# Psychotherapy
# E.K. Koranyi Review Course

Benjamin Fortin-Langelier, MD FRCPC

Jan 2021

# Plan

- Psychotherapy and Common Factors
- Royal College identified modalities:
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal psychotherapy (IPT)
  - Psychodynamic /Brief and Long-term
  - Family Therapy
  - Group Therapy
  - Mindfulness
  - Not covered: Motivational interviewing, DBT

# 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.

Wampold & Imel 2015

# Psychotherapy requirements in Canada

| Proficiency | Working knowledge | Introductory knowledge |
|---|---|---|
| Cognitive Behavioral 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 Behavior 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

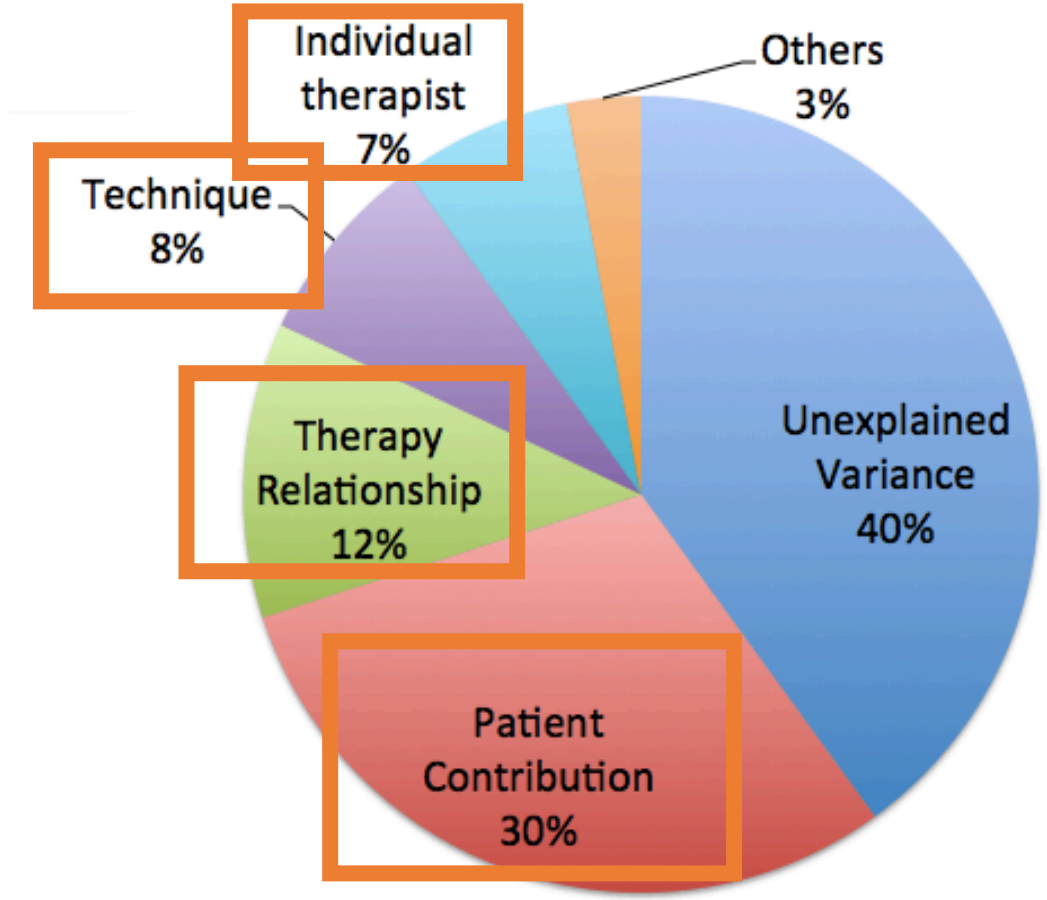
Objectives of training in psychiatry, royal college of physicians and surgeons of Canada, 2015

# MCQ 1

- In a randomized controlled trial of CBT vs IPT for depression it was found that reduction of symptoms correlated with the strength of the therapeutic alliance regardless of whether patients were treated with CBT or IPT. This is an example of:

a) Researcher allegiance bias in psychotherapy research
b) Common factor in psychotherapy research
c) Technique effect in psychotherapy research
d) Corrective emotional experience in psychotherapy research

# Common factors in Psychotherapy




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*

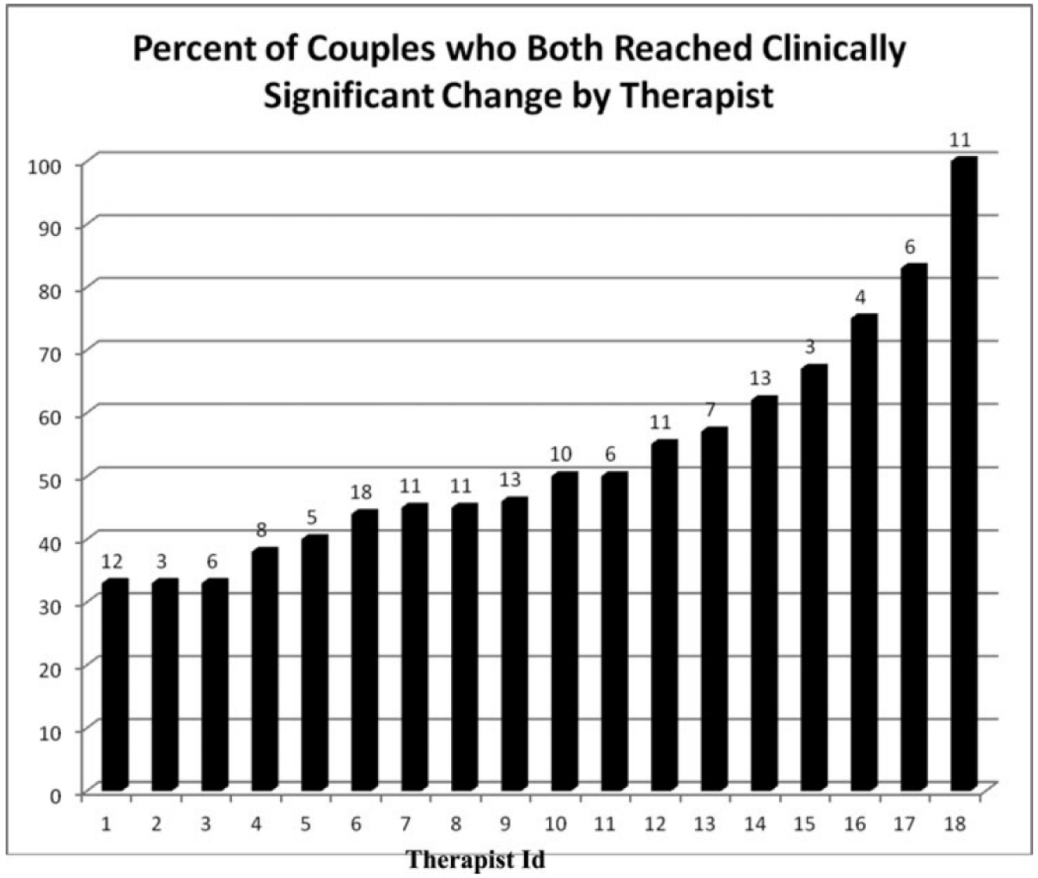
Horvath's Working Alliance inventory

# 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

# 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

# Therapist Factors & 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

# 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)

# 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

# Common factors in CANMAT 2016 MDD

**Table 4.** Evidence-based Therapy Relationships: Therapist Factors That Improve Clinical Outcomes.[45,47,48,50,162-167]

| | Elements of a Therapeutic Relationship |
|---|---|
| Demonstrably effective | • *Alliance* in individual psychotherapy—a collaborative stance predicated on agreement on goals, with consensus on the therapeutic tasks, and an emotional bond<br>• *Empathy*—understanding with communicative attunement<br>• *Collecting patient feedback*—monitoring treatment response with standardized scales |
| Probably effective | • *Goal consensus*—congruent understanding, agreement, and commitment to goals<br>• *Collaboration*—mutual cooperative involvement of patient and therapist<br>• *Positive regard*—in which patient feels respected and appreciated |
| Promising but insufficient research to judge | • *Congruence/genuineness*—therapist awareness and authentic use of his or her internal in-session experiences with the patient<br>• *Repairing alliance ruptures*—recognizing and resolving tensions or impasses in the therapeutic alliance to restore collaboration, understanding, or communication<br>• *Managing countertransference*—therapist awareness and self-management of strong feelings precipitated by the patient's manner of relating and/or the therapist's unresolved conflicts |

Adapted with permission from Norcross (2011).

Parik et al 2016

# MCQ 2

- What is correct about the history of CBT?

a) 1st wave CBT focuses on process and experiencing
b) Albert Ellis and Aaron Beck are key figures in 2nd wave CBT
c) 3rd wave CBT focuses on conditioning and shaping behavior
d) 1st wave CBT focuses cognitive processes.

# Cognitive Behavioral Therapy

- 1st Wave: Behaviorists:
  - Pavlov – Classical conditioning (learning by association)
  - Skinner – Operant Conditioning (shaping / reinforcement & punishment)
- 2nd Wave: Cognitive
  - Albert Ellis (1950), Aaron Beck (1970) (Trained in psychoanalysis). Cognitive triad. Cognitive therapy (CT)
  - Randomized controlled trials (RCT) followed by development of CBT models for DSM disorders
- 3rd Wave: Functional process as opposed to self related beliefs
  - Dialectical Behavioral Therapy
  - Mindfulness
  - Acceptance and Commitment Therapy

