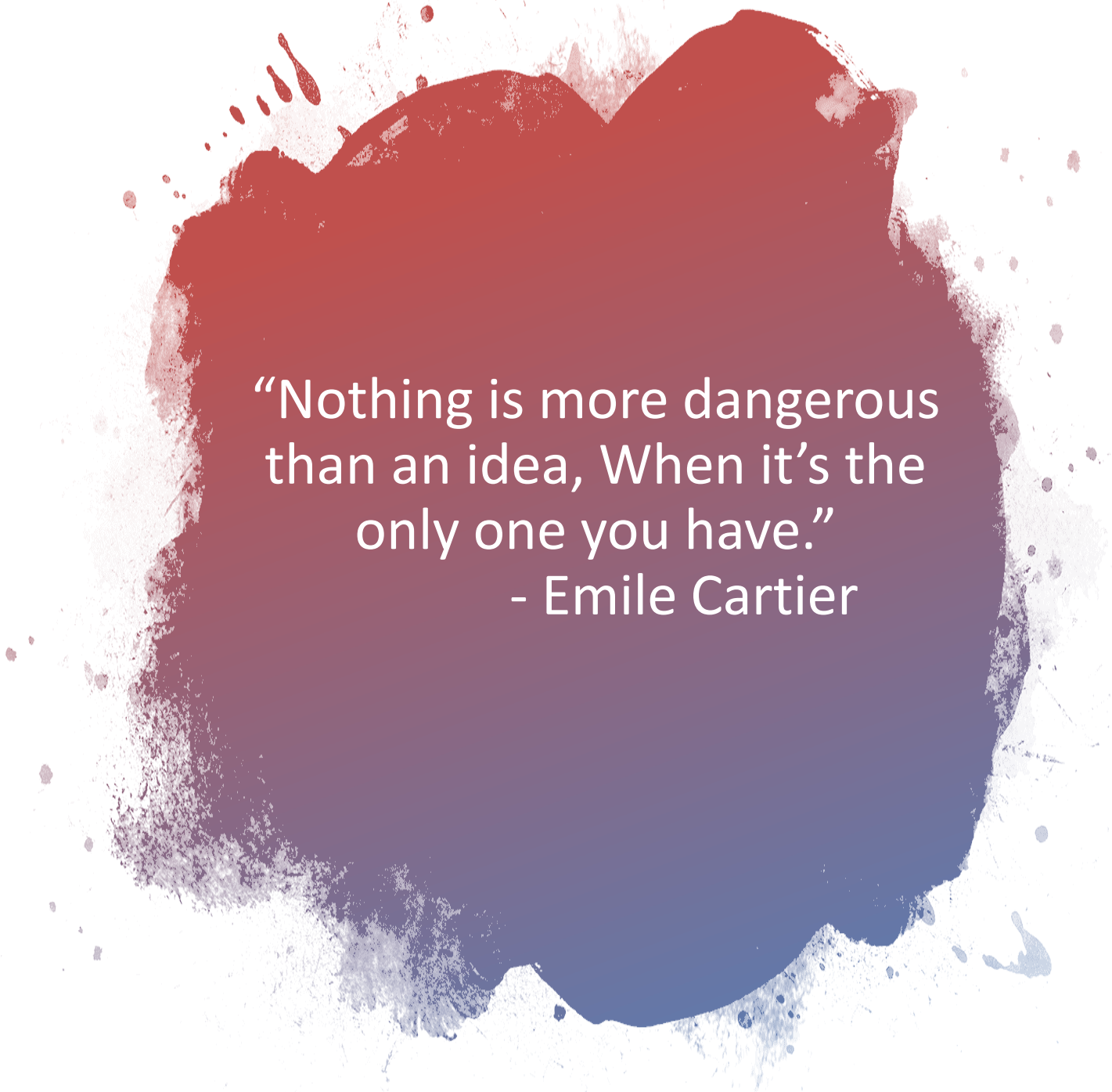
Need to identify objective is to change the nature of a situation so that it is no longer a problem (**problem-focused goal**) vs. accepting a situation that cannot be changed (**emotion-focused goal**)l

