Psychotherapy is the "talking cure." Through the use of words to create understanding, guidance, and support and lead the patient to new experiences, the psychotherapist aims to eliminate symptoms and increase the patient's productivity and enjoyment of life. The brain itself is the target of psychotherapy. Behavior, thoughts, and emotions derive from brain activity and have a neuroanatomical, neurochemical, and neurophysiologic basis. The psychotherapies aim to alter brain "patterning" and function. Psychopathology frequently limits a patient's ability to see and experience options and choices. The patients' behaviors, thoughts, and feelings are constricted by their psychiatric illness. Through the various psychotherapies, the therapist attempts to increase the patients' range of behavioral options and decrease painful constricting symptoms.

Psychotherapeutic approaches to psychopathology vary widely and reflect different concepts and theories of mental life, personality development, abnormal behavior, and the role of environmental and biological determinants. The increasing understanding of the nature of the interaction of human beings with each other as individuals and as members of social groups has facilitated the application of some of these principles to the psychotherapeutic relationship as a treatment tool. Experience indicates that an integrated approach to treatment is the most successful approach. Different patients benefit from different types of psychotherapy. In addition, patients may substantially benefit from the appropriate combined use of medications and psychotherapy. Because of this, the medically trained psychiatrist can
provide the most comprehensive evaluation for combining medication with psychotherapeutic treatment. The psychiatrist can use combined medication and psychotherapeutic treatments and is trained to recognize and manage the potential interactions of these two treatments. The psychiatrist is also alert to changes in the patient's medical status that can be a cause of or a result of psychiatric illness. Patients with significant medical illness as part of their health history (e.g., migraine, ulcers, psychosomatic illnesses, and so forth) are best treated by the psychiatrist who, as a physician, is knowledgeable of these disorders and their effects on feelings, behaviors, and life adjustment and is a skilled psychotherapist. Often the seriously depressed or psychotic patient may also be more comfortable with a psychiatrist who is trained in managing life-and-death issues, chronic illness, and the medical side effects of medication.

In the following pages, the major psychotherapies are reviewed. An understanding of these techniques and their theoretical concepts used in patient selection is important to the treatment armamentarium of inpatient, outpatient, and consultation-liaison psychiatric practices as well as general medical practice.

PSYCHOANALYTIC PSYCHOTHERAPIES

Psychoanalysis

Psychoanalysis was developed by Sigmund Freud in the late 19th century. Freud found that patients' life difficulties were related to unrecognized (unconscious) conflicts that arise in the course of child development and continue into adult life. Such conflicts are typically between libidinal and aggressive wishes and the fear of loss, condemnation retaliation, the constraints of reality, or the opposition of other incompatible wishes. "Libidinal wishes" are longings for both sexual and emotional gratification. Sexual gratification in psychoanalysis refers to the broad concept of bodily pleasure, the state of excitement and pleasure experienced by various bodily sensations beginning in infancy. Aggressive wishes may either be primary destructive impulses or arise in reaction to perceived frustration, deprivation, or attack. Such (neurotic) conflicts may give rise to a variety of manifestations in adulthood, including anxiety, depression, and somatic symptoms, as well as work, social, or sexual inhibitions and maladaptive ways of relating to other people.

The goal of psychoanalysis is to understand the nature of the patient's childhood conflicts (the "infantile neurosis") and their consequences in adult life. This is accomplished through reexperiencing these conflicts in relation to the analyst (the "transference neurosis"). This is a major undertaking that requires a great deal of the patient to sustain the treatment. It requires individuals who are able to access their fantasy lives in an active and experiencing manner and are able to "leave it behind" at the end of a session. Psychoanalysis is frequently criticized for being used to treat reasonably healthy people. However, all medical treatments require certain innate capacities of the patient (e.g., an intact immune system for successful antibiotic therapy). As with a generally healthy person with a relatively focal, yet painful physical disorder that impairs their functioning, a generally healthy person may have painful neurotic conflicts that interfere with both their work and personal life, and therefore require treatment.
Psychoanalysis focuses on the recovery of childhood experiences as they are re-created in the relationship with the analyst (Sandler et al., 1973). This recreation in the doctor-patient relationship of the conflicted relationship with a childhood figure is called the "transference neurosis" (see Table 17–1). In the therapeutic relationship with the analyst, the emotional conflicts and trauma from the past are relived. The feelings and conflicts toward major figures in the child's development, most frequently the parents, are "transferred" to the analyst. When the transference neurosis is present, the patient emotionally experiences and reacts to the analyst in a very real manner "as if" the analyst was the significant figure from the past. Frequently, this experience is accompanied by other elements of the past being experienced in the patient's life. Countertransference, the analyst's transference response to the patient, is increased by life stress and unresolved conflicts in the analyst. It can appear as either an identification with or a reaction to the patient's conscious and unconscious fantasies, feelings, and behaviors. Understanding their own countertransference reactions can allow analysts to recognize subtle aspects of the transference relationship and better understand the patient's experience.

Psychoanalytic treatment attempts to set up a therapeutic situation in which the patient's observing capacity can be used to analyze the transference neurosis. Transference reactions occur throughout life in all areas and are a frequent accompaniment of the doctor-patient relationship in the medical setting. However, psychoanalysis is unique in its efforts to establish a setting in which the transference, when it appears, can be analyzed and worked through in an intense manner to facilitate recovery from psychiatric illness.

Modern psychoanalysis requires four to five sessions per week (45 to 50 minutes per session) continued, on the average, for 3 to 6 years. This extensive amount of sessions is necessary for patients to develop sufficient trust to explore their inner life and their subjective experience. Likewise, given the number of events that occur daily in one's lifetime, the frequent meetings are necessary for the patient to be able to explore fantasies, dreams, and reactions to the analytic situation instead of focusing

<table>
<thead>
<tr>
<th>Table 17–1 Psychoanalysis</th>
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</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
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<tr>
<td><strong>Selection Criteria</strong></td>
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<tr>
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<tr>
<td><strong>Technique</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
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</table>
only on daily reality-based crises and stresses. Individuals who are in severe crisis and, therefore, are focused on the crises in their life are generally not candidates for psychoanalysis. If major crises do occur during analysis, formal analysis may be temporarily suspended for a more supportive psychotherapeutic approach. In general, psychoanalytic patients are encouraged to use a recumbent position on the couch to further facilitate their ability to freely associate and verbalize their thoughts and feelings. In addition, the analyst usually sits out of the patient's view to assist unencumbered the process of free association.

Free association, the reporting of all thoughts that come to mind, is a major element in psychoanalytic technique. In point of fact, free association is difficult to attain, and much of the work of psychoanalysis is based on identifying those times when free association breaks down (the occurrence of a defense, clinically experienced by the analyst as "resistance"). When the patient is able to free associate easily, the neurotic conflicts have been largely removed and the termination of treatment is near.

Early in treatment, the analyst establishes a therapeutic alliance with the patient that allows for a reality-based consideration of the demands of the treatment and for a working collaboration between analyst and analysand (patient) directed toward understanding the patient. The analyst points out the defenses the patient uses to minimize awareness of conflicts and disturbing feelings. Dreams, slips of the tongue, and symptoms provide avenues to the understanding of unconscious motivations, feelings, and ideas.

The specific treatment effects of psychoanalysis result from the progressive understanding of defensive patterns and, most important, the feelings, cognitions, and behaviors that are "transferred" to the analyst from significant individuals in the patient's past. In the context of the arousal associated with the reexperiencing of these figures from the past and the simultaneous understanding of the experience, behavioral change occurs. Interpretation is an important technical procedure in this process. An interpretation links the patient's current experience with the analyst to an experience with a significant childhood figure during development.

The analyst operates under several rules that facilitate the analysis of the transference. These include the rule of neutrality, by which the analyst favors neither the patient's wishes (id) nor the condemnations of these wishes (superego), and the rule of abstinence, whereby the analyst does not provide emotional gratification to the patient similar to that of the wished-for childhood figure.

Medications are infrequently used in psychoanalysis, although some analysts are integrating psychoanalytic treatment with medication, particularly for mood disorders. In these cases, psychoanalysis is directed toward aiding the change in behaviors that may have been learned over a long time and may be interfering with the return of good psychosocial functioning. In general, however, the necessity for the use of medication may indicate the patient's need for greater support and structure than can be provided in the psychoanalytic treatment.

