

**EUROPEAN FEDERATION
OF PSYCHIATRIC TRAINEES**

Psychotherapy guidebook

A guidebook made by and for psychiatry trainees

EFPT Psychotherapy working group
(London, Porto, Antwerp, Istanbul Forums)

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Introduction

Psychotherapy is an important aspect in psychiatry. When patients ask about different therapy options, psychiatrists should know about these, and preferably be able to deliver some therapy themselves. In our recent survey of 574 trainees and young psychiatrists in Europe, 92 % considered psychotherapy important for their professional identity, and 90% wanted to practice psychotherapy after psychiatry training. However, the training possibilities are scarce and only 52 % of trainees were training (or trained) in psychotherapy. (Gargot et al, 2017).

Psychotherapy efficacy studies are quite hard to produce as there are still methodological problems to consider, but a lot of studies show a size effect comparable with biological treatments, even for severe illnesses like schizophrenia (Xia, et al, 2011).

Some authors state that there are more than one hundred kinds of psychotherapies. Thus, it is difficult to comprehend and to orientate ourselves in this jungle. The literature argues that even if the basic underpinnings and the practical aspects are very different between types of psychotherapies, there are important common factors (motivation of the patient, empathy, transference, the therapeutic alliance) that lead to a general efficacy of psychological therapies.

That's why, as trainees throughout Europe, we wanted to share with you our different tastes of different kinds of psychotherapies based on our interest. Even though the diversity is large, we tried to use the same template for every kind of psychotherapy, and to promote books, psychotherapy associations and congresses related to each school. This work doesn't pretend to be exhaustive but would like to open trainees to the richness of this field.

As a psychiatrist, one needs to keep an open mind to other disciplines. In the past, discoveries about the unconscious inspired psychoanalysis, neuropsychology inspired cognitive remediation therapy, theatre inspired psychodrama, ancient Buddhism inspired mindfulness. Patients and family associations always challenged our practices in psychoeducation and Institutional psychotherapy to become as patient-centred as possible.

Maybe in the future, social psychology (eg. cognitive dissonance and engagement theories) will improve our understanding of general factors and improve the links with Patient centered psychotherapy and Motivational Interviewing. An Emerging field of combinations of drugs with psychotherapy (for instance exposure and beta-blockers after a trauma) will be interesting to follow, and neuropsychanalysis could inspire new psychotherapeutic approaches. New technologies challenge psychotherapy with computer-based cognitive remediation and psychoeducation. They also offer easier training with massive open online courses like the cognitive behavioural therapy programmes run by the European Psychiatry Association or the Beck Institute. The road of psychotherapy is still open and long.

This work is still in progress and any feedback is appreciated. We struggled hard against social loafing and perfectionism to present you this work that we hope will inspire you! We thank the EFPT board that encouraged and found this project, and Chantelle Wiseman (a native English speaker) who revised the different articles.

Thomas Gargot, MD, Psychiatry, PhD Student, on behalf of the psychotherapy working group



Figure 1 Psychotherapy working group physical meeting in Istanbul, during the EFPT forum 2017

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Cognitive Behavioural Therapy (CBT)

Chapter written by Olga Sidorova Psychiatry Trainee from Rīga Stradiņš University– Department of Psychiatry and Addiction Medicine – Riga, Latvia

Cognitive behavioural therapy (CBT) is the most widely used evidence-based psychotherapy for improving mental health.

Brief historic overview

Cognitive behavioural therapy is a fusion of the behavioural and cognitive theories of human behaviour and psychopathology. Modern CBT development had three “waves”.

The first, or behavioural wave was inspired and developed by notable people such as John B. Watson, Joseph Wolpe, Ivan Pavlov, Hans Eysenck, Arnold Lazarus and B. F. Skinner and comes from learning theory (Skinner et Pavlov). Learning theory is a concept describing the process of gaining, keeping and recalling knowledge. Behavioural learning theory assumes that learning is built on responses to environmental stimuli. I. Pavlov introduced a concept of classical conditioning where behaviour is a reflexive and involuntary response to stimuli. The exposure, which originated from the works of Pavlov and Watson, is a widely used instrument in CBT. It is a process of changing the unwanted, learned response or behaviour to a more desirable response. In addition to this, B. F. Skinner later shaped a concept of operant conditioning, which is based on the voluntary behaviour that is modified through the use of positive and negative reinforcements. The foundation for the second or “cognitive wave” of CBT can be tracked to numerous ancient philosophical ideas, notably in Stoicisms. Stoic philosophers, particularly Epictetus, believed that logic could be used to identify and discard false beliefs that lead to destructive emotions and that individuals are responsible for their own actions, which they can examine and control through rigorous self-discipline. These philosophical ideas inspired Alfred Adler, one of the first therapists who implemented cognition into a psychotherapeutic approach. He developed the concept of basic mistakes and showed how they create unhealthy behavioural and life goals. Albert Ellis, inspired by Adler's work, developed the earliest cognitive-based psychotherapy, known as rational emotive behaviour therapy (REBT). (Check the REBT chapter in this book p.10)

Meanwhile, in the early 1960's Dr Aaron T. Beck (who was a fully trained and practicing psychoanalyst), in his search of explanations for depression identified distorted, negative cognitions as a primary feature of the disease. He developed a short-term treatment with a focus on reality testing of patients' depressed thinking.