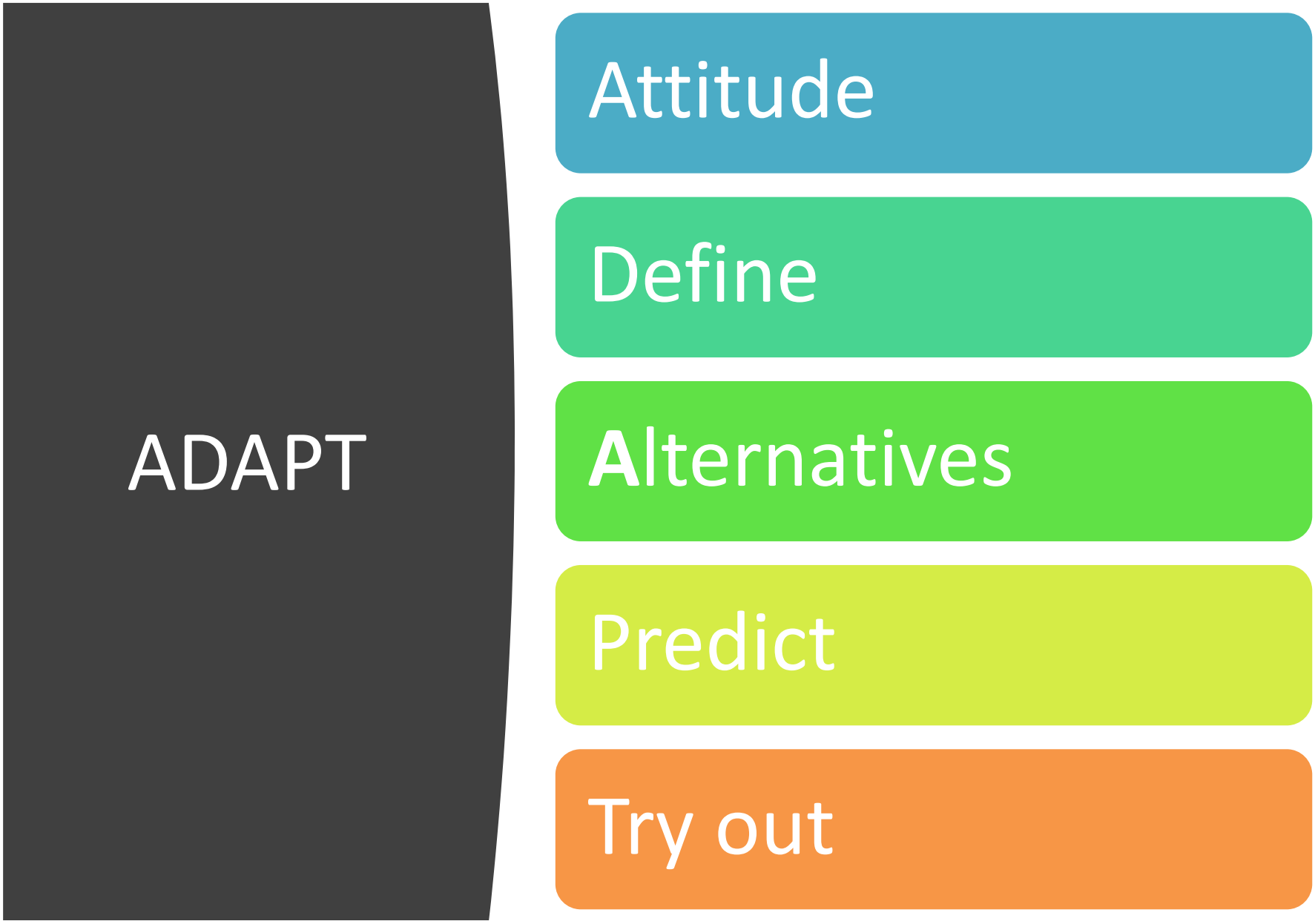
Important messages

keep patient focused on defining the problem rather than describing the solution

This helps to identify many more alternative ways to solve the problem

Encourage the patient to find his or his own solutions rather than accept advice of others as patient is in best place to know their own goals, values, resources and skills that he or she possesses


“Nothing is more dangerous than an idea, When it’s the only one you have.”
- Emile Cartier


ADAPT
Attitude
Define
Alternatives
Predict
Try out

Brainstorming principles

Quantity principle

Deferment principle

Variety principle

1.Quantity Principle

Important to generate as many ideas or solutions as possible

Research demonstrates that people will improve the selection of high-quality ideas by increasing the number of alternative solutions

Using the **externalization principle** it is important for the person to write a list of ideas rather than composing a list in one's head

2. Deferment Principle

To facilitate judgment it is important to *defer judgment*

Premature rejection of ideas can limit productive and creative thinking

Even if an idea seems silly or initially impossible it may lead to another idea which is more practical

3. Variety Principle

The greater range and variety of solution alternatives generated, the more good quality ideas will be made available

Have patient identify all the different **strategies** they are using

Strategies are general courses of action people can take to try and improve a problematic situation

Tactics are specific steps involved in putting the strategy in action

Problem solving are likely to be less effective or productive if limited by use of only one strategy

Therefore important for patient to think about a wide variety of both strategies and tactics