The assessment of a patient for psychoanalysis must include diagnostic considerations as well as an assessment of the patient's ability to make use of the psychoanalytic situation for behavior change. A patient's ability to use psychoanalysis depends on the patient's psychological-mindedness, the availability of supports in their
real environment to sustain the psychoanalysis (which can be felt as quite depriving), and the patient's ability to experience and simultaneously observe highly charged emotional states. Because of the frequency of the sessions and the duration of the treatment, the cost of psychoanalysis can be prohibitive. However, low-fee training clinics frequently make a substantial amount of treatment available to some patients who could not otherwise afford it. Psychoanalysis has been useful in the treatment of obsessional disorders, conversion disorders, anxiety disorders, dysthymic disorders, and moderately severe personality disorders. Individuals with chaotic life settings and an inability to establish long-term, close relationships are usually not good candidates for psychoanalysis. In the present cost-effective climate, psychoanalysis is more frequently recommended after a course of brief psychotherapy has proved either ineffective or insufficient. Little empirical research is available on the efficacy of psychoanalysis compared with other psychotherapies. In general, those patients who can use understanding, introspection, and self-observation to modify their behavior find the treatment beneficial and productive.

**Intensive (Long-Term) Psychoanalytically Oriented Psychotherapy**

Psychoanalytically oriented psychotherapy, also known as psychoanalytic psychotherapy, psychodynamic psychotherapy, and explorative psychotherapy, is a psychotherapeutic procedure that recognizes the concepts of transference and resistance in the psychotherapy setting (Bruch, 1974; Reichmann, 1950). Both long-term and brief psychodynamic psychotherapy are possible. (See following section for brief psychodynamic psychotherapy.) Psychoanalytic psychotherapy is usually more focused than is the extensive reworking of personality undertaken in psychoanalysis. In addition, psychoanalytic psychotherapy is somewhat more "here and now" oriented, with less attempt to completely reconstruct the developmental origins of conflicts.

The psychoanalytic techniques of interpretation and clarification are central to psychoanalytic psychotherapy. Psychoanalytic psychotherapy makes more use of supportive techniques—such as suggestion, reality testing, education, and confrontation—than does psychoanalysis. This allows for its application to a broader range of patients, including those with the potential for severe regression.

Patients in long-term psychoanalytic psychotherapy are usually seen two or three times per week, although once per week is also increasingly common. Patient and therapist meet in face-to-face encounters with free association encouraged. Psychoanalytic psychotherapy may extend several months to several years, at times being as long as a psychoanalysis. The length is determined by the number of focal problem areas undertaken in the treatment. Medications can be used in psychoanalytic psychotherapy and provide another means of titrating the level of regression (the experience of feelings, thoughts, and actions from childhood being readily accessed) a patient may experience.

The same patients who are treated in psychoanalysis can be treated in psychoanalytic psychotherapy (see Table 17–2). The psychosocial problems and internal conflicts of patients who cannot be treated in psychoanalysis, such as those with major depression, schizophrenia, and borderline personality disorder, can be ad-
Table 17–2  **Psychoanalytically Oriented Psychotherapy**

| Goal | Understanding conflict area and particular defense mechanisms used  
|      | More “here and now” than psychoanalysis  
|      | Selection  
|      | Similar to psychoanalysis  
|      | Also includes personality disorders with psychotic potential  
|      | (Borderline, Narcissistic)  
|      | Some major depressions and schizophrenia may be helped when combined with medication during periods of remission for the treatment of psychosocial features  
| Techniques | Face to face—sitting up  
|            | Free association  
|            | Interpretation and clarification  
|            | Some supportive techniques  
|            | Medication as adjunct  
| Duration | Months to years  

addressed in a long-term psychoanalytic psychotherapy. In long-term psychoanalytic psychotherapy, the regressive tendencies of such patients can be titrated with greater support, medication and reality feedback through the face-to-face encounter with the therapist. Little empirical data are available on the efficacy of psychoanalytically oriented psychotherapy, although it is highly valued by many clinicians and patients. Recent studies tend to support the importance of working with the transference to create behavioral change (Luborsky and Crits-Cristoph, 1990). Interpersonal psychotherapy (IPT) (Klerman et al, 1984) has many psychodynamic principles and has been shown effective in studies using combined psychotherapy and medication interventions.

**Brief Psychodynamic Psychotherapy**

Following World War II there was a rapid growth in the demand for psychotherapy that considerably increased the pressure upon psychiatrists to develop briefer forms of psychotherapy. In addition, the community mental health movement and, more recently, the increasing cost of mental health care have stimulated efforts to find briefer forms of psychotherapy. At present, brief psychotherapy is a necessary part of the psychiatrist’s armamentarium rather than the “second-best” alternative, as it was viewed in the 1950s.

The goals of brief psychotherapy are described by most authors as facilitation of health-seeking behaviors and the mitigation of obstacles to normal growth. From this perspective, brief psychotherapy focuses on the patient’s continuous development throughout adult life in the context of conflicts relating to environment, interpersonal relationships, biological health, and developmental stages. This picture of brief psychotherapy supports modest goals and the avoidance of “perfectionism” by the therapist.
While many of the selection criteria emphasized in the literature of brief psychotherapy are common to all kinds of psychodynamic psychotherapy, certain unique selection criteria are required because of the brief duration of treatment (see Table 17–3). Patients in brief psychodynamic psychotherapy must be able to engage quickly with the therapist, and terminate therapy in a short period of time. The necessity of greater independent action by the patient mandates high levels of emotional strength, motivation, and responsiveness to interpretation. The importance of rapidly establishing the therapeutic alliance underlies a substantial number of the selection and exclusion criteria.

Some exclusion criteria for brief psychotherapy were developed by Malan (1975). He excludes patients who have had serious suicidal attempts, drug addiction, long-term hospitalization, more than one course of electroconvulsive therapy (ECT), chronic alcoholism, severe chronic obsessional symptoms, severe chronic phobic symptoms, or gross destructive or self-destructive behavior. Patients who are unavailable for therapeutic contact or those who need prolonged work to generate motivation, penetrate rigid defenses, deal with complex or deep-seated issues, or resolve intense transference reactions are also not likely to benefit from brief psychotherapy and may have negative side effects.

The importance of focusing on a circumscribed area of current conflict in brief psychotherapy is mentioned by most authors (Davanloo, 1980; Malan, 1975; Mann, 1973; Sifneos, 1972). They also emphasize the importance of the evaluation sessions to determine the focus of treatment. The formulation of the focus to the patient may be, for example, in terms of the patient’s conscious fears and pain, but it is important for the therapist to construct the psychodynamic focus at a deeper level in order to understand the work being done. Maintaining the focus is the primary task of the therapist. This enables the therapist to deal with complicated personality structures in a brief period of time. Resistance is limited through “benign neglect” of potentially troublesome but nonfocal areas of personality. The elaboration of techniques of establishing and maintaining the focus of treatment is critical to all brief individual psychodynamic psychotherapies.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Clarify and resolve focal area of conflict that interferes with current functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection Criteria</td>
<td>High ego strength</td>
</tr>
<tr>
<td></td>
<td>High motivation</td>
</tr>
<tr>
<td></td>
<td>Can identify focal issue</td>
</tr>
<tr>
<td></td>
<td>Can form strong interpersonal relationships, including with therapist, in a brief time</td>
</tr>
<tr>
<td></td>
<td>Good response to trial interpretations</td>
</tr>
<tr>
<td>Techniques</td>
<td>Face to face</td>
</tr>
<tr>
<td></td>
<td>Interpretation of defenses and transference</td>
</tr>
<tr>
<td></td>
<td>Setting of time limit at start of therapy</td>
</tr>
<tr>
<td></td>
<td>Focus on patient reactions to limited duration of treatment</td>
</tr>
<tr>
<td>Duration</td>
<td>12-40 sessions; usually 20 sessions or less</td>
</tr>
</tbody>
</table>
Transference interpretations (that is, making comments that link the patient's reactions to the therapist to feelings for significant individuals from the patient's past) are generally accepted as important in brief psychotherapy. However, the manner and rapidity in which transference is dealt with varies considerably.

There is remarkable agreement on the duration of brief psychotherapy. Although the duration ranges from 5 to 40 sessions, authors generally favor 10 to 20 sessions. The duration of treatment is critically related to maintaining the focus within the brief psychotherapy. When treatment extends beyond 20 sessions, therapists frequently find themselves enmeshed in a broad character analysis without a focal conflict. Change after 20 sessions may be quite slow. Clinical experience generally supports the idea that brief individual psychodynamic psychotherapy should be between 10 and 20 sessions unless the therapist is willing to proceed to long-term treatment of greater than 40 or 50 sessions.