Ruggiero et al 2018

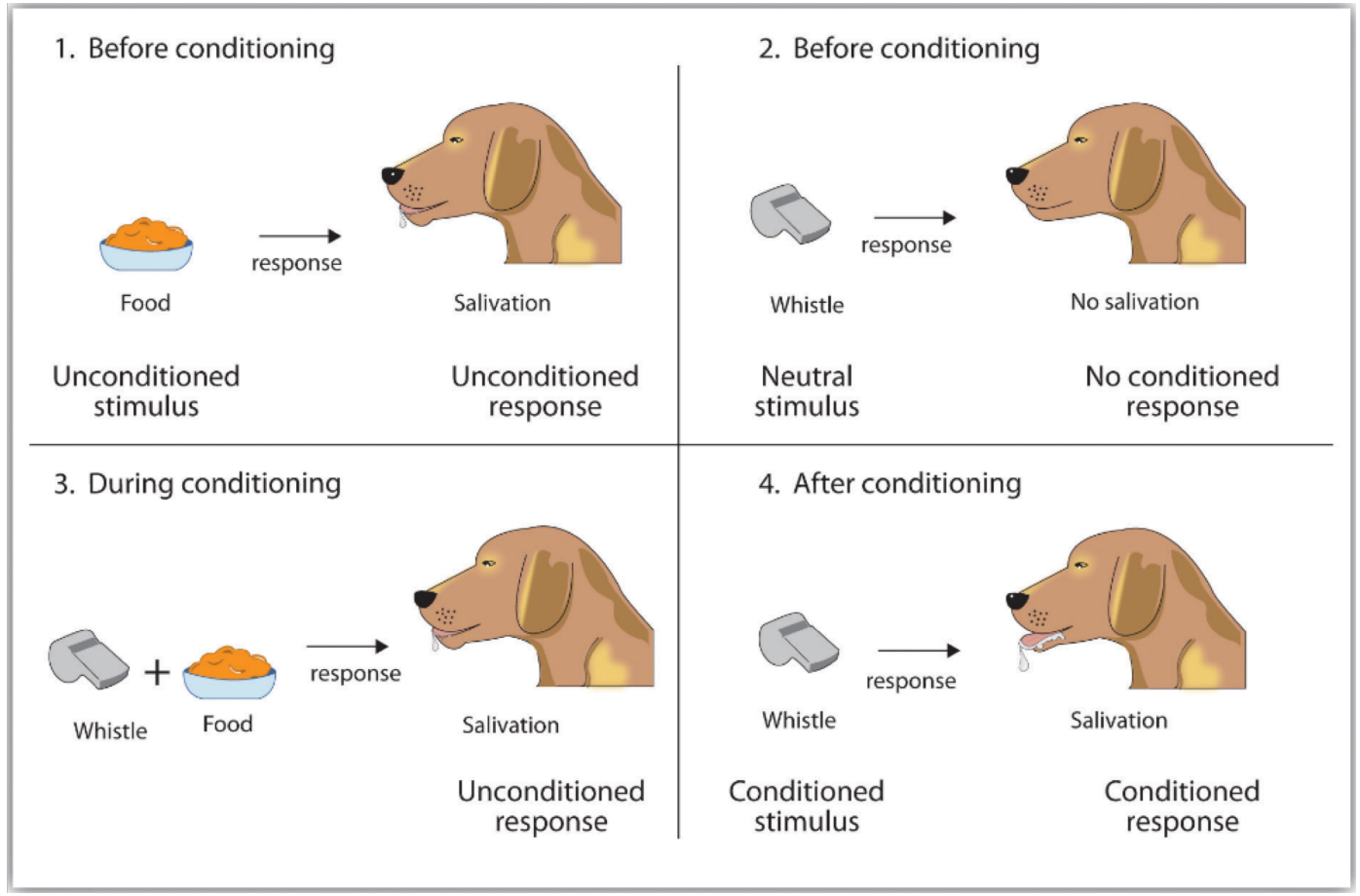
# Moving from 2nd to 3rd wave CBT

- Top down regulation:
  - Observing / changing Thoughts and Beliefs to manage affect
  - Cognitive Therapy. Cognitive distortions, schemas
  - Cortical to subcortical
- Bottom-up regulation strategies:
  - Engaging with emotion/physiological process
  - Mindfullness, Experiential approaches

Ruggiero et al 2018

# Theoretical models: Classical Conditioning

- Learning by association.




Clinically:

Exposure/Phobias
Insomnia

Kaplan & Sadock 2009

# Theoretical models: Operant Conditioning

| | Increase a Behavior (Reinforcement) | Decrease a Behavior (Punishment) |
|---|---|---|
| Add (+) Something | Positive Reinforcement | Positive Punishment |
| Remove (-) Something | Negative Reinforcement | Negative Punishment |
| *RESULT* | Learning | |

Clinically:

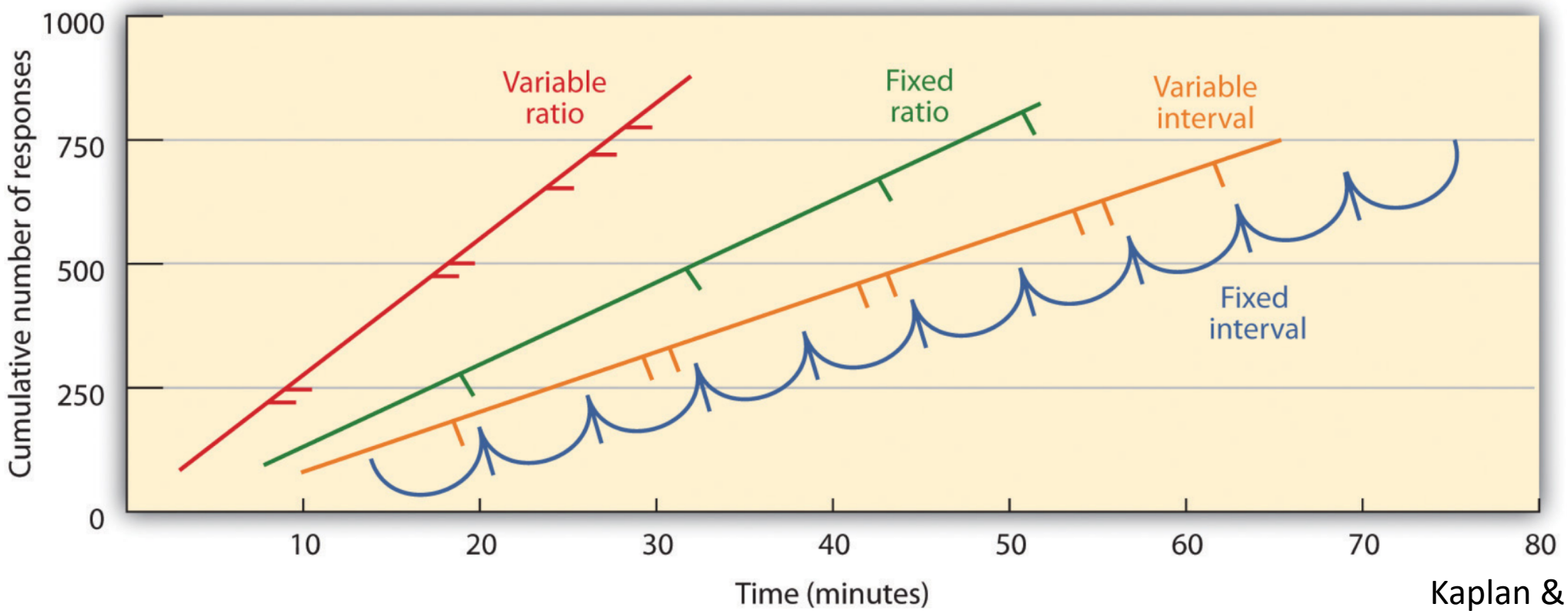
Behavioral Activation

Conduct-Behavior problem

Kaplan & Sadock 2009

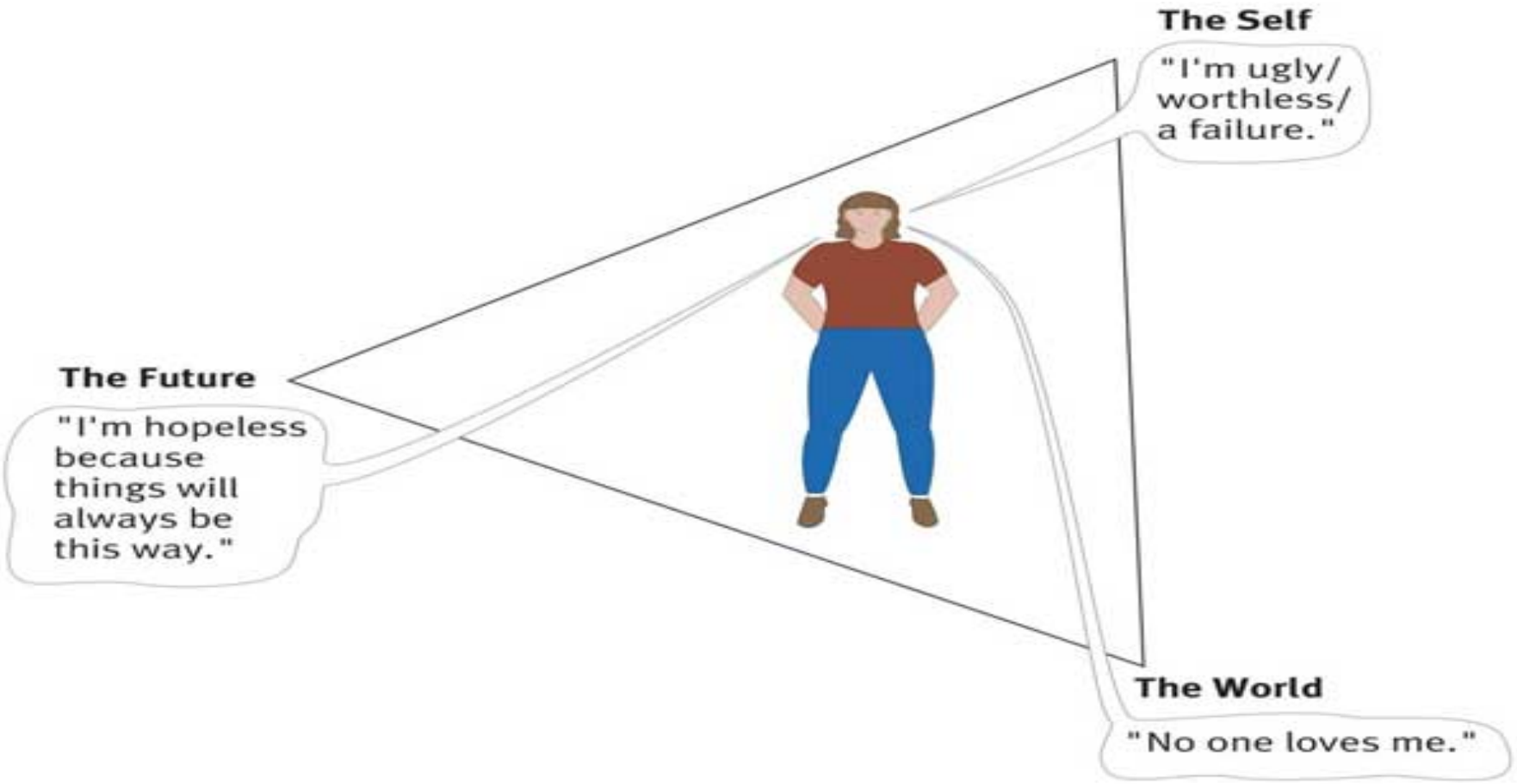
# Theoretical models: Operant Conditioning

- Schedule of reinforcement.
  - After # responses (Ratio), after time duration (Interval).
  - Continuous > Variable > Fixed




Kaplan & Sadock 2009

# Cognitive formulation of Depression – Beck cognitive Triad



# CBT - Present & Past

- Present-oriented:
  - Automatic thoughts in specific situations
  - Cognitive restructuring

- Schemas: lense you use to make sense of what is going on around you based on your past experiences
  - Schema identification and restructuring
  - Attachment as a schema

# Cognitive Restructuring

- Learning to identify thoughts and interpretations in link with the **emotion** experienced
- Assessing thoughts and interpretations that may be negative, incorrect or irrational.
- Logically challenging assumptions

# Cognitive Traps/Distorsions

- Mind reading:
  - You assume that you know what people think
    - “He thinks I’m stupid.”
- Fortunetelling:
  - You predict the future negatively.
    - “I’ll fail that exam,” or “I won’t get the job.”
- Catastrophizing:
  - You believe that what will happen will be so unbearable that you won’t be able to stand it.
    - “It would be terrible if I failed.”