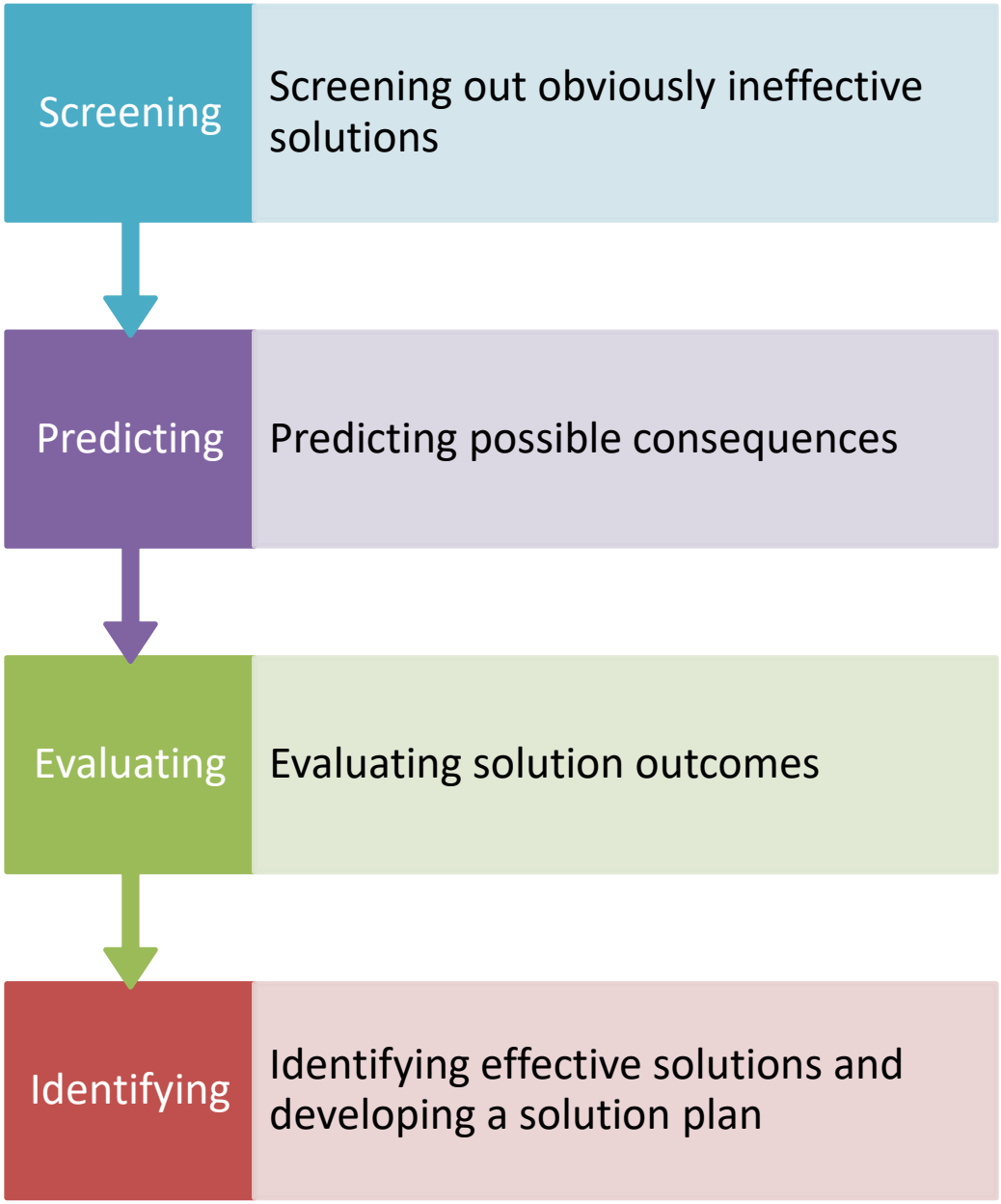
“There are in nature neither rewards nor punishments, There are consequences”

-Robert Ingersoll

ADAPT

- Attitude
- Define
- Alternatives
- **P**redict
- Try out

4 Steps in Making Effective Decisions



An *effective solution plan* should be consistent with the general goal of resolving the problem satisfactorily, while maximizing positive consequences and minimizing negative effects

Solution plan

Once the solution plan has been prepared the final step before it out is to fill in the details as to exactly **how**, **when** and **where** it will be implemented

ADAPT

- Attitude
- Define
- Alternatives
- Predict
- **T**ry out

Solution implementation and assessment

- Need to keep expectations realistic
- Even with most creative and useful ideas it is important for patient to have a step-by-step plan for implementation
- Writing down steps of plan (externalization) and imagine plan (visualization) can be helpful techniques

Performance evaluation

- Ask the patient the following questions:
  - ✓ Was the problem solved?
  - ✓ Was the effect on him or her more positive than negative?
  - ✓ Was the effect on others more positive than negative?