COGNITIVE PSYCHOTHERAPY

Cognitive psychotherapy is a method of brief psychotherapy developed over the last two decades by Aaron T. Beck and his colleagues at the University of Pennsylvania primarily for the treatment of mild and moderate depressions and for patients with low self-esteem (Beck, 1976; Rush and Beck, 1988). It is similar to behavior therapy in that it aims at the direct removal of symptoms rather than the resolution of underlying conflicts, as in the psychodynamic psychotherapies. However, unlike traditional behavioral approaches, the subjective experience of the patient is a major focus of the work. Cognitive therapists view the patient's conscious thoughts as central to producing and perpetuating symptoms such as depression, anxiety, phobias, and somatization. Both the content of thoughts and thought processes are seen as disordered in people with such symptoms. Therapy is directed toward identifying and altering these cognitive distortions.

The cognitive therapist sees the interpretations that depressed persons make about life as different from those of nondepressed individuals. Depressed people tend to make negative interpretations of the world, themselves, and the future (the negative cognitive triad). Depressed individuals interpret events as reflecting defeat, deprivation, or disparagement and see their lives as filled with obstacles and burdens. They view themselves as unworthy, deficient, undesirable, or worthless and see the future as bringing a continuation of the miseries of the present. These evaluations are the result of the negative biases inherent in depressive thinking and applied regardless of the objective nature of the individual's circumstances. Other psychiatric conditions have their own characteristic cognitive patterns that determine the nature of the symptoms. The "thinking" distortions in depression include arbitrary inferences about an event, selective use of details to reach a conclusion, overgeneralization, overestimating negative and underestimating positive aspects of a situation, and the tendency to label events according to one's emotional response rather than the facts.

Such cognitions (verbal thoughts) often feel involuntary and automatic. This kind of thinking is so automatic in response to many situations—and the resultant cognitions so fleeting—that people may often be virtually unaware of them. Such
automatic thoughts differ from unconscious thoughts in that they can easily be made fully conscious if attention is directed to them. A large portion of the work of cognitive psychotherapy is to train patients to observe and record their automatic thoughts.

Cognitive theory postulates a chronic state of depression-proneness that may precede the actual illness and remain after the symptoms have abated. Depression-prone individuals have relatively permanent depressive cognitive structures ("cognitive schemas") that determine how new stimuli are perceived and conceptualized. Typical schemas of depression include "I am stupid," or "I cannot exist without the love of a strong person." Unlike automatic thoughts, patients are not typically aware and cannot easily become aware of such underlying general assumptions. These must be deduced from many specific examples of distorted thinking. Schemas such as "I am stupid" may lie dormant much of the time only to be reactivated by a specific event, such as difficulty in accomplishing a task. These enduring self-concepts and attitudes are assumed to have been learned in childhood on the basis of the child's experiences and the reactions of important family members. Once formed, such attitudes can be self-perpetuating.

Just as depressive thoughts can be triggered by events, episodes of depressive illness may, from the cognitive perspective, be triggered by sufficient stress. Such stresses may be specific to the individual and her or his particular sensitivities developed in childhood. Alternatively, sufficient degrees of nonspecific stress may precipitate depression in vulnerable individuals. Experiences of loss, a setback in a major goal, a rejection, or an insolvable dilemma are especially common precipitants of depression. The onset of medical illness, with its attendant limitations and associated meanings, is also seen as likely to trigger depression in many people.

Researchers have accumulated considerable evidence that depressed individuals do indeed manifest negative biases in their views of themselves, their experiences, and the future. In addition, they have attitudes (schemas) that distinguish them from nondepressed subjects as well as distortions in logic and information processing. It is less clear whether all depressed people show the thinking distortions that Beck has described. Much of the cognitive depression research has been criticized because the studies have been on nonpatient populations, such as student volunteers, with relatively mild degrees of depression. These individuals may be very different from actual psychiatric patients. Whether cognitive distortions are a predisposing factor to depression is also unclear. Most researchers have found that most distorted thinking disappears when depression is successfully treated, even with antidepressant medication, suggesting that these distortions are a symptom of depression rather than an enduring trait of depression-prone people. Clearly, further research is needed to test the causality of cognitive factors in depression.

**Technique of Cognitive Psychotherapy**

Cognitive psychotherapy is a directive, time-limited, multidimensional psychological treatment. The patient and therapist together discover the irrational beliefs and illogical thinking patterns associated with the patient's depressive affects (see Table 17-4). They then devise methods by which patients themselves can test the validity of their thinking. The therapist helps patients to become aware of their
Table 17-4  **Cognitive Psychotherapy**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Identify and alter cognitive distortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection</td>
<td>Unipolar, nonpsychotic depressed outpatients</td>
</tr>
<tr>
<td></td>
<td>Contraindications include delusions, hallucinations, severe depression, severe cognitive impairment, ongoing substance abuse, enmeshed family system</td>
</tr>
<tr>
<td>Technique</td>
<td>Behavioral assignments</td>
</tr>
<tr>
<td></td>
<td>Reading material</td>
</tr>
<tr>
<td></td>
<td>Taught to recognize negatively biased automatic thoughts</td>
</tr>
<tr>
<td></td>
<td>Identify patients' schemas, beliefs, attitudes</td>
</tr>
<tr>
<td>Duration</td>
<td>Time limited: 15-25 sessions</td>
</tr>
</tbody>
</table>

Irrational beliefs and distorted thinking ("automatic thoughts") and to see for themselves whether their ideas are objectively true or logical.

Cognitive psychotherapy was developed for unipolar, nonpsychotic, depressed outpatients. The presence of bipolar illness, delusions or hallucinations, or extremely severe depression is a contraindication for cognitive psychotherapy as the sole or primary treatment modality. Other contraindications include the presence of underlying medical illness or medications that may be causing the depression, the presence of an organic mental disorder, or an ongoing problem of substance abuse. In addition, cognitive psychotherapy may not be indicated as the sole form of treatment for major or "endogenous" depression (which may be accompanied by endocrine, sleep, or other biological abnormalities in which antidepressant medication or ECT is needed) or for patients enmeshed in family systems that maintain a fixed view of themselves as helpless and dependent. Cognitive psychotherapy may be useful in patients who refuse to take, fail to respond to, or are unable to tolerate medication, as well as those who prefer a psychological approach in the hope of greater long-term benefits.

Cognitive psychotherapy is generally conducted over a period of 15 to 25 weeks in once-weekly meetings. With more severely depressed patients, two or three meetings per week are recommended for the first several weeks. While cognitive psychotherapy was developed and is usually administered as an individual treatment, its principles have also been successfully applied to group settings.

A course of cognitive psychotherapy proceeds in a succession of regular stages. The first stage is devoted to introducing the patient to the procedures and rationale of the therapy, setting goals for the treatment, and establishing a therapeutic alliance. The therapist may assign reading material on the cognitive theory of depression. In the next stage, the therapist begins to demonstrate to the patient that cognitions and emotions are connected. Patients are taught to become more aware of their negatively biased automatic thoughts and to recognize, both during and outside of the psychotherapy hours, that negative affects are generally preceded by such thoughts. Behavioral assignments may be used.

In the next phase, which normally comprises the majority of the work, the emphasis shifts to a detailed exploration of the patient's cognitions and their role in perpetuating depressive feelings. In the final stage of psychotherapy, patients will have had a great deal of experience in recognizing their habitual thought patterns, testing their validity, and modifying them when appropriate, with the result of
substantial symptomatic relief. Psychotherapy then focuses on the attitudes and assumptions that underlie the patient's negatively biased thinking. For example, the patient might assume that, “If I’m nice, bad things won’t happen to me.” A logically equivalent assumption would then be, “If bad things happen to me, it is my fault because I am not nice.” Target symptoms that might be the focus of a session include intense sadness, pervasive self-criticism, passivity and avoidance, sleep disturbance, or other affective, motivational, or cognitive manifestations of depression. The therapist repeatedly formulates the patient’s beliefs and attitudes as testable hypotheses and helps the patient to devise and implement ways of verifying them. The therapist maintains an inquiring attitude toward the patient’s reactions to the therapist and the therapeutic procedures. Such reactions are explored for evidence of misunderstanding and distortion, which are then dealt with in the same way as the patient's other cognitions.