# Cognitive Traps/ Distorsions

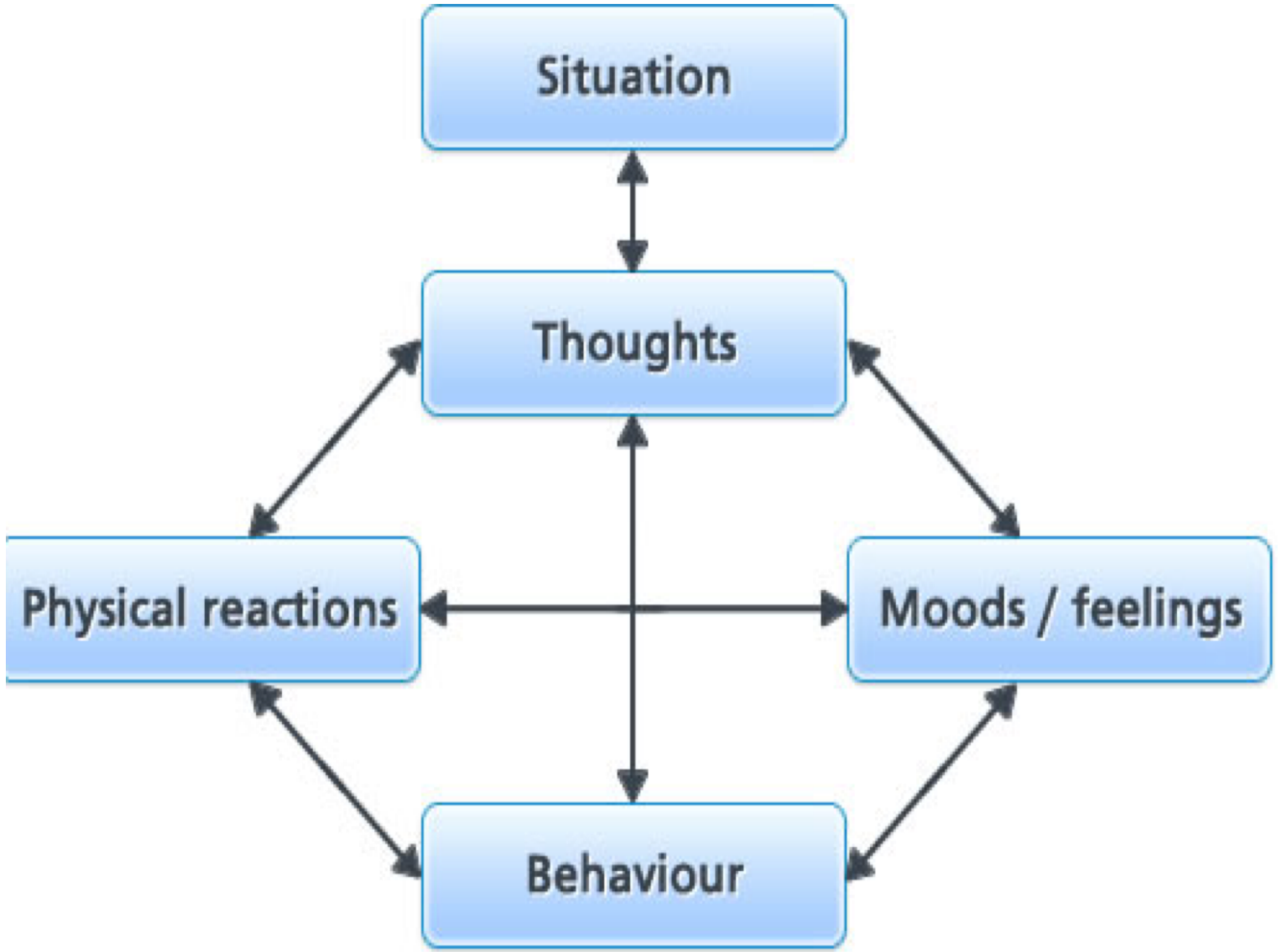
- What if?:
  - You keep asking a series of questions about “what if”
    - “What if I can’t remeber anything?”
- Discounting positives:
    - “The exam was easy”
- Negative filtering:
  - You focus almost exclusively on the negative
    - “Look at all of the people who don’t like me.”

# Thought Record

| Situation | Emotions | Automatic Thoughts | Alternative Thoughts |
|---|---|---|---|
| Doing a presentation in front a large audience | Anxious | What if I say something stupid<br><br>What if I don't remember<br><br>What if I do not know how to answer a question | It is probably unlikely that it would be that bad<br><br>It has never happened to me<br><br>I am not supposed to know everything |

# Cognitive Component

- How we interpret situation has a great impact on how we will feel, act and react
- (Sometimes physical reaction is left out)



# Questions to ask oneself

- What is the worst outcome? The best outcome? **The most likely outcome?**
- What are the costs and benefits of worrying about this?
- What evidence do you have from the past that worrying has been helpful to you?
- If someone else were facing the same events, what advice would you give him or her?

# Example of Domino Effect

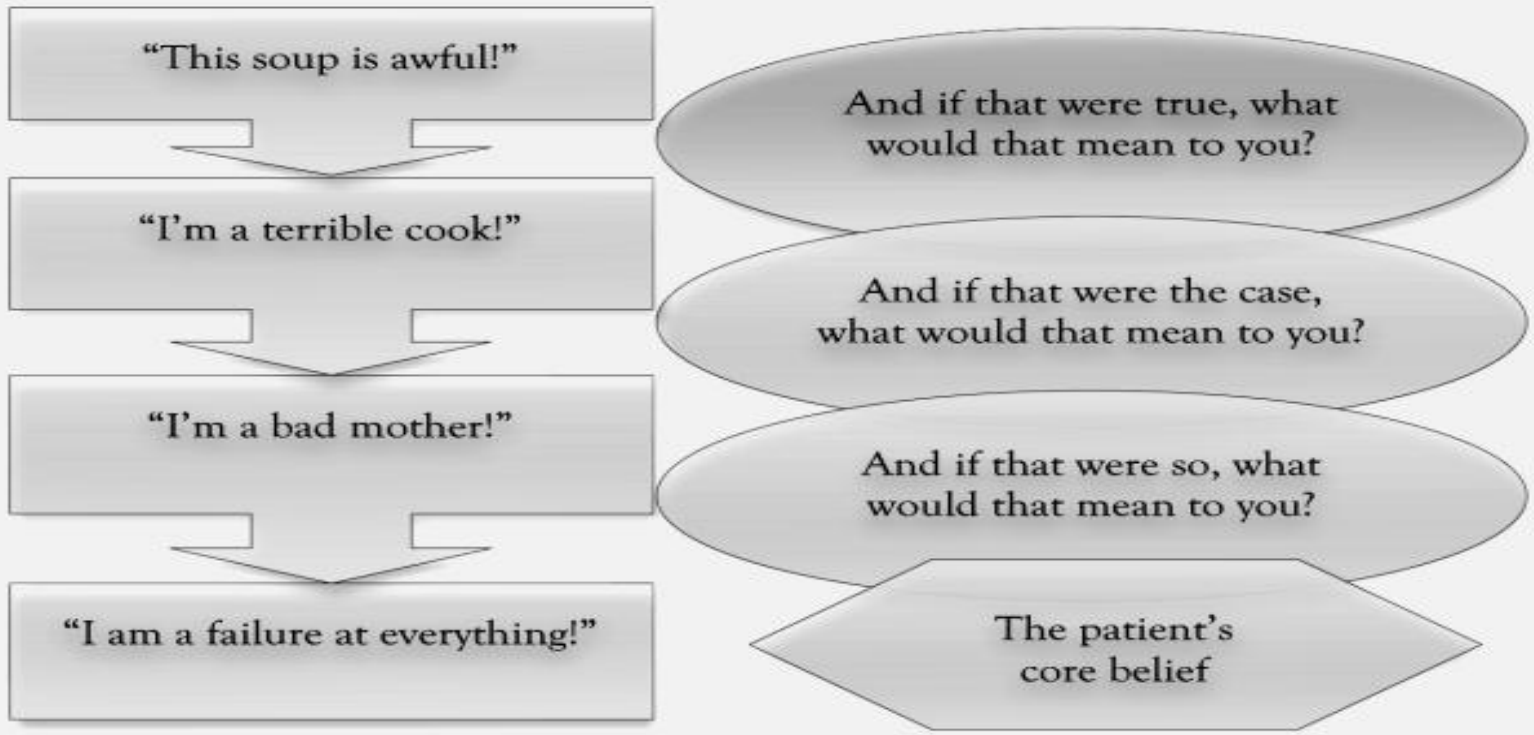



Fig. 9.1. An example of the downward arrow technique.

# CBT

- Multiple protocols with significant differences for different disorders.
- You may want to have an idea of how a specific disorder is formulated using CBT and what the CBT approach entails.
- CBT for psychosis
- CBT for GAD
- CBT for eating disorders

# CBT - OCD: Formulation

| Behavioral Model | Cognitive Model (Foa) | Cognitive Model (Salkovskis) |
|---|---|---|
| A. A Conditioned stimuli (ex: bathroom) is paired with Unconditioned stimulus of Danger.<br>B. Then the association is maintained through avoidance/escape (or compulsion) | A. Attribution of high probability of danger to safe situation (Doorknob -> Illness)<br>B. Exaggerate the cost of bad thing or mistaken Meaning (Illness -> Death).<br>C. If something is not safe it's dangerous | A. Having a thought about an action is like performing the action<br>B. Failing to prevent harm to self or others = causing the harm<br>C. Responsibility is not attenuated<br>D. Not neutralizing when an intrusion has occurred is wanting the harm to happen<br>E. One should (and can) exercise control over one's thoughts |