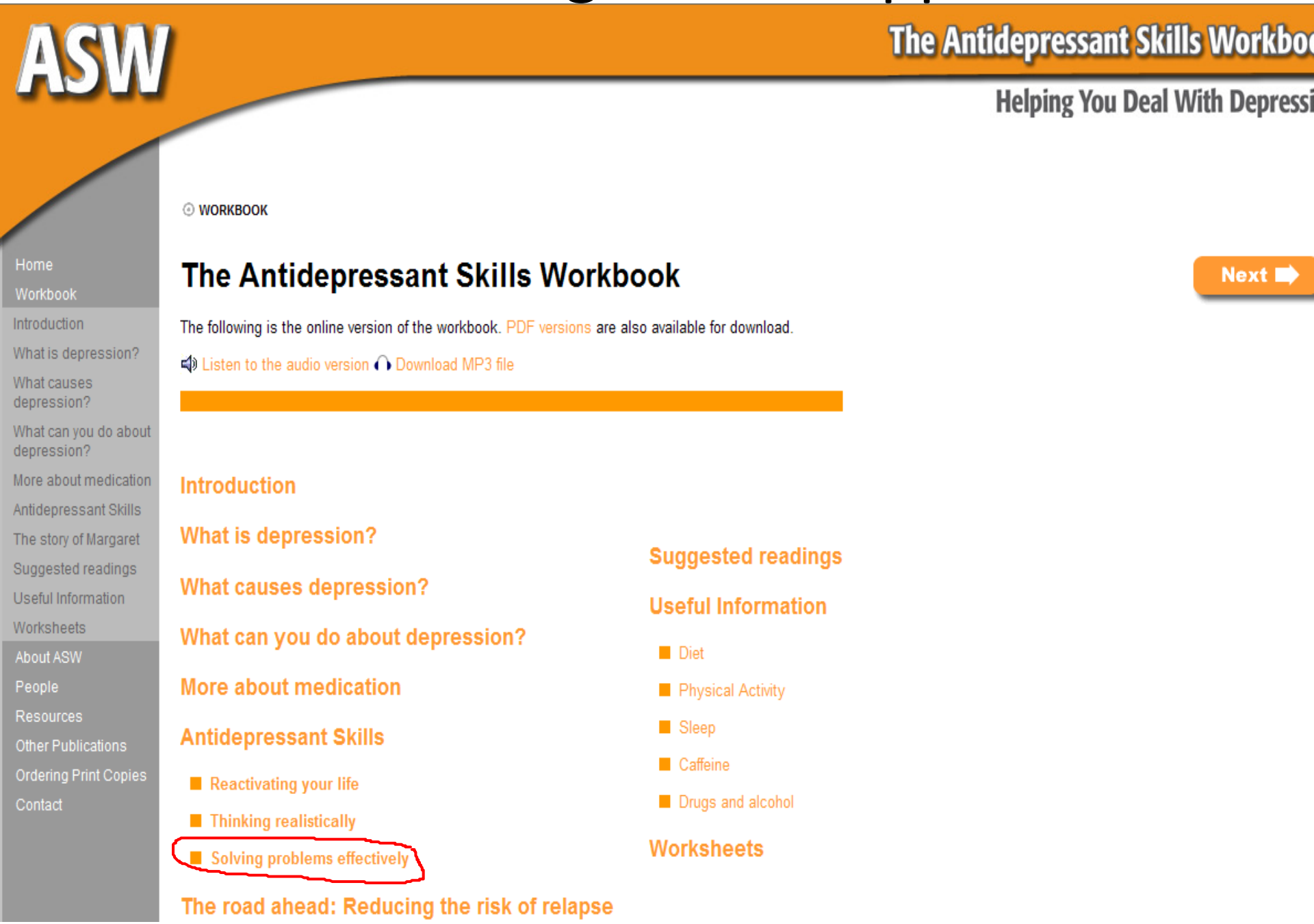
Other things to consider

- Make sure patient **rewards** him or herself for effort not just for outcome
- Important to **troubleshoot** area of difficulty if solution did not work out
  - Was the solution plan optimally carried out?
  - Were all important consequences identified?
  - Was the goal realistic?
  - Does the goal need to be changed?