A great variety of different techniques are used by cognitive therapists to break the cycle of negative evaluations and dysfunctional behaviors. Behavioral methods are often useful in the beginning of psychotherapy, particularly when the patient is severely depressed. Activity scheduling, mastery and pleasure exercises, graded task assignments, cognitive rehearsal, and role-playing may all be used.

More cognitively oriented methods are applied in the middle and late stages of psychotherapy as psychotherapy progresses. The therapist and patient explore the patient's inner life in a spirit of adventure. Patients become more observant of their peculiar construction of reality and usually focus more on actual events and their meanings. The fundamental cognitive technique is teaching patients to observe, record, and validate their cognitions.

**Efficacy of Cognitive Psychotherapy**

In contrast to most other psychotherapies, there is a growing literature on the efficacy of cognitive psychotherapy. Although the number is still relatively small, all studies examining the outcome of cognitive psychotherapy have found it to be an effective treatment at least in ambulatory outpatients with mild to moderate degrees of depression. Cognitive psychotherapy has been shown to be more effective than no psychotherapy in treating both depressed volunteers and psychiatric patients with diagnoses of depression.

It should be emphasized that the choice of treatment for a depressed patient should often involve a combination of both psychotherapy and antidepressant medication. To withhold antidepressants from patients who have a clear biological component to their depression, based on their signs and symptoms and family history, because of a "bias" toward one sort of psychotherapy or another is unjustifiable on clinical grounds. Hence, integrated psychotherapeutic and pharmacologic treatment is often indicated and should be considered in every patient.

**SUPPORTIVE PSYCHOThERAPY**

Supportive psychotherapy aims to help patients maintain or reestablish the best level of functioning given the limitations of their illness, personality, native ability, and life circumstances (see Table 17-5). In general, this goal distinguishes supportive
Table 17-5 Supportive Psychotherapy

<table>
<thead>
<tr>
<th>Goal</th>
<th>Maintain or reestablish best level of functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection</td>
<td>Very healthy individuals exposed to stressful life circumstances (e.g., Adjustment Disorder)</td>
</tr>
<tr>
<td></td>
<td>Individual with serious illness, ego deficits, e.g., Schizophrenia, Major Depression (psychotic)</td>
</tr>
<tr>
<td></td>
<td>Individuals with medical illness</td>
</tr>
<tr>
<td>Techniques</td>
<td>Available, predictable therapist</td>
</tr>
<tr>
<td></td>
<td>Limited interpretation of transference</td>
</tr>
<tr>
<td></td>
<td>Support intellectualization</td>
</tr>
<tr>
<td></td>
<td>Therapist acts as a guide/mentor</td>
</tr>
<tr>
<td></td>
<td>Medication frequently used</td>
</tr>
<tr>
<td></td>
<td>Supportive techniques: suggestion, reinforcement, advice, teaching, reality testing, cognitive restructuring, reassurance</td>
</tr>
<tr>
<td></td>
<td>Active stance</td>
</tr>
<tr>
<td></td>
<td>Discuss alternative behaviors, social/interpersonal skills</td>
</tr>
<tr>
<td>Duration</td>
<td>Brief (days-weeks) to very long term (years)</td>
</tr>
</tbody>
</table>

Psychotherapy from the change-oriented psychotherapies that aim to reverse primary disease processes and symptoms or restructure personality.

The line between supportive and change-oriented psychotherapy, however, is frequently not clear. The situation is somewhat analogous to the medical treatment of viral versus bacterial infections. Treatment of the former is basically supportive in that it aims to maintain normal bodily functions (e.g., fever reduction, control of cerebral edema, dietary compensation for liver failure) in the face of infection, while in the latter, the aim is to eliminate the infection. However, in addition to the supportive aspects of treating bacterial infections, antibiotic treatment itself is supportive in the sense that it works as an adjunct to the body’s natural immune system, without which it is relatively ineffective. However, there are supportive elements in all effective forms of psychotherapy, and the terms “supportive” and “change-oriented” merely describe the balance of efforts in a particular case.

Patients who are generally very healthy and well adapted but who have become impaired in response to stressful life circumstances, as well as those who have serious illnesses that cannot be cured, can receive supportive psychotherapy. Supportive psychotherapy may be brief or long-term. The “healthy” individual, when faced with overwhelming stress or crises (particularly in the face of traumas or disasters), may seek help and be a candidate for supportive psychotherapy. The relatively healthy candidate for supportive psychotherapy is a well-adapted individual with good social supports and interpersonal relations, flexible defenses, and good reality testing who is in acute crisis. This individual continues to show evidence of well-planned behaviors and a healthy perspective on the crisis, making use of social supports, not withdrawing, and anticipating resolution of the crisis. Although the patient is functioning below his or her usual level, this patient remains hopeful about the future and makes use of resources available for problem solving, respite, and growth. This patient uses supportive psychotherapy to more rapidly reconstitute, to avoid errors in judgment by
"talking out loud," to relieve minor symptomatology, and to grow as an individual by learning about the world.

The more typical candidate for supportive psychotherapy has significant deficits in ego functioning, including poor reality testing, impaired impulse control, and difficulties in interpersonal relations. Patients who have less ability to sublimate and are less introspective are frequently treated in supportive psychotherapy, where more directive techniques and environmental manipulation can be used.

Ego strength and the ability to form relationships may be more important than diagnosis in the selection of patients for supportive psychotherapy (Werman, 1984; Rockland, 1989). The ability of the patient to relate to the therapist, a past history of reasonable personal relationships, work history and educational performance, and the use of leisure time for constructive activity and relaxation bear importantly on the treatment recommendation. Almost no information is known regarding which characteristics of the patient may predict a good result from supportive psychotherapy rather than merely a poor response to the change-oriented psychotherapies. Delineation of the minimum level of personal strengths needed to benefit from supportive individual psychotherapy is an important task for future research.

Technique of Supportive Psychotherapy

Psychoanalytic theory provides the major contributions to the theory of the supportive psychotherapy. In-depth psychological understanding of patients in supportive psychotherapy is as necessary as in the change-oriented, explorative psychotherapies (Rockland, 1989; Pine, 1986; Werman, 1984). Understanding unconscious motivation, psychic conflict, the patient-therapist relationship, and the patient's use of defense mechanisms is essential to understanding the patient's strengths and vulnerabilities. This knowledge is critical to providing support as well as insight.

Therapists who are predictably available and safe (i.e., who accepts the patient and puts aside their own needs in the service of the treatment) assume some of the holding functions of the "good parent." In such a therapeutic situation, the patient is able to identify with and incorporate the well-functioning aspects of the therapist, such as the capacity for self-observation and the ability to tolerate ambivalence (Pine, 1986).

The containment of affect and anxiety is an important supportive function. Patients in need of supportive psychotherapy typically fear the destructive power of their rage and envy. They are helped to modulate their emotional reactions by the reliable presence of the therapist and the therapeutic relationship that remains unchanged in the face of emotional onslaughts.

The therapist fosters the supportive relationship by refraining from interpreting positive transference feelings and waiting until the intensity of feelings has abated before commenting about negative transference feelings. Interpretations of the negative transference are limited to those needed to assure that the treatment is not disrupted. While maintaining a friendly stance toward the patient, the therapist respects the patient's need to establish a comfortable degree of distance. The therapist must not push for a more intimate or emotion-laden relationship than the patient can tolerate. The rapport with the patient, which the supportive psychotherapist tries
to establish, differs from the "therapeutic alliance" of insight-oriented therapy. The doctor-patient relationship does not require the patient to observe and report on their own feelings and behavior to the same extent as in the change-oriented, explorative psychotherapies. The therapist acts more as a guide and a mentor.

There is virtually unanimous agreement among writers on supportive psychotherapy that fostering a good working relationship with the patient is the first priority. The therapist must be available in a regular and predictable manner. Rather than approach the patient as a "blank screen," the therapist actively demonstrates concern, involvement, sympathy, and a supportive attitude. The therapist serves as an "auxiliary ego" for the patient. The auxiliary ego functions of the therapist can be seen in the therapist's use of suggestion, reinforcement, advice, teaching, reality testing, cognitive restructuring, and reassurance. In taking such an active stance, it is especially important for the therapist to guard against grandiosity and personal biases so as not to "become an omnipotent decision maker." Rather the therapist acts as "a strong, benign individual who is reasonably available when needed." To the extent that patients develop the capacity to observe themselves, the psychotherapy may proceed beyond support and take on features of the explorative and change-oriented psychotherapies.