Franklin, & Foa, 2011

# CBT - OCD: Psychotherapy
# Exposure & Response Prevention (Ex/RP)

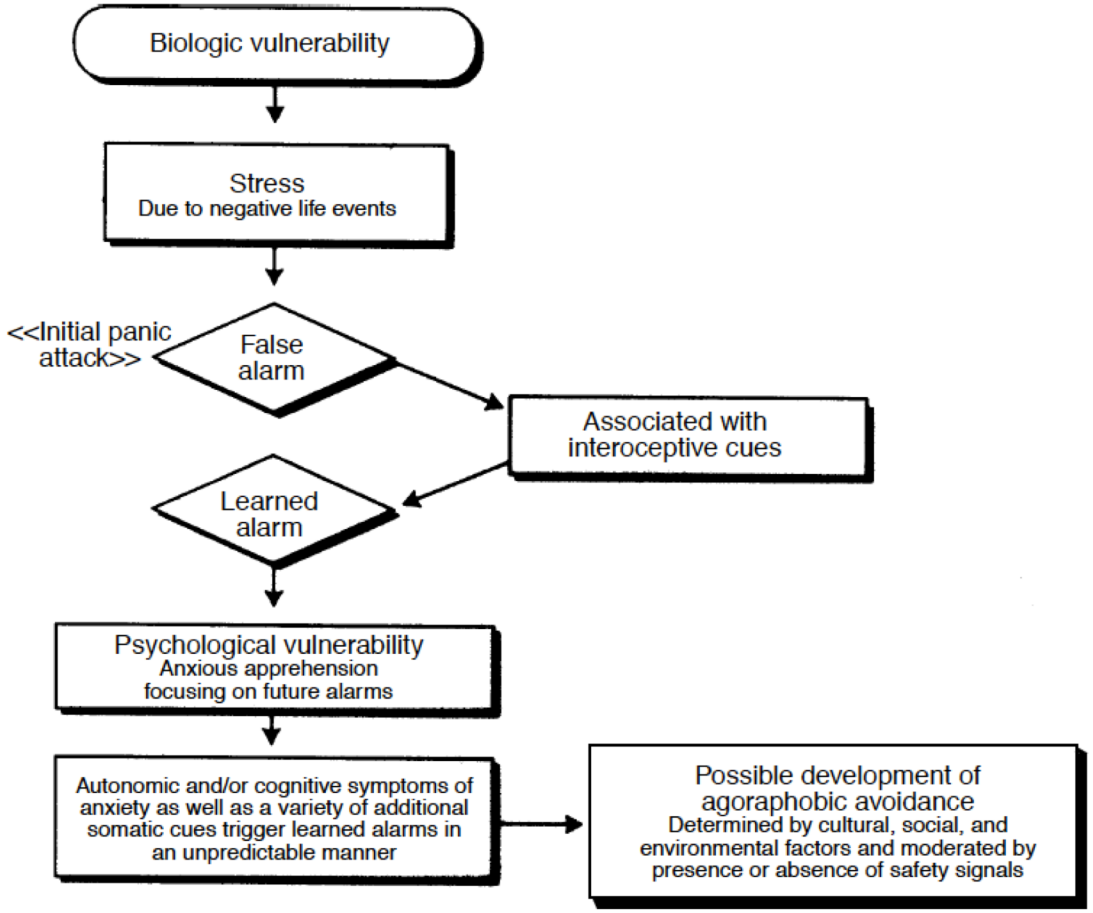
- (1) Prolonged exposure to obsessional cues (2) Blocking rituals (3) Discussions of mistaken beliefs.
- Exposures are done in real-life settings (in vivo), prolonged contact with feared external (e.g., contaminated surfaces) or internal stimuli.
- Fear consequences of not completing rituals are addressed via imaginal exposure. Creating image scripts and listening to these scripts until less anxiety provoking.
- Exposure exercises prompt obsessional distress; then provide information that disconfirms mistaken associations held by the patients and thereby promotes habituation. Exposure is typically conducted gradually.
- Exposure practices are assigned between sessions. Complete ritual abstinence is the stated goal. Patients are reminded that negative reinforcement provided by ritualizing maintains fear, whereas refraining from rituals promotes its dissipation

Franklin, & Foa, 2011

# Cognitive Behavioral Formulation of Panic Disorder

- "Misfiring" of normal stress response in genetically and psychologically vulnerable individuals.

Figure 1. A Model of the Etiology of Panic Disorder*




Barlow, 1997

# Cognitive Behavioral Formulation Panic Disorder (2)

- Classical conditioning:
  - Association of shopping mall or crowd with Panic
  - Association of panic bodily cues with danger.

- Operant conditioning:
  - Reinforcement of fear/danger attribution by avoidance

# Cognitive Behavioral Treatment – Overview for Panic Disorder

1. Diagnosis
2. Psycho-education
   a. What is the disorder
   b. How it's maintained
   c. How treatment is expected to work
3. Component of distress tolerance / Relaxation
4. Cognitive Restructuring
5. Exposure

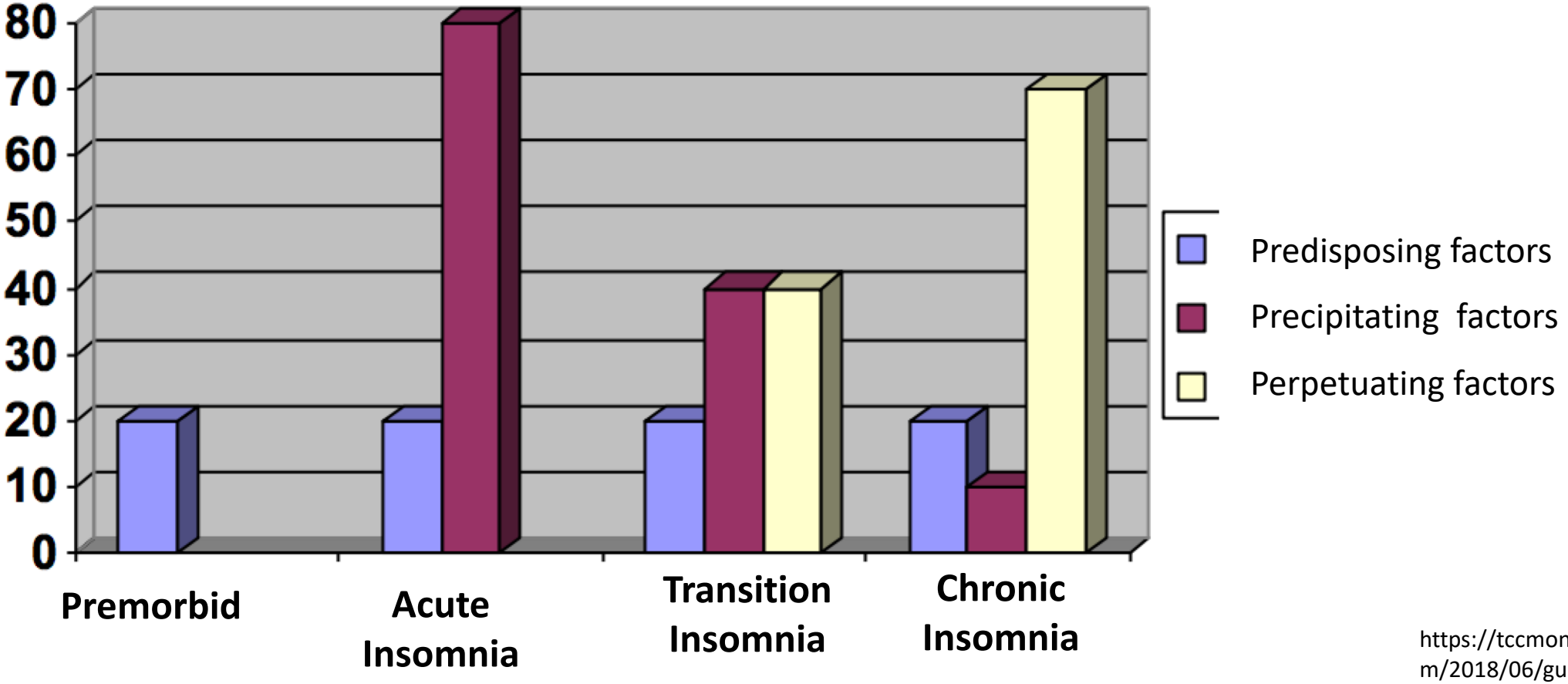
# MCQ 3

- Which one is **not** a goal of CBT for insomnia?

a) Increasing sleep efficiency (SE)
b) Increasing total sleep time (TST)
c) Decreasing wake after sleep onset (WASO)
d) Increasing total time spent in bed (TSB)

# Cognitive Behavioral Therapy - Insomnia

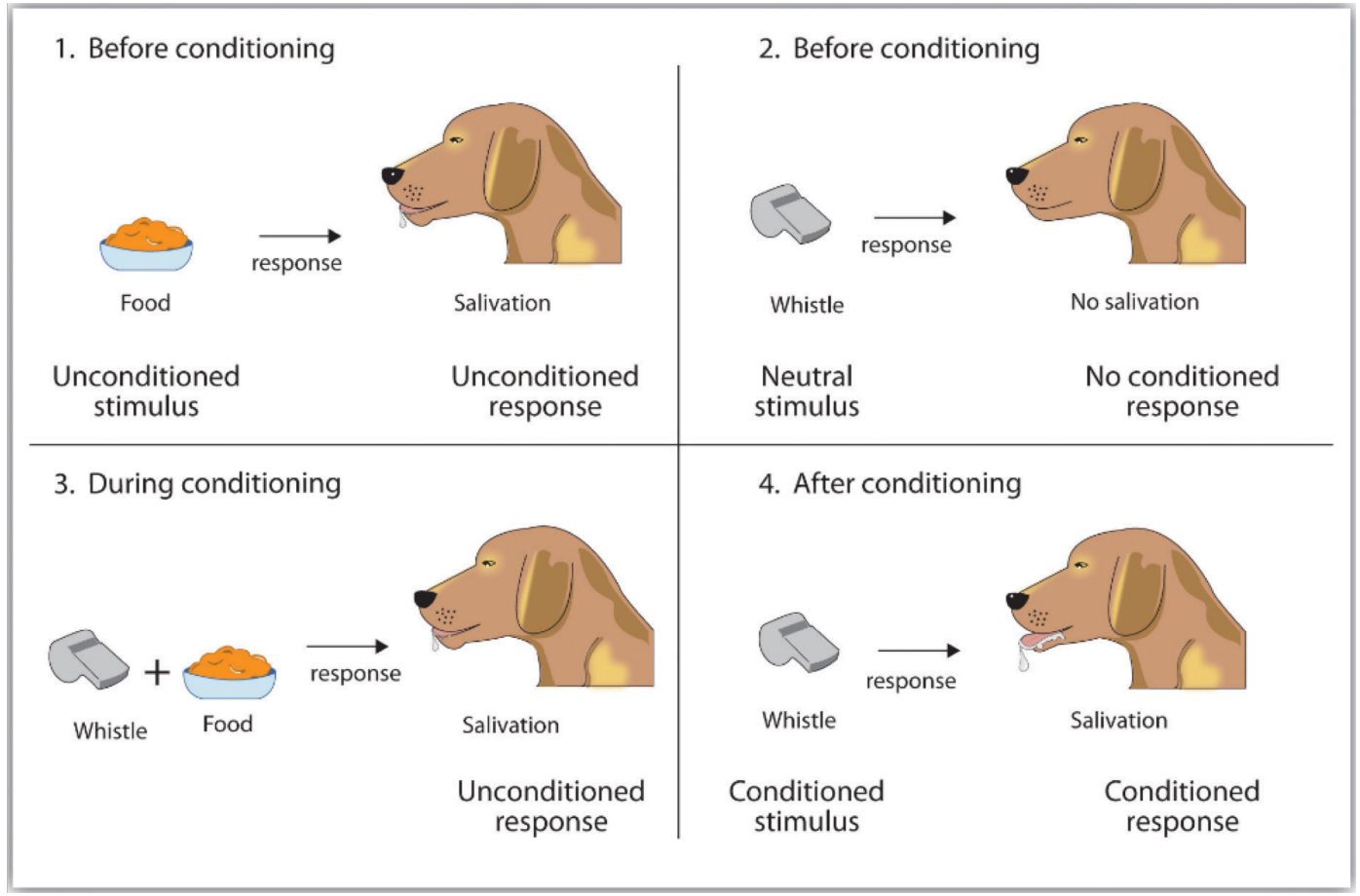
- Formulating Insomnia as a cognitive Behavioral Problem




https://tccmontreal.files.wordpress.com/2018/06/guide-de-pratique-insomnie-version-isbn-juin-2018.pdf