Problem Solving Worksheet

Step 1	Identify the Problem Break it down into smaller steps and decide what you need to action first
Step 2	Brainstorm and write down as many ideas as you can that might help solve the problem, no matter how silly they seem – don't dismiss any possible solutions.
Step 3	Consider the pros and cons of each possible solution, using a separate piece of paper.
Step 4	Choose one of the possible solutions that looks likely to work, based on the advantages and disadvantages
Step 5	Plan out step-by-step what you need to do to carry out this solution. What? When? How? With whom or what? What could cause problems? How can you get around those problems? Is this realistic and achievable?
Step 6	Do it! Carry out the plan
Step 7	Review how it went. Was it helpful? Did you achieve what you set out to achieve? If not, how could you have done it differently? Did you achieve any progress, however small, towards your goal? What have you learned?
Step 8	If you achieved your goal – consider tackling the next step of your original problem. If you didn't fully achieve your goal – make adjustments to your chosen solution, or return to steps 3 and 4 and choose another possible solution.

Self Management Support



Moving Forward Mobile App

Moving Forward is a smartphone application designed to provide practical information and interactive tools for effective problem-solving and stress reduction. With Moving Forward, users are able to recognize their problem solving style and stress levels and learn how to become better problem solvers. The app is based on a cognitive behavioral therapy program successfully used by Veterans around the country. Veterans have given the program high marks, noting that it helped them feel more confident about their future, more able to cope with stress, and more optimistic about handling difficult problems. Although it is designed for Veterans and Service Members, Moving Forward is useful for anyone with stressful problems.

Moving Forward can help individuals facing challenges such as difficulties with balancing school and family life, finances, relationships, physical injuries, or adjustment to civilian life. The app provides education and tools to increase optimism, reduce stress, and develop a strategic approach to overcoming obstacles. The app may be used alone or in combination with the Moving Forward online course (www.startmovingforward.org).

Moving Forward Features

This FREE, evidence-based app is available now on iTunes.

Users can learn about Problem-Solving Training and topics such as:

- The role of stress
- Problem-solving attitudes
- Possibility of change

7 guided exercises to help users stop and slow down and prepare themselves for problem solving, including:

- Simplification
- Deep breathing
- Visualization

Quick access to preferred stress reduction tools

Users can:

- Identify strengths & weakness of problem solving style
- Assess stress level
- Track stress level and monitor progress over time

Guided problem-solving worksheets to:

- Identify a problem
- Set goals
- Brainstorm
- Create a plan
- Evaluate the outcome

Users have access to 3 different types of support:

- Personal contacts
- Links to crisis hotlines and professional mental health services
- Other resources, such as a link to the Moving Forward web-based course: www.startmovingforward.org

Case

- 65 year old married woman on dialysis presents with severe depressive symptoms and passive suicidal ideation expressing feelings of hopelessness and helplessness about her situation and a sense of being “overwhelmed”
- Had been treated with various antidepressants but had never had any type of psychotherapy
- Main stressors related to health issues, relationship issues, problems with her home environment and lack of support

Case (contd.)

- Her medication was switched from Celexa to Zoloft given her severe depressive symptoms (PHQ-9 of 20)
- Problem-solving model and rationale was presented to her
- She initially expressed interest as she said she had always been a good problem-solver but then went on to say that she had thought of every possible solution to her problems and “there were none”

ADAPT

- **A**ttitude
- Define
- Alternatives
- Predict
- Try out

How would you describe her problem orientation?

How would you describe her problem solving style?