The defenses of denial and avoidance are handled by encouraging the patient to discuss alternative behaviors, goals, and interpretations of events. Reassurance has a variety of forms in supportive psychotherapy, including: supporting an adaptive level of denial (such as a patient may employ in coping with a terminal illness); the patient's experience of the therapist's empathic attitude; or the therapist's reality testing of the patient's negatively biased evaluations of themselves or their situation. Reassuring a patient is not easy. Reassurance requires a clear understanding of what the patient fears. Overt expressions of interest and concern may be reassuring to a patient who fears rejection but threatening to one who fears intrusion. Interpretations in supportive psychotherapy are limited to those that will decrease anxiety and strengthen (rather than loosen) defenses, particularly the defenses of intellectualization and rationalization.

The therapist's expressions of interest, advice giving, and facilitation of ventilation reinforce desired behaviors. Expressions of interest and solicitude are positively reinforcing. Advice can lead to behavioral change if it is specific and applies to frequent behaviors of the patient. Desired behaviors are rewarded by the therapist's approval and by social reinforcement. Ventilation of emotions is useful only if the therapist can help the patient safely contain and limit them, thus extinguishing the anxiety response to emotional expression. Cognitive and behavioral psychotherapeutic interventions that strengthen the adaptive and defensive functions of the ego (e.g., realistic and logical thinking, social skills, containment of affects such as anxiety) contribute to the supportive aspects of the psychotherapy.

**Efficacy of Supportive Psychotherapy**

Most data on the effectiveness of supportive psychotherapy come from studies in which supportive psychotherapy has been used as a control in testing the efficacy of other treatments. In such studies, the procedures used in supportive psychotherapy
tend to be poorly specified, and no attempts are made to correlate individual supportive techniques with outcome. There are no studies in which supportive psychotherapy is compared with no treatment or minimal treatment. However, despite its limitations, the research literature offers some evidence that supportive psychotherapy is an effective treatment, particularly when combined with medication. This appears to be true in the treatment of depression, anxiety disorders, and schizophrenia.

There is a body of research indicating that supportive psychotherapy is an effective component of the treatment of patients with a variety of medical illnesses, including those with ulcerative colitis or myocardial infarction and cancer patients undergoing radiation treatment. In general, patients in supportive psychotherapy improve emotionally and have fewer days in the hospital, fewer complications, and more rapid recovery.

The evidence to date, though preliminary, suggests that supportive psychotherapy can be effective in both psychiatric and medical illnesses and is frequently more cost effective than more intensive psychotherapies for some disorders. More research is needed on the indications, contraindications, and techniques of supportive psychotherapy.

**BEHAVIORAL THERAPY**

Behavioral therapy (behavior modification) is based on the concept that all symptoms of a psychological nature are learned maladaptive patterns of behavior in response to environmental or internal stimuli. It does not concern itself with the intrapsychic conflicts that are the focus of the psychodynamically oriented psychotherapies. Rather, it uses the concepts of learning theory to eliminate the involuntary, disruptive behavior patterns that constitute the essential features of psychopathology and substitutes these with highly adaptive and situation-appropriate patterns (Lazarus, 1971). Behavioral therapy has been useful in a wide range of disorders when specific behavioral symptoms can be targeted for change and this change is central to recovery. Eating disorders, chronic pain syndromes and illness behavior, phobias, sexual dysfunction, and conduct disorders of childhood are frequently treated with behavioral therapy techniques.

**Techniques of Behavioral Therapy**

A variety of techniques exist that permit the modification of undesirable and unwanted behaviors when applied by therapists skilled in their use (see Table 17–6). These approaches require careful history taking and behavioral analysis in order to identify the behaviors to be targeted for extinction or modification. Often, adjunctive techniques, such as the use of hypnosis and drugs, are used to facilitate behavior modification but are not requisite for therapeutic success. Present-day behavioral therapists are usually alert to interpersonal and emotional aspects of psychiatric symptoms and the doctor-patient relationship. Psychodynamic, cognitive, and interpersonal techniques are frequently integrated into the therapy but are not seen as
Table 17-6  Behavioral Therapy (Behavioral Modification)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Eliminate involuntary disruptive behavior patterns and substitute appropriate behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection</td>
<td>Habit modification</td>
</tr>
<tr>
<td></td>
<td>Targeted symptoms</td>
</tr>
<tr>
<td></td>
<td>Phobias</td>
</tr>
<tr>
<td></td>
<td>Some psychophysologic responses, headache, migraine, hypertension, Raynaud’s phenomena</td>
</tr>
<tr>
<td></td>
<td>Sexual dysfunction</td>
</tr>
<tr>
<td>Techniques</td>
<td>Systemic desensitization</td>
</tr>
<tr>
<td></td>
<td>Implosion therapy and flooding</td>
</tr>
<tr>
<td></td>
<td>Aversive therapy</td>
</tr>
<tr>
<td></td>
<td>Biofeedback</td>
</tr>
<tr>
<td>Duration</td>
<td>Usually time limited</td>
</tr>
</tbody>
</table>

central to the therapeutic effect. Four of the more common behavioral techniques follow.

**Systematic Desensitization**

Systematic desensitization refers to a technique whereby individuals suffering primarily from phobic responses are gradually exposed to anxiety-provoking situations or objects in small increments. The therapist first identifies a hierarchy of behaviors directed to approaching the phobic object or situation. Relaxation techniques are used to decrease anxiety at each stage of the hierarchy. The patient moves up to the next level of intensity when the stimulus no longer provokes intense anxiety. This particularly effective technique is useful in an office setting as well, because experience has demonstrated that the patient can confront the anxiety-provoking stimulus in his imagination with very much the same effects. Again, a hierarchy of increasingly anxious imaginary scenes is constructed. The patient visualizes each scene and reexperiences the anxiety associated with it and then uses relaxation techniques to gradually become comfortable with the fantasy. Patients move up the hierarchy of images until they are able to fully visualize the phobic object/situation without undue anxiety. Usually, this in vitro technique will be accompanied by in vivo practice exposures. Hypnotic procedures and the use of anxiolytic drugs are useful adjuncts in certain types of patients. There is some controversy regarding the mechanisms underlying the effect of systematic desensitization. Various explanations have been suggested regarding the underlying mechanisms. It is possible, for example, that the graduated exposure to the anxiety-provoking situation represents nothing more than a sequential or progressive “flooding” technique (see next section). It is also possible that by exposing the individual to only small, and therefore more tolerable, amounts of anxiety, the individual is able to develop more appropriate and successful coping mechanisms. Other authors have suggested that the key to systematic desensitization lies in the suppression of anxiety, which is achieved by evoking a competitive physiological response such as deep muscle relaxation.
Implosion Therapy and Flooding

These two techniques vary only in the presentation of the anxiety-eliciting stimulus. Animal behaviorists discovered early on that avoidant behavior, which by its very nature can be expected to be highly resistant to extinction, could be extinguished rather rapidly by submitting the subject to a prolonged conditioned stimulus while restraining it and making the expression of the avoidant behavior impossible. In the therapeutic situation, the patient is directly exposed to the stressful stimulus until the anxiety subsides. This is in contrast to the graded exposure of systematic desensitization. In theory, each session should result in ever-decreasing intervals between exposure and cessation of anxiety. In implosion therapy the patient uses mental images as substitutes for the actual feared object or situation, whereas in the flooding approach the therapist conducts the procedure in vivo. Results appear to indicate that both approaches are equally effective. Some have questioned the ethics of submitting patients to such painful experiences, especially when other alternatives are available. A risk associated with this technique is the danger that the patient may refuse to submit to such an uncomfortable experience and may terminate the exposure prior to the abatement of the anxiety. This will result in a successful “escape” and will therefore reinforce the phobic response.