# Theoretical models: Classical Conditioning

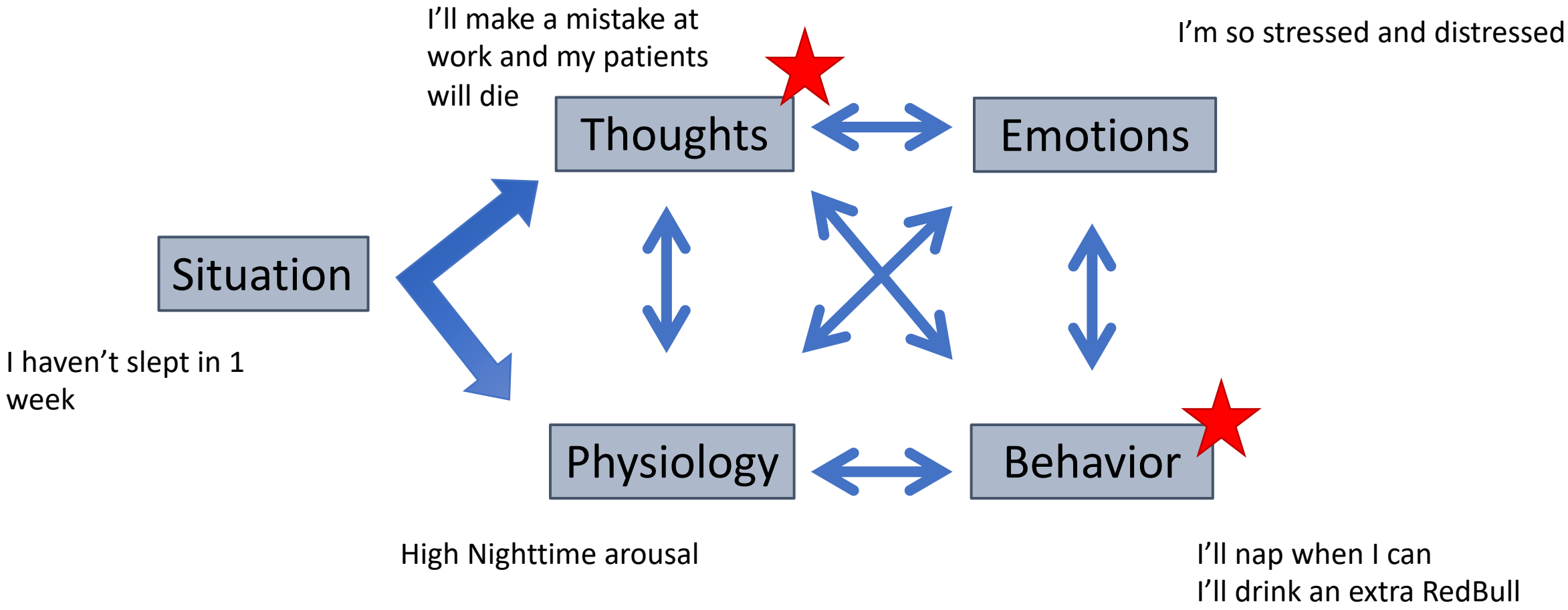
- Learning by association.




- BED = SLEEP

Kaplan & Sadock 2009

# Insomnia – Cognitive Behavioral Therapy



# Stimulus Control

- Bed is for Sleep and Sex
  - No Reading, TV, phone
  - No laying in bed if not asleep
- Leave bed to go do quiet activity in different room if not asleep after 20 minutes.
- As well as sleep hygiene basics:
  - No Caffeine after 12pm. Limit to 1-3 coffee, tea, soft drink.
  - Cool temperature, dark, quiet bedroom
  - No naps
  - Limit use of alcohol & cigarettes
  - Regular exercise

# Sleep Restriction

- **Goal**: Increase Sleep Efficiency (time asleep / time in bed) *Quality*
- **Task**: Use Sleep Debt (Homeostatic Process S sleep drive) to normalize sleep pattern
- **Tool**: Establish treatment plan and monitor impact using Sleep Diary.

## Sleep Efficiency

vs

## Increase Time Sleeping

# Sleep Restriction – Sleep Diary

Prescribing Sleep Restriction:

1. Choose Wake up time (Wake up time = Time out of bed)
2. Consolidate time sleeping by delaying time to bed.
   i. Ex: 6hr total sleep time and 7am wake up time = 1am time to bed
   ii. Usually prescribe 5hr of sleep minimum
3. If SE < 80 % delay Time to bed by 30min
4. If weekly average Sleep Efficiency is at 85% prescribe earlier time to bed by 30min (1 week at the time) until resolution of daytime somnolence.
5. Goal is for 80-85% Sleep Efficiency

# Insomnia – Cognitive Behavioral Therapy

- Evidence-Based

| Outcome measure | Impact of CBT-I (20 studies) Early f-u (4wks) | Effect size (*g*) |
|---|---|---|
| **SOL** | - 12 min | -0.47 |
| **WASO** | -40 min | |
| **TST** | +30min | |
| **SE** | +11% | 0.63 |
| **ISI (severity index)** | | 0.82 |

Trauer et al 2015

van Straten et al 2017

***Table 2.*** Glossary

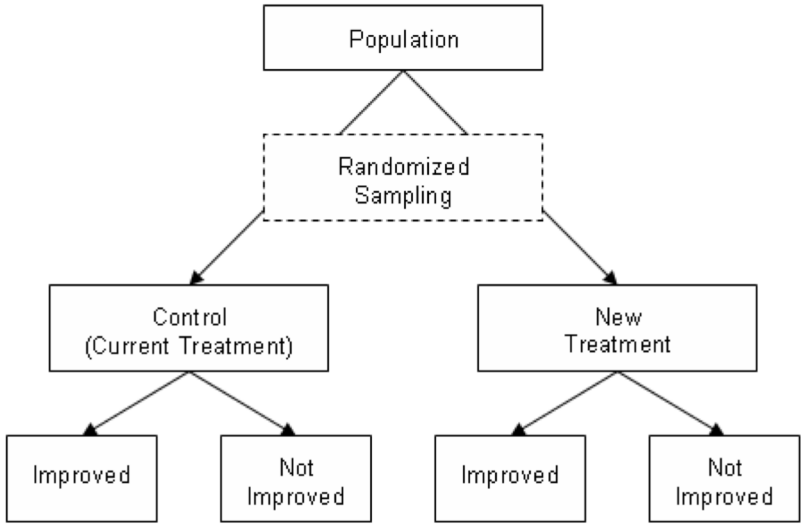
| Outcome Measure | Definition | Abbreviation | Unit |
|---|---|---|---|
| Sleep onset latency | Average time to enter sleep after lights out, over the diary period | SOL | Minutes |
| Wake after sleep onset | Average time spent awake during the night after first entering sleep, over the diary period | WASO | Minutes |
| Total sleep time | Average total nighttime sleep, over the diary period | TST | Minutes |
| Sleep efficiency | Total sleep time divided by average time spent in bed, over the diary period | SE% | Percentage |

# Interpersonal Psychotherapy

- Developed in 1960’s to 1970’s. A product of depression research. Gerald Klerman (1928-1992).
- High quality supportive therapy, non-inferior to amitriptyline.
- Manual published in 1984. Gerald Klerman, Myrna Weissman. New edition 2017 (John Markowitz).

# Interpersonal Psychotherapy (IPT)

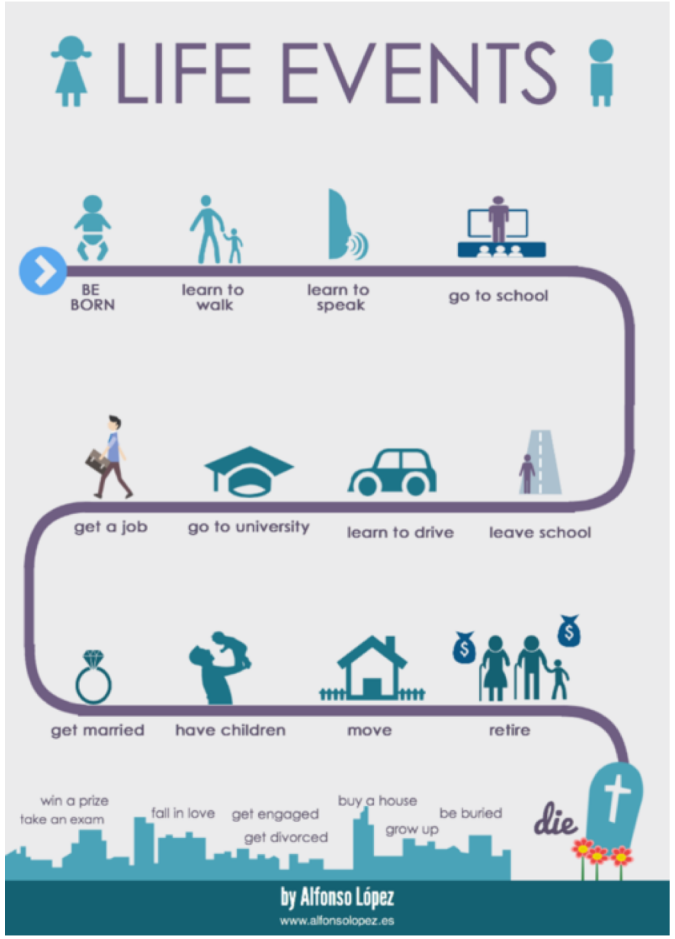
Brief
(16 sessions)




Evidence-based
(Effective in randomized trials)