Both Aaron T. Beck and Albert Ellis, developed approaches which gained wide popularity among behavioural therapists.

The third wave is the evaluation and use of emotions with Mindfulness based therapies and acceptance based therapies, like Acceptance and Commitment therapy. (Check the Mindfulness chapter in this book p. 20)

Description

CBT treatment is based on a cognitive formulation, the beliefs and behavioural strategies that characterise a specific disorder. CBT has certain basic principles for treatment listed here:

CBT is based on an ever-evolving formulation of patients' problems and an individual conceptualisation of each patient in cognitive terms.

CBT requires a therapeutic alliance.

CBT emphasises collaboration and active participation.

CBT is goal-oriented and problem-focused.

CBT initially emphasises the present.

CBT is educational, and aims to teach the patient autonomy, how to be her own therapist and emphasizes relapse prevention.

CBT aims to be time-limited.

CBT sessions are structured.

CBT teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.

CBT uses a variety of techniques to change thinking, mood, and behaviour.

Main uses (indications)

CBT started as a therapy for patients with depression. Lately adapted and developed to diverse set of disorders and problems. CBT can be used with patients with divergent levels of education and income, various cultural background and ages, from children to seniors.

Partial List of Disorders Successfully Treated by Cognitive Behaviour Therapy		
Psychiatric disorders	Psychological problems	Medical problems with psychological components
Major depressive disorder	Couple problems	Chronic back pain
Generalized anxiety disorder	Family problems	Pain
Panic disorder	Pathological gambling	Tinnitus
Agoraphobia	Complicated grief	
Social phobia	Caregivers distress	
Obsessive-compulsive disorder	Anger and hostility	
Substance abuse		Erectile dysfunction
Attention-deficit/hyperactivity disorder		
Eating disorders		Insomnia
Health anxiety		Obesity
Body dysmorphic		Vulvodynia

disorder Eating disorders Sex offenders Personality disorders		Hypertension PTSD
Bipolar disorder (with medication) Schizophrenia (with medication)		

Adapted from Judith S. Beck Phd Cognitive Behavior Therapy Basics and Beyond, Second Edition

Efficacy

CBT has been widely tested since 1977, and today more than 1000 research studies (e.g., Hofmann 2012) have demonstrated the efficacy of CBT for various psychiatric disorders, psychological problems and medical problems with a psychological component.

Comment from an expert and or quote from a famous psychotherapist:

"What matters is our attitude toward facts rather than the facts themselves. This also applies to the facts of our inner life."

Viktor Frankl

Comment from a trainee with experience

CBT is a comprehensive psychotherapy focusing pragmatically on how to help the patient. Many specific tools can be useful in everyday practice: for instance exposure, assertiveness techniques, role-plays, motivational interviewing, and cognitive restructuring. The functional analysis and the vicious circles taken from learning theory helps to conceptualize the functioning of the patients, destigmatise their symptoms and help them to understand better how to have more distance with their functioning and change it.

Thomas Gargot

Books, manual, videos, application, published online courses or international association

- Research possibilities and Courses

Beck Institute online training

<https://beckinstitute.org/get-training/online-training/>

MOOC Understanding Anxiety, Depression and CBT

<https://www.futurelearn.com/courses/anxiety-depression-and-cbt>

The European Psychiatric Association is preparing its first Massive Open Online course about CBT

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- Bill, Y. (2016). *Cognitive Behavioral Therapy: CBT Techniques to Manage Your Anxiety, Depression, Compulsive Behavior, PTSD, Negative Thoughts and Phobias [Audiobook]*. John Leddy
- Thrive: The Power of Evidence-Based Psychological Therapies - Richard Layard, David M. Clark -Book, ALLEN LANE HB collection, 2014

Links to Societies

Europe:

European Association for Behavioural and Cognitive Therapies

<http://www.eabct.eu/>

National CBT associations can be found here <http://www.eabct.eu/find-a-therapist/>

The EABCT organize a yearly congress to present the recent developments of CBT.