Aversive Therapy

This treatment modality has its roots in classical and operant conditioning. Controversial by its very nature, it has nevertheless found acceptance as a potentially useful avenue of therapy for a narrow range of disorders and unwanted habits. Perhaps the most common form of aversive therapy is the use of disulfiram (Antabuse) in alcoholics. This treatment approach is based on the fear of an extremely unpleasant, and indeed sometimes fatal, physiologic response (the unconditioned stimulus) when someone who has been taking Antabuse then imbibes alcohol (which becomes the conditioned stimulus). In theory, the alcoholic patient on Antabuse therapy will avoid alcohol to avoid the alcohol–Antabuse reaction. The use of mild aversive stimuli has also been found to be useful in smoking-cessation programs. Because of safety considerations, and to ensure continued patient participation, aversive stimuli used under these conditions are often mild and may not constitute much more than having to hold the smoke in the oral cavity for a prolonged period of time. Various aversive techniques have also been used in the treatment of sexual offenders and have included the use of such stimuli as mild electric shocks and unpleasant odors. Ethical considerations, understandable patient reluctance to participate in treatment, and pejorative associations by the general public with torture and other forms of maltreatment have resulted in rather limited applications for these techniques. In addition, its effectiveness has been more variable than that of other behavioral techniques.

Biofeedback

Biofeedback is not a type of behavioral therapy per se but rather a tool or technique that can be integrated with other operant procedures for the management of a number of psychophysiological disorders. Some of the conditions in which there is documented short-term efficacy for biofeedback are: hypertension, migraine head-
aches, tension headaches, some cardiac arrhythmias, and Raynaud's phenomenon. This approach presumes that many pathological psychophysiologic responses could be subject to modification if the individual could become aware of their existence and of positive changes incurred as a result of learned responses (Gaarder and Montgomery, 1977). For the conditioned response to be reinforced and learning to take place, the organism must be aware that a response has taken place. The biofeedback techniques consist of the use of sophisticated instrumentation to detect changes in skin temperature, muscle tension, or heart rate. Biofeedback first burst on the scene amid great publicity and exaggerated claims regarding its efficacy. This was followed by an expected period of disenchanted and skepticism. Nevertheless, for selected patients, especially those suffering from psychophysiological disorders characterized by measurable vascular and neuromuscular changes, such as chronic tension headaches, this approach may be of some use either by itself or in conjunction with other therapies, including medication and formal psychotherapy. Biofeedback is often administered in clinics by technicians. There is a paucity of evidence, however, that for tension-related syndromes such as chronic headache it is any more effective than simple relaxation exercises.

**Effectiveness of Behavioral Therapies**

The behavioral approaches have proved to be of considerable value in the treatment of a wide spectrum of disorders, particularly phobias and muscle tension, as well as migraine headaches. They also may be considered as valuable adjunct techniques in the overall management of psychiatric and other medical conditions such as headaches and eating disorders. Often, much time and effort are devoted to discussing the relative merits of the behavioral techniques versus the psychodynamic therapies. Elements from each approach play a significant factor in the other. Even in the most dynamically oriented therapy situation, the achievement of new insights, improvements in the quality of life, and the lessening of anxiety facilitate the progress toward wellness. Similarly, there has been little research into the nature of the relationship between the patient and her or his behavioral therapist. The degree to which conflicts between the behavioral therapist and the patient may re-create past relationships and how this is handled and influences treatment progress are not well known.

**GROUP THERAPIES**

In its most basic form, group therapy can be described as the attainment of therapeutic goals through the skilled manipulation of group processes or mechanisms. The changes effected can be limited and situation-specific or they can be far-reaching and foster personality development and growth. Family therapy and couples therapy are specific forms of group therapy directed to the family and the couple—usually the marital couple—in special group/interpersonal settings. In contrast to the individual therapies, the group therapies have direct access to the interpersonal processes of the patient with individuals of varying age and sex. Intrapsychic, interpersonal, communication, and system theories, as well as a knowledge of family and couple development
and roles are used to elucidate various aspects of behavior and increase the patient’s awareness. In addition, new behaviors can be tried in the group with the therapist present (Yalom, 1986). The different types of group therapy emphasize different theoretical perspectives and may have different group compositions (see Table 17–7). All groups provide members with support, a feeling of belonging, and a safe, secure environment where change can be effected and tried out first. The therapist uses the vast array of processes at work in a group to facilitate interaction among its members and to guide the work of the group toward the desired goal. Skill, training, and a keen understanding of group dynamics are required. Particular awareness of group fantasies, projections, scapegoating, and denial are a part of most group therapy work. Frequently, cotherapists run the group. This often increases the ability to attend to the many processes occurring in the group and aids in the avoidance of countertransference pitfalls.

**Group Psychotherapy**

Group psychotherapists use a variety of techniques derived from knowledge of the dynamics and behavior of social groups to foster desired change in the individual members (Yalom, 1986). The theoretical framework supporting the various therapeutic modalities, however, varies with the goals and purposes of the group, the type of group, and the composition of the group. A review of the literature reveals widely diverging definitions and classifications. Different approaches achieve a measure of fame and popularity, such as the so-called encounter groups, then recede from the scene. In general, however, groups can be divided into three separate and distinct categories: (1) directive, (2) psychodynamic/interpersonal, and (3) analytic. This classification is based largely on the degree to which the group fosters the exploration and evocation of repressed, unconscious material. As a result, each group type will vary widely in approach, techniques, composition, conceptual model, and defined goals. Group psychotherapy occurs both in inpatient and outpatient settings.

<table>
<thead>
<tr>
<th>Table 17–7</th>
<th><strong>Group Therapies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Alleviation of symptoms</td>
</tr>
<tr>
<td></td>
<td>Change interpersonal relations</td>
</tr>
<tr>
<td>Selection</td>
<td>Varies greatly based on type of group</td>
</tr>
<tr>
<td></td>
<td>Homogeneous groups target specific disorders</td>
</tr>
<tr>
<td></td>
<td>Adolescents and personality disorders may especially benefit</td>
</tr>
<tr>
<td></td>
<td>Families and couples where the system needs change</td>
</tr>
<tr>
<td></td>
<td>Contraindications: substantial suicide risk, sadomasochistic acting out in family/couple</td>
</tr>
<tr>
<td>Types</td>
<td>Directive/Supportive Group Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Psychodynamic/Interpersonal Group Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic Group Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Family Therapy</td>
</tr>
<tr>
<td></td>
<td>Couples Therapy</td>
</tr>
<tr>
<td>Duration</td>
<td>Weeks to years; time limited and open-ended</td>
</tr>
</tbody>
</table>
Directive/Supportive Group Psychotherapy

These groups usually have very specific, well-defined, and relatively limited goals. Good examples are the Alcoholics Anonymous (AA) and Overeaters Anonymous groups. The groups function within a very narrow set of guidelines defined by a specific philosophy, set of values, or religious orientation. In the case of AA, for example, the members help each other achieve sobriety and cope with everyday problems of living by adhering to "The Twelve Steps" and entrusting their fate to a "Higher Power." The group leader serves as a role model, stressing commonsense, reality-oriented solutions to problems while using the group to apply peer pressure, enhance self-esteem, foster a feeling of togetherness and belonging, and provide a supportive and nurturing environment. Members usually share at least one major attribute in common (for example, alcoholism), but in many other respects the group is very heterogeneous in composition. There may be a wide divergence in social background, education, personality types, and even the absence or presence of major psychiatric disorders. Behavioral techniques are often applied in similar group situations to treat individuals with phobias while using group support and encouragement to enhance efficacy.

Psychodynamic/Interpersonal Group Psychotherapy

These groups address the individual members' psychopathology, foster the development of insight, promote the development of better interpersonal and social skills, and, in general, promote improved coping skills for the here and now. Defenses are identified and challenged in an atmosphere of support and acceptance. Positive change is encouraged and reinforced. These groups may adhere to any of a wide variety of theoretical models (such as gestalt therapy, psychodrama, and so forth) or may be eclectic in their approach and incorporate aspects of these into the system to fit the needs and characteristics of the group. They tend, however, to focus on the individual's subjective experience and interpersonal behaviors.

Psychoanalytic Group Psychotherapy

This type of group essentially uses the psychoanalytic approach as applied in individual therapy. The therapist remains neutral and nondirective, thus promoting a transference neurosis that can be analyzed. Defenses are identified and resistances interpreted. The group focuses on past experiences and repressed unconscious material as the underlying factors in psychopathology. The therapist attempts to identify individual transferences of the members as well as shared group fantasies or assumptions.