Developed for
Major Depressive Disorder

# Interpersonal Psychotherapy (IPT)

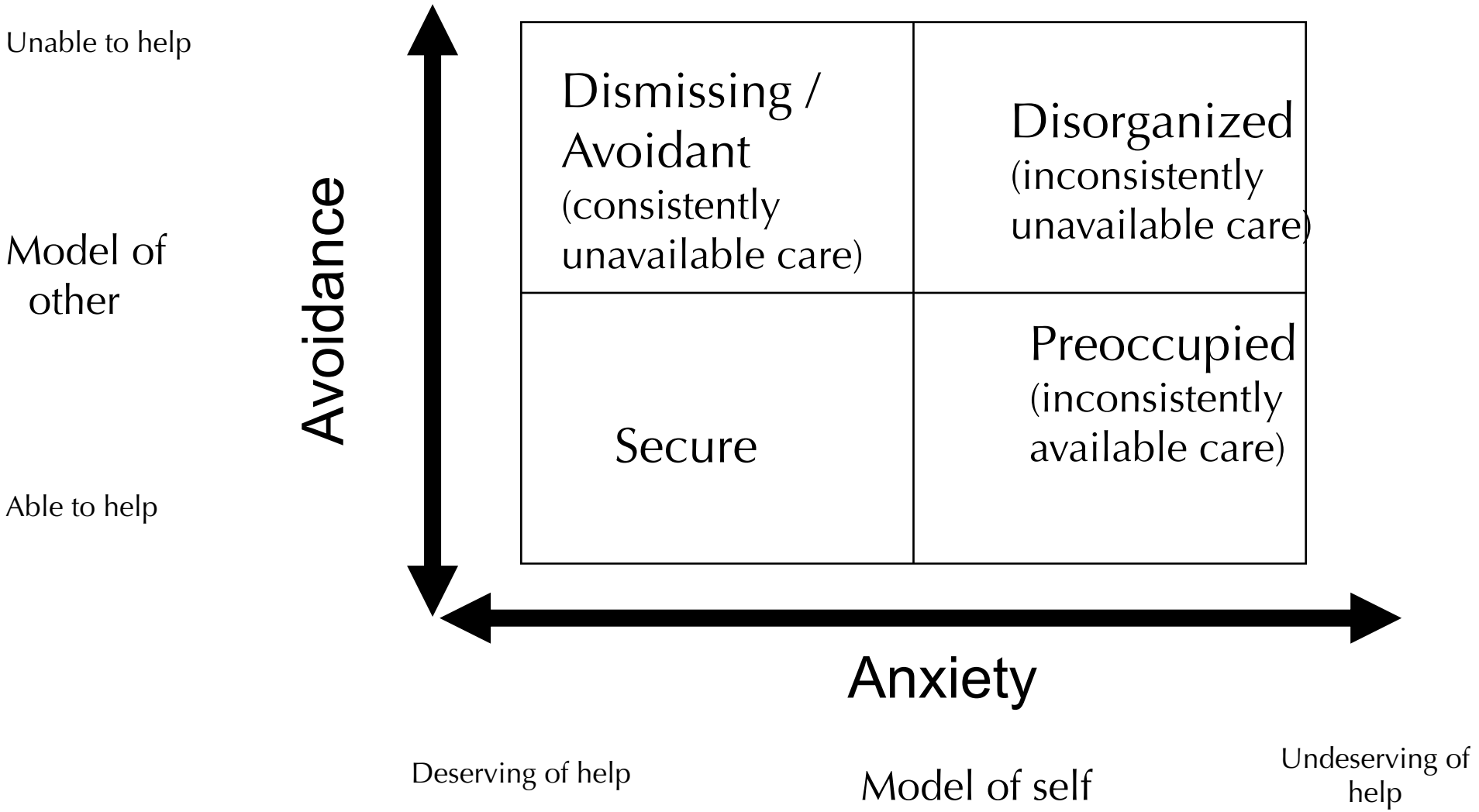



- Transitions
- Conflicts
- Bereavement
- (Deficits)

MDD

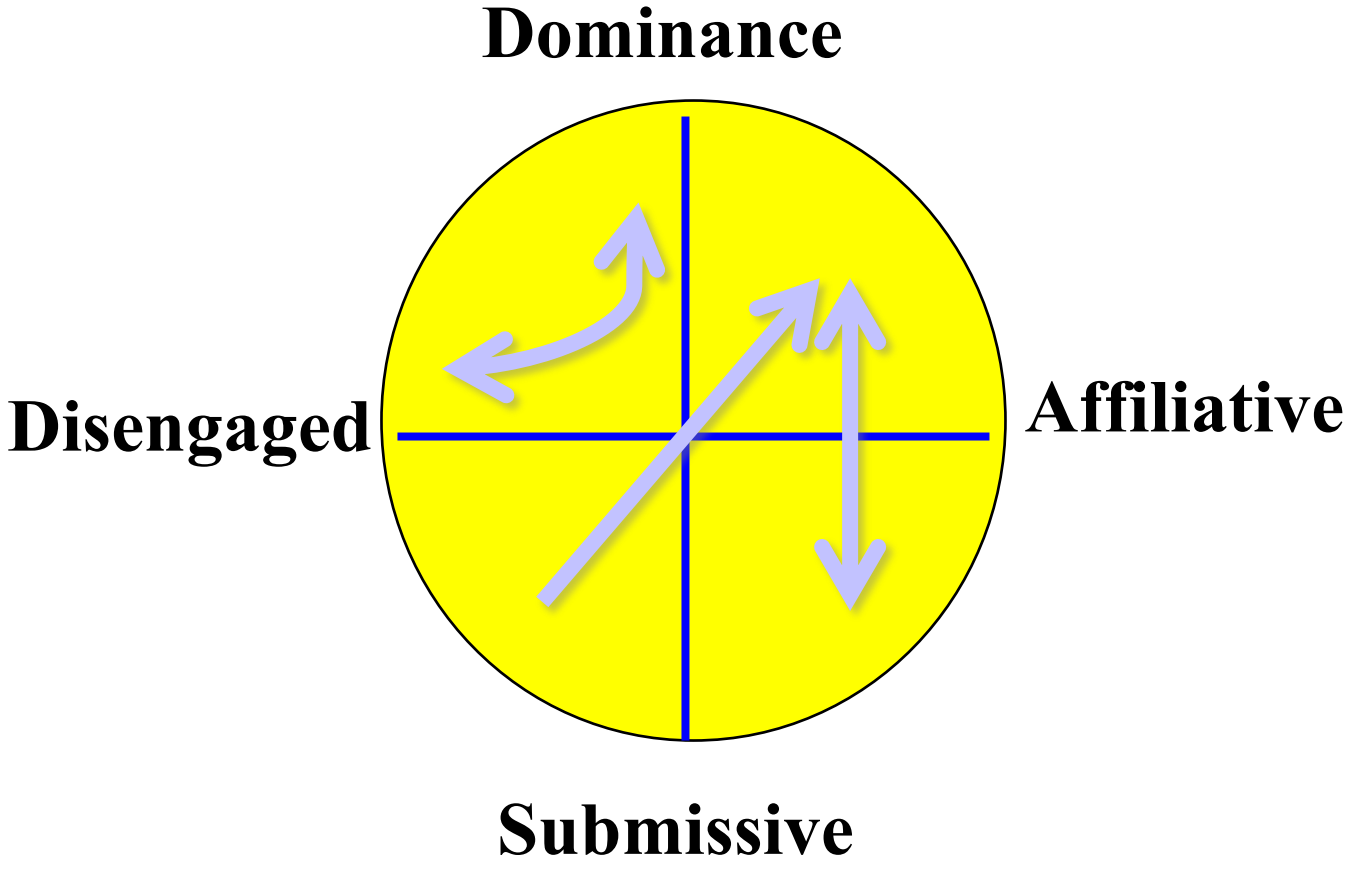
Relationships are essential to mental health

# Attachment Theory



# Interpersonal Theory

- Kiesler's Interpersonal Circumplex. – Communication Theory.



# Adaptations of IPT

- Bipolar disorder. IPSRT. Including Measures of social rhythm to IPT. Evidence in decreasing depressive symptoms and preventing relapse. CANMAT Bipolar 2018 (3rd line level 2). Ellen Frank and Holly Schwartz.
- PTSD. 2015. RCT, non-inferior to Prolonged exposure. Larger VA trial on the way. PTSD is a life event related psychiatric illness. Transition focus (post trauma) or grief. ("Weak evidence for" – VA/DOD PTSD guidelines 2017). John Markowitz.
- Eating disorders. Evidence for IPT in Bulimia Nervosa and Binge Eating disorder or Eating disorder NOS. Less evidence than CBT. Group treatments. Denise Wifley.

- Break

# Psychodynamic therapies

- Long term psychodynamic psychotherapy
- Key formulations:
  - Depression is anger turned inward
- Key Figures / Schools:
  - Ego Psychology - Freud
  - Object Relations - Melanie Klein, Fairbairn, Winnicott
  - Self-Psychology - Heinz Kohut
- Brief dynamic psychotherapy
  - Davanloo, Malan, Sifneos, Mann

Gabbard 2014

# Defining Psychodynamic therapy

1. Focus on affect and expression of emotion
2. Exploration of attempts to avoid distressing thoughts and feelings
3. Identification of recurring themes and patterns
4. Discussion of past experience (developmental focus)
5. Focus on interpersonal relations
6. Focus on the therapy relationship
7. Exploration of fantasy life

Schedler 2010

# Defining Psychodynamic therapy

- “We do not fully know our own hearts and minds, and many important things take place outside of awareness”
- “The terms *ambivalence* and *conflict* refer to inner contradiction. *Conflict* in this context refers not to opposition between people, but to contradiction or dissonance within our own minds. We may seek to resolve contradiction by disavowing one or another aspect of our feelings—that is, excluding it from conscious awareness—but the disavowed feelings have a way of “leaking out” all the same”
- “*we view the present through the lens of past experience*, and therefore tend to repeat and recreate aspects of the past”
- “The term *transference* refers specifically to the activation of pre-existing expectations, templates, scripts, fears, and desires in the context of the therapy relationship, with the patient viewing the therapist through the lenses of early important relationships.”

Schedler 2006

# CANMAT 2016: Long Term Psychodynamic Psychotherapy

- “While long-term PDT is not within the scope defined earlier of an acute treatment for depression, there is limited evidence of efficacy for acute MDD treatment. Thus, the limited evidence base confines general PDT—as separate from specific STPP—as a third-line treatment.”
- “However, there is only weak evidence, and only after prolonged treatment, for efficacy of long-term PDT for acute treatment of MDD.”

Parikh et al., 2016

# LTPP:
# Efficacy Research / RCT - LTPP vs Meds

- Superiority of LTPP at 12 months. Slower onset of benefits of psychotherapy alone.
- Plateau of efficacy of medication at 6 months.