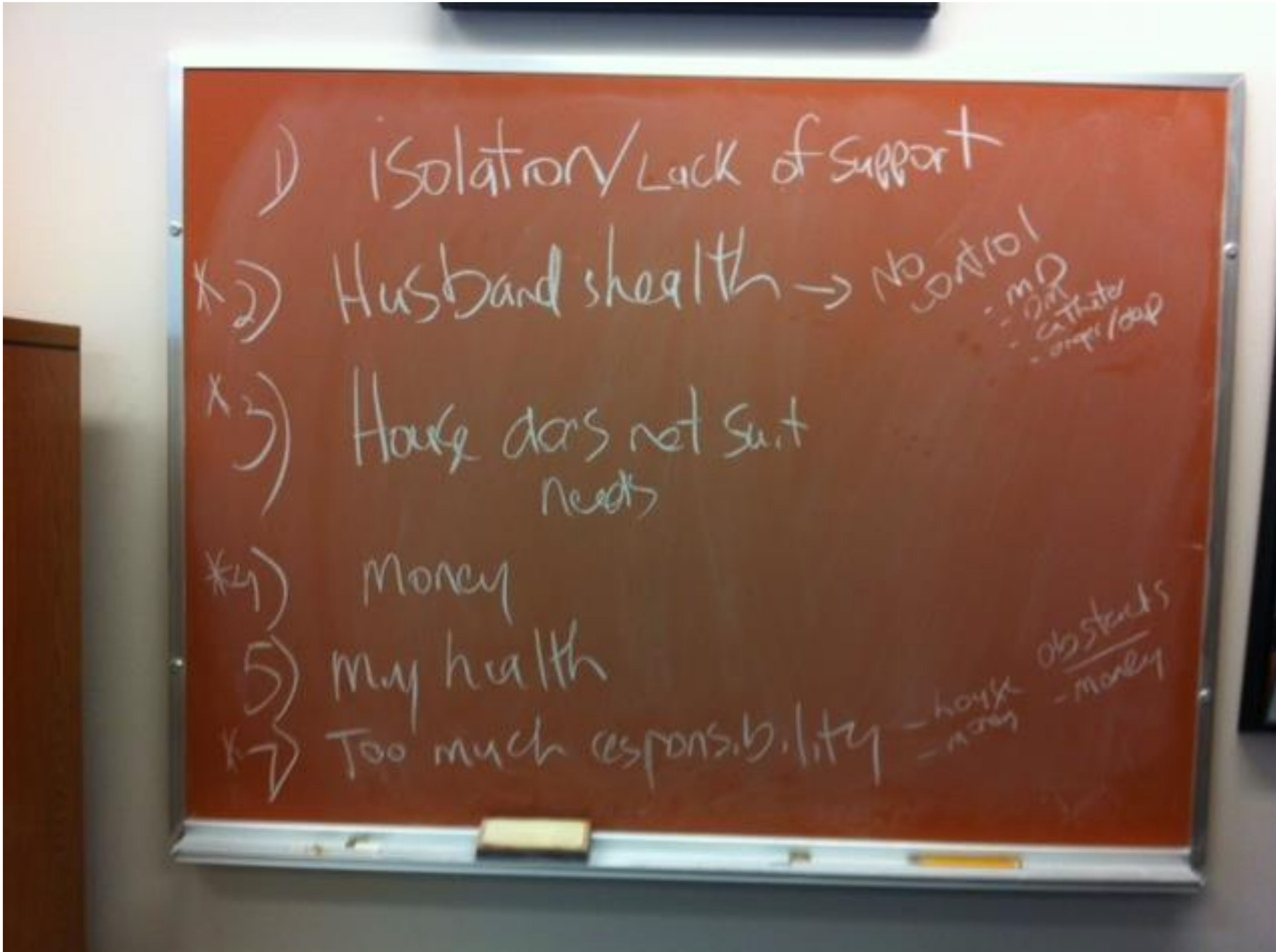
What would you do next?

Case (contd.)

- You address her negative cognitions using CBT and empathic comments and she agrees to generate a list of her problems with you

ADAPT

- Attitude
- **D**efine
- Alternatives
- Predict
- Try out


1) isolation/Lack of Support
x 2) Husband's health → No control
- MD
- catheter
x 3) House does not suit needs
*4) money
5) my health
x 7) Too much responsibility - house - money
obstacles
- money

Case (contd.)

- After much discussion and clarification she agrees to focus on her health problems
- Clarification of her problems indicates that she felt a lack of control of her health and decisions about her care
- With persistent focus on this problem she was able identify feeling ill after dialysis as something she wished to address
- This arose as her “dry weight” remained the same although her actual weigh had increased leading to the withdrawal of more fluid than she was used to which left her more prone to drops in her BP post-dialysis

ADAPT

- Attitude
- Define
- **A**lternatives
- Predict
- Try out

Case (contd.)

- Alternative discussed included:
  - Trying to lose weight
  - Speaking to her nurse
  - Speaking to the attending doctor
  - Trying to cope with the symptoms by doing less after dialysis

ADAPT

- Attitude
- Define
- Alternatives
- **P**redict
- Try out

Case (contd.)

- After discussing the pros and cons she opted to speak with the attending the doctor
- Pros: he or she could write the order
- Cons: may antagonize doctor given her irritability and tendency to dramatize her concerns
- She develops a multi- stepped plan as to how and when to approach the attending physician on the next dialysis day.
- You help her prepare a script to present her concern to the doctor

Solution plan

1. Prepare script to state request and rationale for increase in dry weight to the doctor and bring this to dialysis
2. After set up on dialysis ask nurse to tell the doctor that need a few minutes to ask a question
3. Try to stay calm by using breathing techniques for anxiety
4. Use script if necessary when speaking to the doctor

ADAPT

- Attitude
- Define
- Alternatives
- Predict
- **T**ry out

Case (contd.)