In general, most patients who benefit from individual psychotherapy benefit from group psychotherapy. Empirical data are lacking except for directive/supportive group psychotherapy approaches (e.g., AA, Overeaters Anonymous, type A personality). The differences and similarities in behavior change following group and individual psychotherapy are largely unknown. Although there is no hard evidence for the greater or lesser efficacy of either technique applied to appropriate patients, not all patients will do well in all groups, and some patients should not be considered for inclusion in a treatment group under any circumstances. Specifically, severely depressed and suicidal individuals should not be assigned to outpatient groups. Their
emotional state will prevent them from becoming integrated into the group, and the lack of an initial strong therapeutic relationship with a specific therapist may increase the risk of suicide. Such patients should be considered for individual and other more intensely supportive modalities, and inpatient hospitalization when indicated. Manic patients tend to be disruptive to group process, and their impulsivity and lack of control prevent them from obtaining any real benefit from group work. Some types of personality disorders, such as explosive, narcissistic, borderline, and antisocial personalities, may also present insurmountable difficulties for treatment with this modality. Schizophrenics may do well in highly directive groups with emphasis on reality testing and improving interpersonal coping skills. Group therapy can be used as a useful adjunct to either individual psychotherapy or psychotropic medications. Inpatient group psychotherapy is a very common treatment modality and differs from outpatient treatment because of the heterogeneity of the group and its frequent change in membership. Group psychotherapy may be particularly helpful with adolescents who are highly sensitive to peer group support and influence. Groups also provide a powerful arena in which individuals with personality disorders can become increasingly aware of their interpersonal problems.

Family Therapy

In family therapy, psychological symptoms are considered to be the pathological expression of disturbances in the social system of the family. For the purposes of this discussion, the latter can include any members, ranging from the basic couple to children, grandparents, distant relatives and, in some cases, even close friends of the family. The essential feature is the relationship among the various members and how their behavior can affect the group as a whole as well as the individual family members. The theoretical models may run the whole gamut of therapeutic approaches, ranging from the psychoanalytic to the behavioral (Beels, 1988).

Most family therapists agree that family groups are extremely complex and dynamic systems with a definite hierarchical structure that is a result of cultural and societal proscribed roles, repetitive behavior patterns, and ingrained ways in which the family members have interrelated. Family structure can be seen as a self-regulating system with multiple control mechanisms designed to ensure some degree of a homeostatic equilibrium. The family system seeks stability and inherently resists change. When the system is subjected to internal or external stresses, the family may respond by “designating” one of its members as the “patient,” and his or her “illness” may act as a safety valve to maintain system integrity. This same resistance to change will of course oppose any therapeutic efforts and may take the form of refusal to explore family issues by the other members of the family, missed appointments, no apparent therapeutic progress, and so forth. Some change does occur in any family as the passage of time thrusts on the system irresistible forces such as maturation of children, illness, death, old age, and, of course, personal growth and maturity. The family system may thus be conceived as three-dimensional: highly structured, homeostatic, but slowly evolving and changing its character over long periods of time.

The clinical indications for family therapy are very broad. Psychopathology in any member of a family will undoubtedly influence family dynamics, and vice versa.
The treatment of children and adolescents frequently requires family therapy to deal with the environment that may be causing or sustaining the symptoms. Recent research indicates the particular value of family therapy in the treatment of schizophrenic patients in reducing rehospitalization rates. Practical considerations such as geographical distance, economic situation, or refusal to participate can rule out family participation. When family members are being extremely destructive to the family unit or important familial relationships, family therapy should not be instituted or should be suspended for a brief time. The treatment of childhood disorders, eating disorders, alcoholism, and substance abuse generally requires a family therapy intervention.

Each clinician brings to the field their own conceptual framework, clinical experience, philosophical orientation, and training background. The orthodox psychoanalyst may conceive of family therapy as the individual treatment of the symptomatic member, while at the other end of the spectrum, the social worker specializing in this form of treatment may include any or all members of the family in the sessions and may use a highly directive approach including didactic presentations and environmental manipulation. The focus of most family therapy is on current issues (the here and now) and achievement of discrete changes toward an identifiable goal. Developmental conflicts, communication patterns, boundary management, flexibility, familial conflict resolution techniques, and roles accepted and proscribed by the system for each member are areas of therapeutic attention. Exploration of individual unconscious material is usually avoided. The use of family (or couples) therapy, when an individual psychotherapy is stalled, can help resolve environmental and family system variables that are inhibiting further individual progress. In such cases, a course of family (or couples) therapy can frequently reestablish the momentum of an individual treatment. Family therapy can be an important adjunct to inpatient treatment to facilitate discharge and psychosocial readjustment.

No single technique or procedure dominates family therapy. Therapists may see one or two members of the family or they may see the entire group. The family may be seen together by a single therapist, individually by different therapists, together by more than one therapist, or more than one family may be seen in special forms of multifamily group therapy. Similarly, the therapeutic techniques can range from inducing change by crisis to focusing on small aspects of how the family functions in order to create positive changes that the system can assimilate and incorporate over varying periods of time.

Coupled Therapy

Coupled therapy is the treatment of dysfunctional couples. In modern society, this includes both married and unmarried "dyads" as well as homosexual couples. It is very similar to, and, in fact, may be described as a form of, family therapy. The same theoretical concepts and treatment approaches described above apply. If the couple has an extreme sadomasochistic relationship, therapy may be blocked. During times when one partner is being overly destructive to the relationship or the other partner, the therapist may need to directly intervene. If this cannot be limited in the treatment, a brief individual therapy with each partner separately may sufficiently resolve the
tension to allow the couples therapy to continue. The goal of treatment may be to resolve conflict and reconstruct the dyadic relationship or to facilitate disengagement in the least painful way possible.

**SEXUAL DYSFUNCTION THERAPY**

The term "sexual dysfunction therapy" encompasses the entire spectrum of accepted psychotherapies from the purely behavioral techniques to the psychodynamically oriented approaches. Treatment may be restricted to a single form of therapy or may consist of a combination of approaches. The focus, however, is on the resolution of a specific sexual dysfunction, such as premature ejaculation, impotence, orgasmic dysfunction, or vaginismus (Masters and Johnson, 1970). Most sex therapists emphasize focusing on symptom relief with the use of behavior modification techniques followed by attempts at resolution of underlying conflicts (which may represent the core of the disorder) by more traditional insight-oriented dynamic methods (see Table 17-8). In general, the brief focused therapies, whether used singly or in combination with other forms, seem to have a greater success rate with specific symptom relief than do the longer-term treatments.

The evaluation of sexual dysfunction should include a complete investigation of possible medical causes (see Chapter 14). A considerable number of physical illnesses, injuries, and congenital malformations can result in symptoms suggestive of a psychosexual disorder and, if not addressed, will render all other therapies useless. Intraabdominal adhesions and masses, for example, can result in pain during intercourse. Endocrine disturbances may affect sexual drive, and spinal injuries can inhibit penile erections. Similarly, a number of medications can result in dysfunctional symptoms causing great distress to the patient. Thoridazine, a commonly used neuroleptic, is often associated with reversible retrograde ejaculation in the otherwise normal male. In this situation, simple counseling and reassurance may suffice to calm the patient. Thus, the role of careful history taking, a complete physical examination, and indicated laboratory testing cannot be overemphasized.

<table>
<thead>
<tr>
<th>Goal Selection</th>
<th>Resolution of specific sexual dysfunctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types</td>
<td>Behavior modification techniques, including systematic desensitization, homework, education</td>
</tr>
<tr>
<td>Duration</td>
<td>Couples therapy as needed to deal with the system dynamics</td>
</tr>
</tbody>
</table>

Table 17-8 Sexual Dysfunction Therapies
The human sexual response cycle may be divided into four distinct phases: (1) appetitive (baseline), (2) excitement, (3) orgasmic, and (4) resolution. For the purposes of our discussion, the last phase bears little relation to disturbances in sexual functioning. The psychosexual disorders may be grouped according to where the dysfunction occurs in the response cycle. Sexual desire disorders are part of the appetitive phase; sexual arousal disorders are part of the excitement phase; and orgasmic disorders are part of the orgasmic phase. Sexual pain disorders are difficult to assign but may directly or indirectly affect the cycle at any level. This classification must be borne in mind when deciding upon the most appropriate therapeutic regimen. Disorders affecting the orgasmic phase are readily treatable by simple behavioral techniques, and the results appear to be dramatic and long lasting. Disorders affecting the appetitive phase, however, reflect deep-seated conflicts and are much more resistant to therapeutic intervention. They often require the use of insight-oriented therapies and the uncovering of repressed material in conjunction with behavioral therapy. The disturbances of the excitement phase fall somewhere between these two in terms of prognosis and choice of treatment.