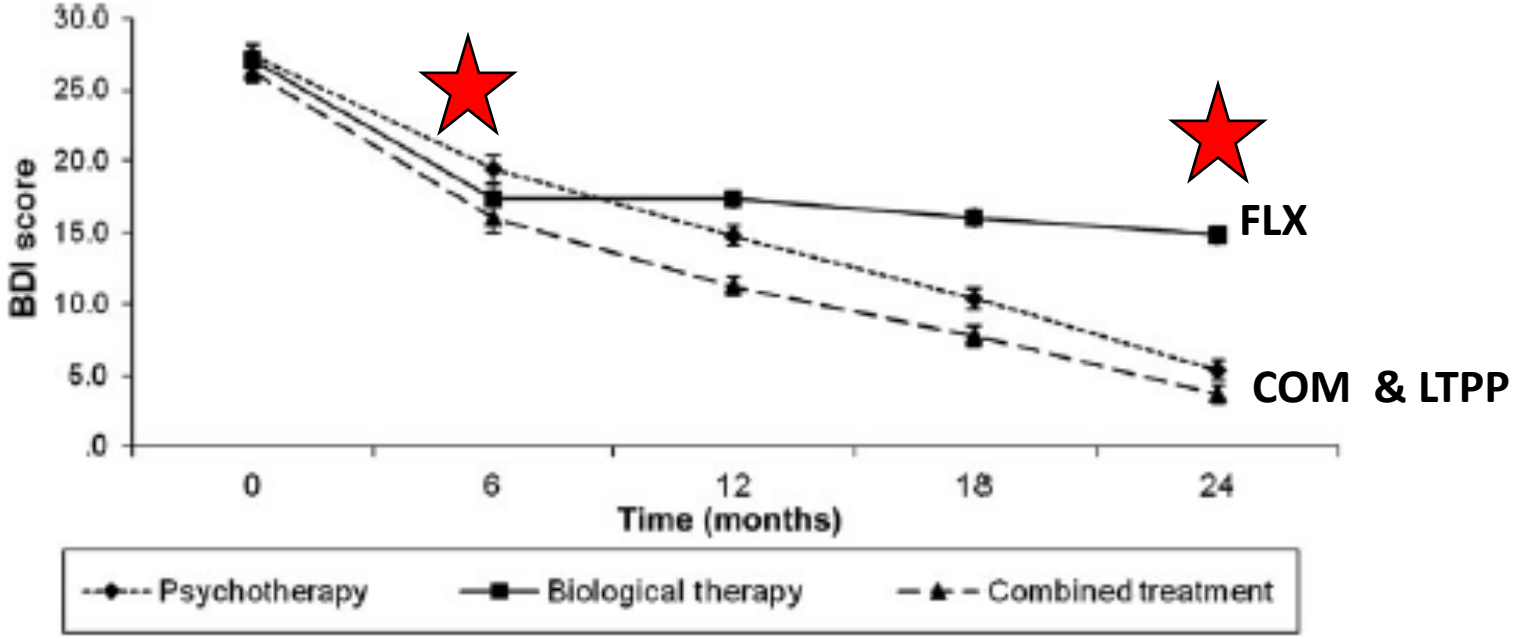


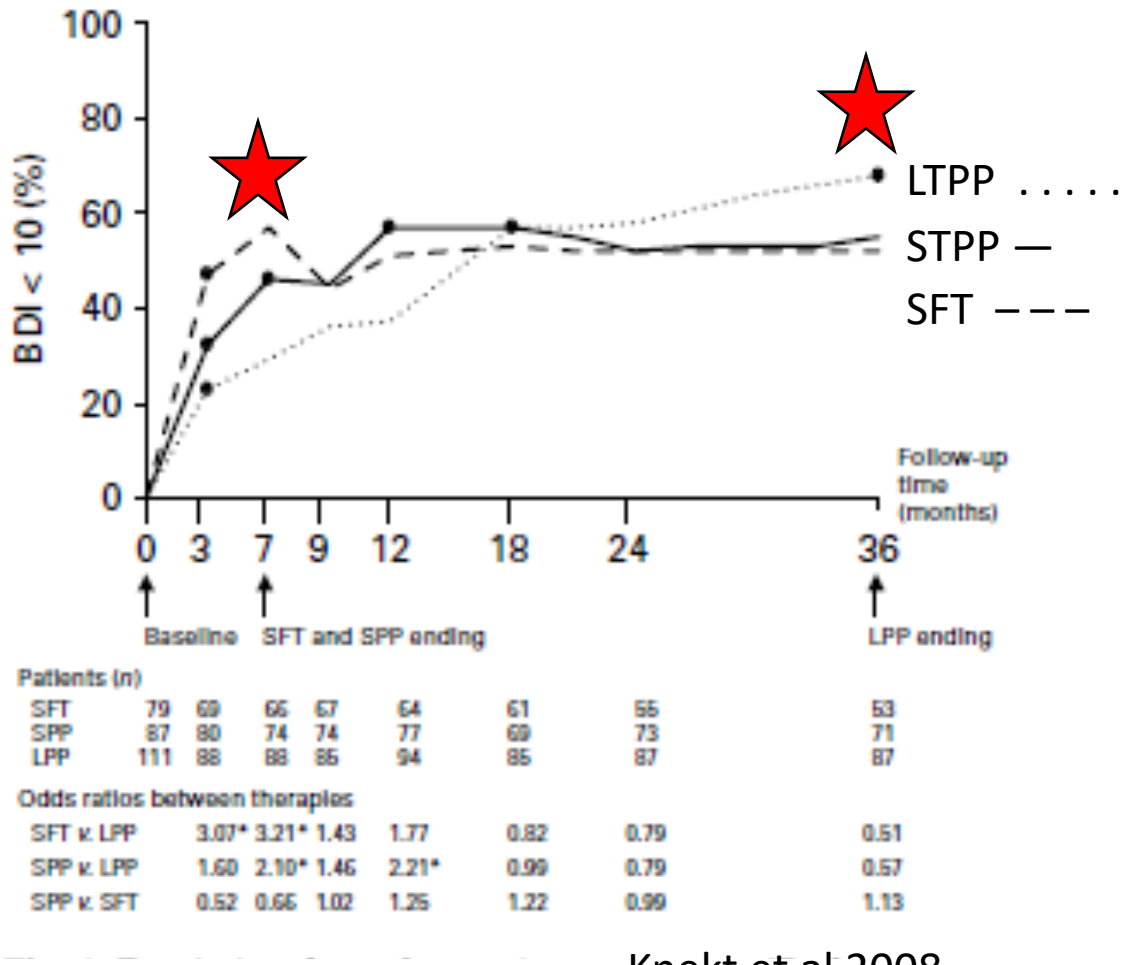

Figure 2. Mean scores on the Beck Depression Inventory in the three treatment groups along 24 months.
Note: Bars represent standard errors.

Bastos, Guimaraes, Trentini 2015

# LTPP:
# Efficacy Research / RCT - LTPP vs Other Therapies

- Remission rate / survival curve.
- What percentage of patients remitted from Depression (as per BDI score) with intervention.

| | # Session Mean (SD) | Duration months Mean (SD) |
|---|---|---|
| LTPP | 232 (S.D.=105) | 31.3 (S.D.=11.9), |
| SFT | 9.8 (S.D.=3.3) | 7.5 (S.D.=3.0) |
| STPP | 18.5 (S.D.=3.4) | 5.7 (S.D.=1.3) |



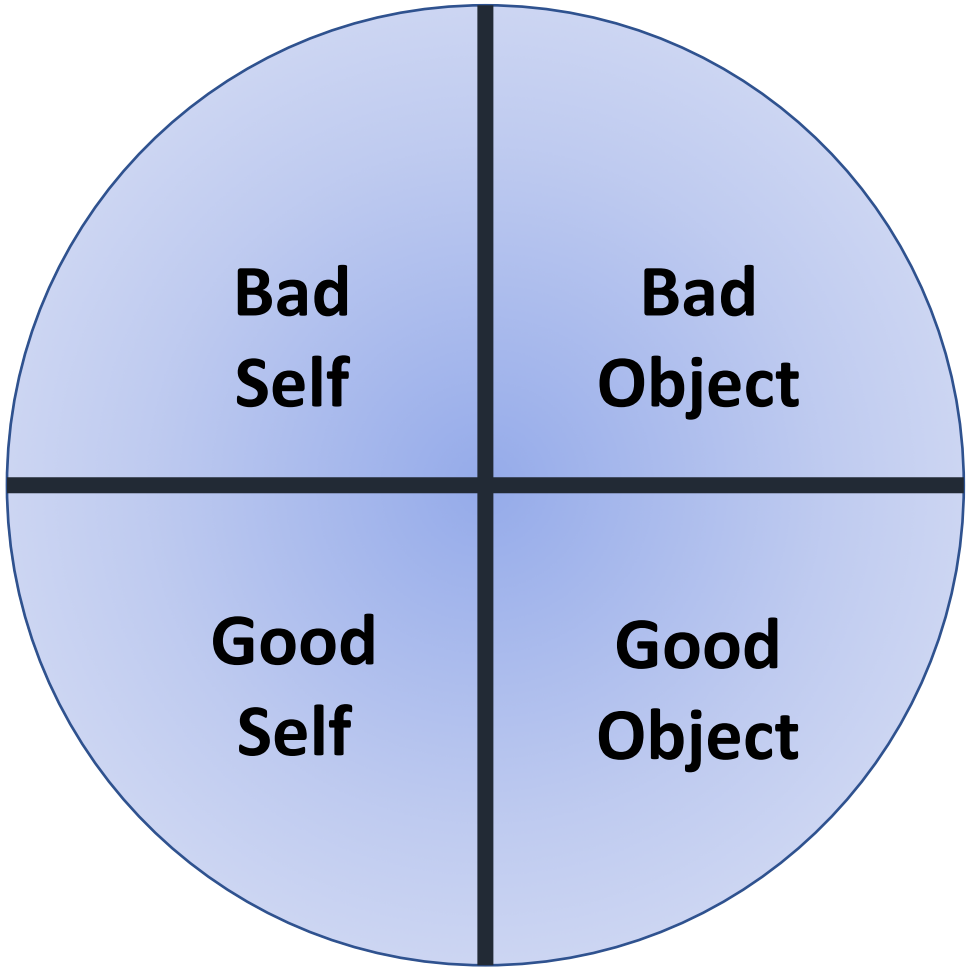

Knekt et al 2008

# Ego Psychology - Defense Mechanisms

- Primitive defenses:
  - Splitting, projective identification, projection, denial, dissociation, idealization, acting out, somatization, regression, schizoid fantasy
- Neurotic defenses:
  - Introjection, identification, displacement, intellectualization, isolation of affect, rationalization, sexualization, reaction formation, repression, undoing
- Mature defenses:
  - Humor, suppression, asceticism, altruism, anticipation, sublimation

Gabbard 2014

# Object relations




- Representation of self and introjected other are typically split at a primitive level.
- Various aspects of self or introjected others may be projected unto the therapist (transference)

Gabbard 2014

# Self-Psychology

- Self-Esteem and self-Cohesion
- Mirroring transference. Need for confirming/validating approval of therapist  “gleam in the mother’s eyes”
- Idealizing transference. All powerful soothing therapist.
- Twinning transference. Wish for merger/imitative behavior
- Selfobjects. May be seen as the functions of others in relation to self (a step beyond internalized others/objects)

Gabbard 2014

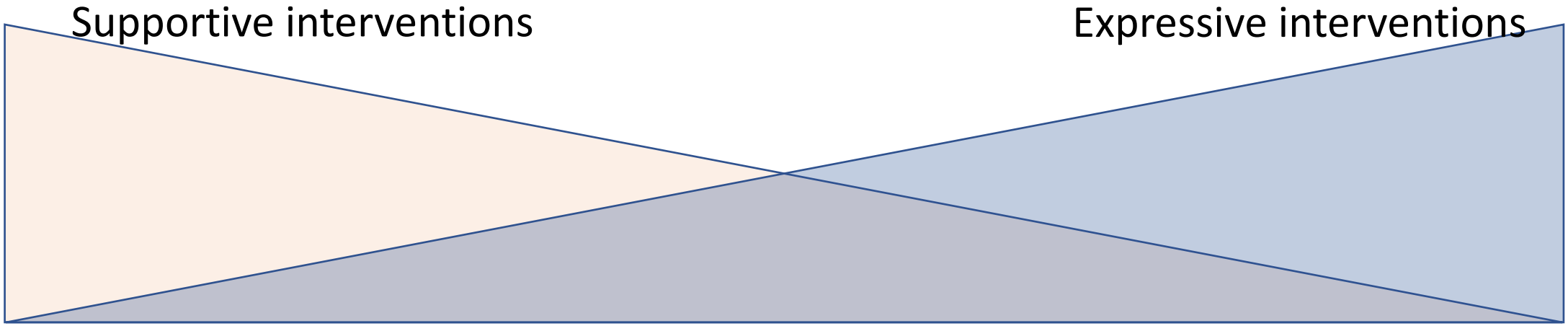
# Development of self

- Primary narcissism -> object love -> secondary narcissism (following rebuff from objects)
- Kohut:
- Fragmented self-nuclei ->
- primary narcissism (nuclei achieves cohesiveness) ->
  - Assigns perfection to grandiose self (mirror transference)
  - Assigns perfection to idealized parental imago (idealizing transference)
- Healthy ambitions, tension arc of talent and skills, ideals and values.