- On the following dialysis day she enacts her plan
- She became nervous and instead of reading from her script blurted out a comment about the doctor either raising her dry weight or she may have to cut her wrists
- The doctor eventually agreed to raise the dry weight although she thinks the doctor finds her “strange”
- Please however with the outcome and admits she now feels slightly less stressed
- You praise for making the effort and encourage her to address other problems with your help

In summary

- Problem-solving is based on the notion that many psychological symptoms arise from failed attempts to address problems found in everyday life
- Problem-solving therapy has been demonstrated to be an effective psychotherapy for depression in primary care
- It can be delivered by different providers, with minimal training
- Using the ADAPT acronym various steps can be easily remembered

Empathy

Deanna Mercer MD FRCPC

CPA September 2017

Objectives

- Describe the literature demonstrating that empathy improves outcomes for patients and reduces physician burnout. Describe ways to maintain empathy in our lives and clinical practice

Case

- Very angry man, believes his wife has tried to poison him, threatening suicide, and angry because no-one believes him and no-one wants to help him
- Diagnosis: MDD with psychosis
- Seroquel XR 50 mg was added to Remeron 45mg
- Patient refusing higher doses as fears sedation as living in his car or a tent and concerned about his safety if too sedated

Empathy: A new idea?

- Central to psychiatry since Karl Jaspers described phenomenology as being the use of empathy to understand our patients
- Newer therapies with a focus on empathy: Mindfulness, Validation (DBT), Mentalization (MBT)
- Core of the “support pillar” in our model of Supportive Psychotherapy
- Hafner 2015

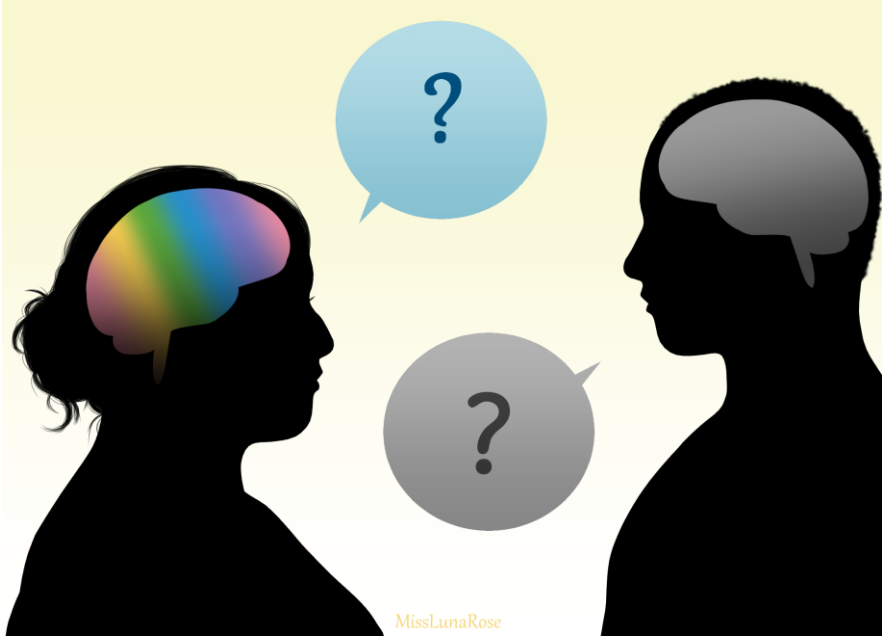
Does Empathy Make a difference ?

- Benefits for patients: improvements in
  - quality of life
  - clinical outcomes: satisfaction with care, reporting symptoms of concern, physician diagnostic accuracy, treatment adherence, self efficacy
  - patient safety, decreased med errors
    - ACES Adverse Childhood experiences study
    - Trauma Surgeons Empathy Study
- Benefits for physicians:
  - Increased: job satisfaction, psychological well being, ratings of clinical competence
  - Decreased: burnout, malpractice claims
- Neuman 2011, Riess 2012, Quince T 2016, Rakel 2009, Steinhausen 2014

Affective Arousal

- Affective arousal and ability to perceive one's own emotional responses
- Mirror neuron functioning linked with empathic ability
  - Decreases signal rate of mirror neurons and capacity for empathy with
    - exposure to extreme callousness or inconsiderateness
    - Anxiety, tension, stress
- Visceral emotional response critical for understanding another's emotions, significantly positively correlated with compassionate behaviour
- High levels of personal distress in response to another's emotion expression inhibits perspective taking and subsequently compassionate behaviour
  - Decety 2008, 2010, Gruehn 2008, Kanske 2016, Bornemann 2017

Emotion Understanding



- “perspective taking”
- theory of mind, mentalizing
- requires self-other awareness
- Understanding of own inner states, particularly negative states, predicts improved TOM capacity

Decety 2008, 2010, Singer 2014, Bockler 2017

Affective and cognitive components of empathy influenced by genetics and environmental factors, enables development of compassionate behaviour

Prosocial/compassionate behaviour mainly due to environmental effect

ie regardless of genetics people can learn compassionate behaviour

Knafo 2008,

- Med students
  - rate themselves slightly higher in empathy than other college students
  - Most authors believe empathy declines in medical school, some disagree
- Psychiatrists vs other physicians:
  - Hojat 2002: 704 physicians, JSPE (self rated)
    - Psych 127
    - family med, int med, peds, ER 121
    - Anaesthesia, ortho, neurology, radiology, surgery 117
- Nunes 2011, Hojat 2009, Bellini 2005, Neuman 2011, Riess 2012,Pedersen 2009, Thomas 2007, Chen 2010, Colliver JA 2011

Yes!