**Choice of Therapeutic Approach for Sexual Dysfunction**

Proponents of the various therapeutic approaches can make a case for the efficacy of their methods in the treatment of these disorders. A basic understanding of the more commonly used and successful treatments is essential for appropriate treatment planning or selection of optimal referral sources.

**Individual Psychodynamic Therapy**

Individual brief-term psychodynamically oriented psychotherapy remains one of the more useful and effective techniques available when dealing with psychosexual disorders that have complex intrapsychic conflicts at their roots with pervasive negative influences over many other aspects of the individuals' lives. In actual practice, individual psychotherapy by itself may not bring about the desired results, but its efficacy may be greatly enhanced by the application of one of the many behavioral therapies in conjunction with the more traditional approach.

**Behavioral Therapy**

The use of behavioral techniques such as systematic desensitization and, to a lesser degree, implosion or flooding therapy is often extremely useful in treating sexual dysfunctions—particularly those associated with disturbances of the orgasmic phase. The actual techniques differ very little from the tried and true methods used in other disorders amenable to treatment by these methods (see Chapter 14). The therapist performs a detailed behavioral analysis and develops a hierarchical list of anxiety-producing situations during the sexual act that culminate in the pathological response, be it premature ejaculation, retarded ejaculation, or inhibited orgasm. Through gradual exposure to the anxiety-provoking stimulus, the patient eventually learns to cope in a more appropriate fashion and to perform sexually in an enjoyable, rewarding fashion. As noted earlier, these techniques are particularly effective when
dealing with disorders of the orgasmic phase, but their primary value when treating
disturbances of the appetitive phase is as an adjunctive technique. Specific tech-
niques of behaviorally oriented therapy for specific types of sexual dysfunction are
discussed in Chapter 14.

Hypnotherapy
Hypnotic suggestion can be used effectively to convince a patient that he or she
does not need to feel pain during intercourse and to relieve disabling anxiety that may
impair performance or consummation and enjoyment of the sexual act.

Group Therapy
Group therapy may be of value for selected patients whose perceived inade-
quacies and concerns about their symptoms may make them feel “different,” socially
isolated, and unable to share their feelings, fears, and irrational fantasies. Support
from other members of the group with whom they can relate and identify may result in
decreased anxiety and improvement in symptoms and may make the patient more
amenable to participation in other forms of treatment, such as behavioral therapy.

Dual Sex (Couples) Therapy
This variant of behavior therapy was initially proposed by Masters and John-
son and in its original form approached sexual dysfunction disorders as a “dyad” issue,
that is, a patient suffering from a psychosexual disorder did so in the context of his
relationship with his sexual partner. The two would be treated together as members of
the “dyad” unit by a team consisting of a male and a female therapist. The latter not
only directed what was for all intents and purposes a behavioral treatment approach,
complete with educational sessions and schedule of assignments (systematic desensi-
tization), but also served as role models for the same-sex member of the “dyad.” In
recent years, adherence to the male–female team and male–male “dyad” concept
has not been as strict, and the makeup of the participants has been tailored to fit
individual circumstances. Nevertheless, it remains an extremely effective approach
that uses education, behavioral modification, modeling, and couples therapy to effect
change in sexual dysfunction.

SUMMARY

The psychotherapies are important components of the treatment plan for nearly
all psychiatric illnesses. Both short- and long-term techniques are available. Which
psychotherapy for which patient with which therapist is less clear. Psychotherapy
provides the patient with new problem-solving techniques. Some patients prefer one
type of problem solving or can learn one type and not another.

How the outcomes from the different psychotherapies may differ and what this
may mean for long-range health/relapse warrant further research. Increasingly, data
indicate the effectiveness of the psychotherapies in reducing hospitalization rates and
the use of other medical resources. Studies on the use of psychotherapy as an adjunct
in the treatment of various physical illnesses also tend to indicate cost benefits in
overall medical care dollars. The ability to use a range of psychotherapies is important in the treatment of psychiatric illness and in obtaining maximum benefit from medical case management and the therapeutic effectiveness of the doctor–patient relationship.

For the nonpsychiatric physician, a referral for psychiatric assessment is essential when psychotherapy may be indicated. The psychiatric consultant can evaluate the interplay of biological, psychological, and social context variables that may be causing or maintaining illness in the patient. A comprehensive treatment plan and goals can then be formulated. Prior to referring a patient, the physician should educate the patient. Many patients will have the belief that psychiatric illness is fake or imaginary. They should be reassured that their distress and pain are real and that there is a wide array of possible treatments. Patients are best prepared when they can understand the role of medication in providing possible relief of symptoms and the role of the psychotherapies in learning new ways to handle the problems that may be precipitating their distress. For instance, the physician refers a patient to physical therapy to learn a new way to walk when the patient has developed a limp to compensate for chronic pain. (The limp may persist even after the pain is relieved by medication.) Similarly, the psychotherapies teach, through various means, new problem-solving techniques to relieve patterns of behaviors, feelings, and thoughts that are causing or maintaining impairment.

Finally, as noted earlier, it should be emphasized that the best form of treatment is often integrated psychotherapy and pharmacotherapy. Psychiatrists or nonpsychiatric clinicians who are polarized one way or the other may offer a narrow range of treatment and overlook a biological or psychological therapy that might potentially be dramatically effective for the patient. Hence, in making a referral for an initial evaluation, it is recommended that one consult a clinician with a balanced, integrated approach. The success of a referral for psychiatric evaluation or psychotherapy is critically dependent on the attitude, confidence, and enthusiasm of the referring physician.

**CLINICAL PEARLS**

- It is important to exhibit confidence and enthusiasm when making a referral for psychiatric evaluation or psychotherapy. Patients will detect ambivalence and skepticism on the physician's part about the need for such treatment. It is usually helpful to recommend a psychiatrist or other health professional who is known personally by the physician.
- Always present the psychiatric referral as part of the patient's ongoing medical care. Some patients will view a psychiatric referral as meaning you are "dumping" them onto another doctor and as a "rejection." Patients should be reassured that any psychiatric treatment will be in parallel with their ongoing medical care.
- Have the name and telephone number of your referral source readily available to give to the patient.
- Call the psychiatrist to personally explain the reason and need for the referral and what role you would like to continue to play in the patient's care.
- Make the appointment for the psychiatric evaluation while the patient is still in the office or clinic.
- Be sure to schedule a follow-up appointment after the date of the psychiatric evaluation to check on the patient's reaction to the referral and their response to initial treatment.

**ANNOTATED BIBLIOGRAPHY**


This book is one of the first written in the area of brief psychodynamic psychotherapy. It is a superb demonstration of a case of brief psychotherapy in an individual with moderately severe psychopathology. The case illustrates the exceptional clinical skill and technical requirements in carrying out a brief psychodynamic psychotherapy.


This eloquent and well-written introduction to psychotherapy presents basic principles of psychotherapeutic relations of the management of psychotherapy that are applicable to nearly all psychotherapeutic endeavors. It is based on the author's extensive career as a psychotherapist. An excellent introduction to psychotherapy.

Coleman J: Aims and conduct of psychotherapy. Arch Gen Psychiatry 18:1–6, 1968

This is a clearly written, classic article that articulates without jargon the basic doctor–patient relationship, goals, and orientation maintained by the psychiatrist in conducting psychotherapy.


This brief book describes the structural elements of psychoanalysis—setting, organization, techniques, and contribution to the treatment. Well written.


This excellent introduction to the psychiatric interview is written from the perspective of the interpersonal school of psychiatry. However, its basic presentation is applicable to all of the psychotherapies. It provides a basic science to the application of talk as a curative agent.


This article is an overview of both individual and group brief psychotherapies. It has a detailed list of references and presents the psychotherapies as medical interventions with substantive technical and selection criteria. In addition, there is a brief overview of the cost-benefit issues in psychotherapy.


This chapter reviews psychodynamic and supportive psychotherapies. It contains an extensive review of supportive psychotherapy, perhaps the most widely used and understood of all the psychotherapies.


This book is a concise, highly readable text on the techniques of psychodynamic psychotherapy. It includes a glossary and sections on supportive and brief psychotherapy.

Werman DS: The Practice of Supportive Psychotherapy. New York, Brunner-Mazel, 1984
This book is one of a very few that describe supportive psychotherapy in a technical manner. It is a substantive contribution to the literature and to the clinician’s ability to learn supportive psychotherapy as a technique.


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