Gabbard 2014

# Interventions in psychodynamic therapy

## Psychodynamic Supportive-Expressive Continuum




Advice
Praise
Psychoeducation
Validation
Encouragement

Interpretation
Observation
Confrontation
Clarification

Gabbard 2014

# Brief Psychodynamic Psychotherapy

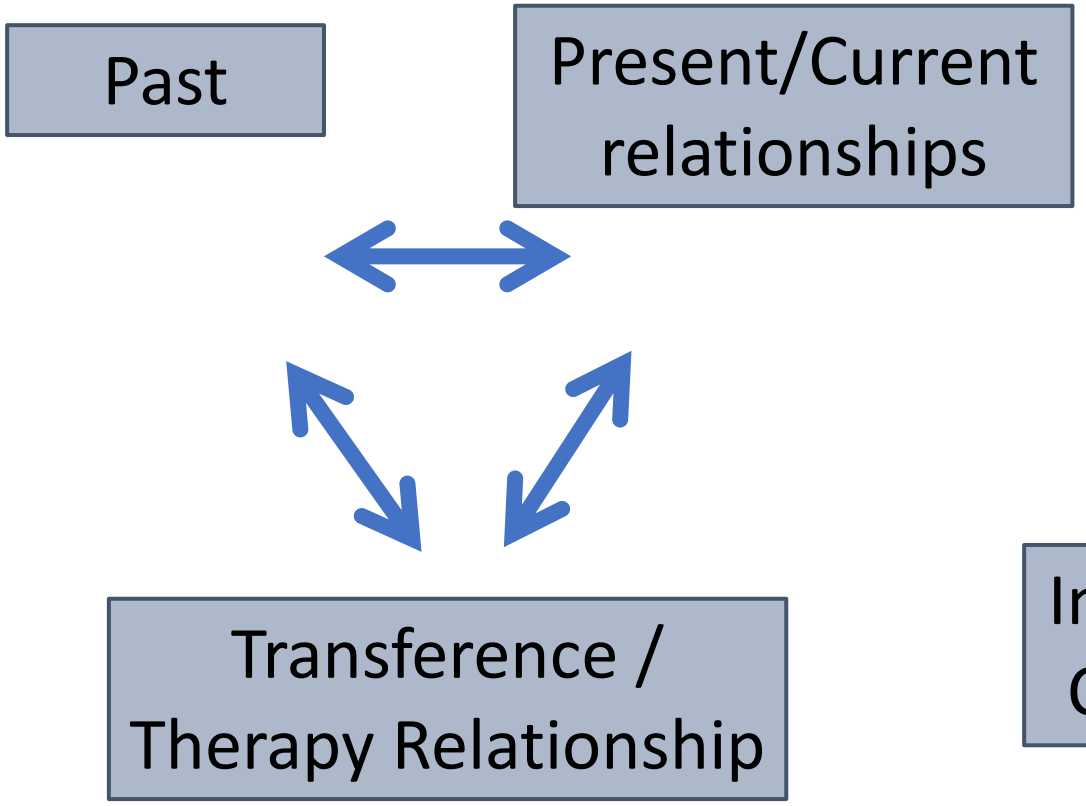
- Classical criteria:
  1. Capacity for insight
  2. High level ego functioning
  3. Strong motivation to understand oneself
  4. Capacity to form in depth relationship
  5. Capacity to tolerate anxiety
- Responds well to “trial interpretation”
- Session # (12-24)

Gabbard 2014

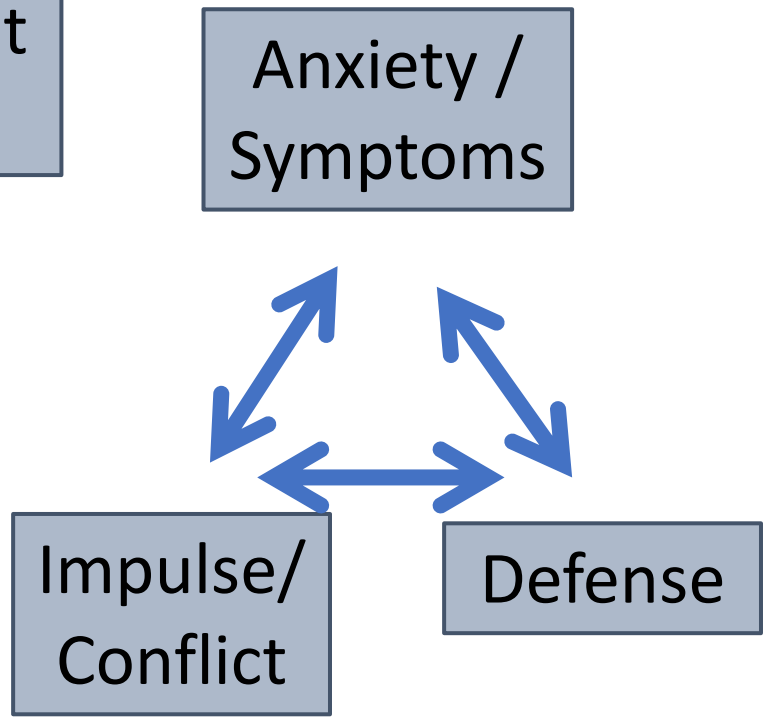
# MCQ 4

- Which of those is **not** part of the triangle of *persons* in Malan's theory.
  a) Anxiety
  b) Current
  c) Past
  d) Therapist

# Malan's triangles




*Triangle of Persons*




*Triangle of Conflict (or insight)*

David Malan, Kaplan & Sadock 2009

# Family Therapy

- Thinking in circle / Process-Content:
  - Circular causality, members of a family mutually influence each other
- Families are stuck trying to solve their problem in the same ineffective way. The role of the therapist is to introduce flexibility.
- Palo Alto School:
  - Meta communication, Double Bind, Homeostasis, Identified Patient
- Salvador Minuchin - Structural approaches.
  - Key concepts: Boundaries, Hierarchies, Enmeshed-Disengaged, First order change vs Second order change (desired-system level), Scapegoating, Joining, Enactment
- Jay Haley - Strategic family therapy:
  - Key features: Directive. Paradox, positive connotation (reframe), close to Milan school
  - “If one makes it more difficult for a person to have a symptom than to give it up, the person will give up the symptom”

Nichols & Davis 2017

# Family Therapy

- Murray Bowen – Bowen Family Systems:
  - Key concepts: Differentiation of Self, Emotional reactivity, undifferentiated family ego mass, Triangulation (dyads are very unstable), emotional cutoff
  - Conflicts in individuals due to triangulation
- McGoldrick - Family life cycle:
  - Stages: Leaving home, joining through marriage, families with young children, adolescence, launching, families in later life
  - Ethnicity and family therapy
- Social constructivism. Family Narratives and Culture.
- Dattilio – CBT for families
- Sue Johnson - Emotion Focused Couple Therapy
  - Emphasis on Attachment

Nichols & Davis 2017

# Family Therapy

- Assessments: From the symptom of the identified patient to formulating the family system.
  - Genograms
  - Circular questioning, process questions
- Evidence:
  - Externalizing disorders of childhood (CD, ODD)
  - Substance abuse - especially adolescent (Brief strategic family therapy, multimodal family therapy)
  - Childhood depression and anxiety
  - Eating disorder (Family based treatment – Maudsley)
  - Couple therapy may be useful in adult depression, PTSD and addiction

Nichols & Davis 2017

# Group Therapy

- Irvin Yalom & Molin Leszcz (2005)
- Group process different than delivering information to a group (psychoeducation).
- Group cohesion = Therapeutic alliance for groups
- Intervention level:
  - Therapist to individual
  - Dyad - Group member to group member (facilitated by therapist)
  - Group level intervention

# Group Therapy - Therapeutic factors (Yalom)

1. Interpersonal Input (learning how I affect others)
2. Catharsis (Expressing feelings)
3. Cohesiveness (Belonging/acceptance)
4. Self-Understanding (understanding oneself/ likes and preferences)
5. Interpersonal output (practicing interpersonal skills)
6. Existential factors (Responsibility, pain, mortality)
7. Universality (Others struggle too / perspective)
8. Instillation of hope (Feeling encouraged)
9. Altruism (Helping others provides self-efficacy and pride)
10. Family Reenactment (understanding family of origin through group dynamics)
11. Guidance (Receiving advice)
12. Identification (Behaving like a group member)

# Mindfulness

- Mindfulness can be understood as the non-judgemental acceptance and investigation of present experience, including body sensations, internal mental states, thoughts, emotions, impulses and memories, in order to reduce suffering or distress and to increase well-being.
- Mindfulness practice is close to a spiritual practice
- Components and interventions include:
  - Body scan, sitting meditation, gentle stretching, yoga
- Wellness approach to promote resilience
  - Preventing burnout (Multiple studies in medical professionals)

Hofman & Gomez, 2017

# Mindfulness

- Manualized approaches:
- Mindfulness Based Stress Reduction is a 8 week group treatment program. (Jon Kabat-Zinn – Emeritus professor of Medicine)
  - 8 session 2.5hrs + 45 min practice at home, and day long retreat.
  - Studied extensively in burnout prevention. Enhancing wellness, coping with chronic pain or stress, and improving general mental health symptoms
- Mindfulness Based Cognitive Therapy (MBCT) is an adaptation of mindfulness meant to specifically treat axis 1 disorders
- Mindfulness is also included in DBT and ACT.

Hofman & Gomez, 2017

# Not fully covered here

- Motivational interviewing:
  - Covered in substance use disorder lecture
  - Based on stages of change
  - Primarily for addiction, but also combined to other therapies re: readiness to change
- Dialectical Behavioral Therapy
  - Covered in Personality disorder lecture
  - In its original format 12 month program group + individual + phone coaching
  - Evidence to reduce self-harm in BPD
  - Evidence in Eating disorder and combined to Prolonged Exposure in PTSD.

# Psychotherapy for Royal College Examination

- Understanding the various models
- How different models formulate psychiatric syndromes
- What is the level of evidence for different approaches according to guidelines.
- CBT is the main modality for all anxiety disorders.
- Clinically it’s useful to have an appreciation of how therapy may be combined with meds or introduced in the course of treatment and its effect size.
- For examination purposes, process, guidelines and indication would be the main focus.

# MCQ 5

- According to CANMAT depression guidelines, which psychotherapy modality is a second line treatment for major depressive disorder:
  a) Cognitive Behavioral Therapy CBT
  b) Interpersonal psychotherapy IPT
  c) Long term psychodynamic psychotherapy LTPP
  d) Short term psychodynamic psychotherapy STPP

# Major Depressive Disorder

- CANMAT 2016

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

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

# Bipolar Disorder

- CANMAT 2018 Bipolar guidelines

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

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

# PTSD: Psychotherapy

- 1st Line VA guidelines: Trauma focused therapies
  - Prolonged Exposure
  - Cognitive Processing Therapy
  - Eye Movement Desensitization & Reprocessing (EMDR)
- 2nd Line VA guidelines: Non-trauma focused therapies
  - Interpersonal psychotherapy (IPT)
  - Stress inoculation
  - Present centered therapy

VA / DOD, 2017

# Eating Disorder

- Bulimia Nervosa:
  - CBT 1st line
  - IPT, Fluoxetine 2nd line
  - Psychodynamic approaches 3rd line

APA 2005