- Kelm 2014 64 studies
- 8/10 “rigorous” studies showed significant increase
- Range of interventions –
  - 30% communication skills*
  - 9% humanities*
  - 11% role play*
  - 50% “other”: mindfulness, balint, combination of approaches*

2 fold approach likely best

- Systems level “humanizing medical education”
  - Reducing exposure to extreme callousness or inconsiderateness Gruehn 2008
  - “optimal stress” - people who are fairly comfortable tend to have lower levels of empathy Singer 2015
- Medical School, Residency, Practice
  - Communication skills, humanities, science of empathy, exposure to mindfulness, balint

McConnville 2017

- Meta-analysis 19 studies of mindfulness interventions for health profession students
- Significant decreases in anxiety, depression, stress and significant increases in empathy

Krasner 2009

- 8 week MBSR and communications skills course
- 70 primary care physicians
- Sig improvements in: empathy, burnout, total mood disturbance, conscientiousness, emotional stability

ReSource project: 229 mid life adults (mean age 41) 9 months of meditative practice

Presence training: breathing meditation, body scan

Perspective training: observing thought (ones' own and in dyad)

Compassion training: loving kindness meditation

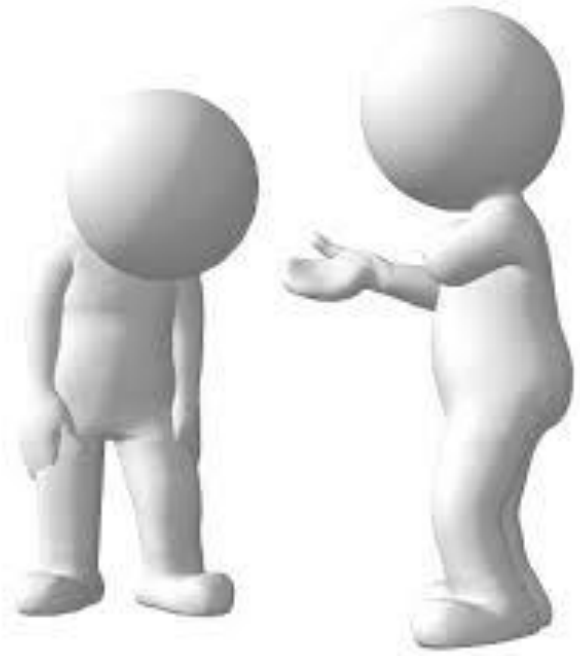
Kok Singer 2017, Klimecki Singer 2014

Which component of empathy?

- All practices (Body scan, breathing, observing thought, loving kindness) increased positive affect, energy, present focus
- Body scan – greatest increases in interoceptive awareness and greatest decreases in thought content
- Observing thoughts – greatest increases in perspective taking
- Kok Singer 2017, Klimecki Singer 2014

Compassion Training

- Reversed negative affect associated with empathy
- Increased positive affect
- Increased “pure altruistic behaviour” vs reciprocity based helping – increases prosocial behaviour
- Increased empathic accuracy REMT Mascaro J 2013, Kok Singer 2017, Klimecki Singer 2015



Enhancing empathy

	Mindfulness	Humanities	Commmunication skills	Exercise	Music training	ACES
Affective arousal/emotion experiencing	◆		◆		◆	◆
Emotion understanding/perspective taking	◆	◆	◆			◆
Emotion regulation	◆		◆	◆	◆	
Sympathy/Empathic Concern/Compassionate behaviour	◆	◆	◆	◆ Team based	◆ group	◆

The Impact of Empathy

- Appointments once per week to “talk”
- Born in a rural community
- Father worked in a mill and was an alcoholic and his mother worked as a waitress
- Described both as physically and emotionally abusive
- Felt “rejected” by them as felt they wanted a daughter
- Left home at age 14 and worked in various jobs in construction and bars

Personal history (contd.)

- At age 14 took up bodybuilding after being bullied and entered and won competitions
- At one point owned his own construction business
- No long term relationship until recent one which lasted 5 years
- Few supports

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score rev hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ **This is your ACE Score**

Course of treatment (contd.)

- Gradually rapport developed
- Agreed to further increase in quetiapine XR to 300 mg at supper in addition to Quetiapine 100 mg po qhs
- Visits became regular 30 minutes appts. every 2 weeks
- Focus shifted more to problems he was facing

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