International:

International Association of Cognitive Behavioral Therapy

<http://www.the-iacp.com/>

Association for Behavioral and Cognitive Therapies

<http://abct.org/Home/>

International Union of Psychological Science

<http://www.iupsys.net/>

Private Centers and Institutes

American Institute for Cognitive Therapy

<http://www.cognitivetherapynyc.com/>

Albert Ellis Institute

<http://www.rebt.org/>

Beck Institute for Cognitive Therapy and Research, they organize online training

<http://www.beckinstitute.org/>

Journals

Cognitive Behaviour Therapy

<http://www.tandfonline.com/loi/sbeh20>

Behavior Therapy

<https://www.journals.elsevier.com/behavior-therapy/>

Journal of Behavior Therapy and Experimental Psychiatry

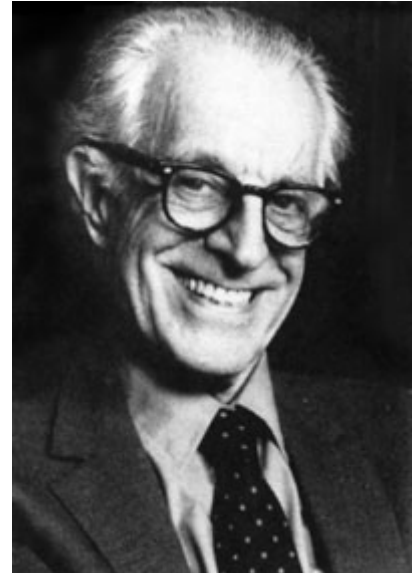
<https://www.journals.elsevier.com/journal-of-behavior-therapy-and-experimental-psychiatry/>

Rational emotive behavior therapy (REBT)

Chapter written by Milos Lazarevic and Vladimir Djuric, psychiatry trainees from Belgrade, Serbia

Brief historic overview

Rational emotive behavior therapy (REBT) is an action-oriented psychotherapy that teaches individuals to identify, challenge, and replace their self-defeating beliefs with healthier ones that promote emotional well-being and goal achievement. REBT was developed in 1955 by Dr. Albert Ellis. Dr. Ellis is considered to be one of the most influential psychotherapists in history, and REBT is now one of the cognitive therapies. Ellis' first major publication on Rational Therapy describes the philosophical basis of it as the principle that a person is rarely affected emotionally by outside things, but rather by 'his perceptions, attitudes, or internalised sentences about outside things and events', which he compares to the writing of the Greek philosopher Epictetus in the Enchiridion: "Men are disturbed not by things, but by the views which they take of them." Shakespeare, many centuries later, rephrased this thought in Hamlet: "There's nothing good or bad but thinking makes it so."



Description

The ABC Theory

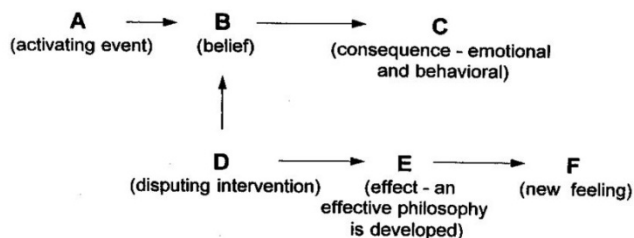


Figure 1

A fundamental premise of REBT is that humans do not get emotionally disturbed by unfortunate circumstances, but by how they construct their views of these circumstances through their language, evaluative beliefs, meanings and philosophies about the world, themselves and others. In REBT, clients usually learn and begin to apply this premise by learning the A-B-C-D-E-F model of psychological disturbance and change (Fig.1). The A-B-C model states that it is not an A (adversity or activating event) that cause disturbed and dysfunctional emotional and behavioral Cs, (consequences), but also

what people B (irrationally belief) about the A (adversity). A (adversity) can be an external situation, or a thought, a feeling or other kind of internal event, and it can refer to an event in the past, present, or future.

The Bs (irrational beliefs) that are most important in the A-B-C model are explicit and implicit philosophical meanings and assumptions about events, personal desires, and preferences. The

Bs (beliefs) that are most significant are highly evaluative and consist of interrelated and integrated cognitive, emotional and behavioral aspects and dimensions. According to REBT, if a person's evaluative *B*, belief about the *A*, activating event is rigid, absolutistic, fictional and dysfunctional, the *C* (the emotional and behavioral consequence), is likely to be self-defeating and destructive. Alternatively, if a person's belief is preferential, flexible and constructive, the *C* (the emotional and behavioral consequence) is likely to be self-helping and constructive. Through REBT, by understanding the role of their mediating, evaluative and philosophically based illogical, unrealistic and self-defeating meanings, interpretations and assumptions in disturbance, individuals can learn to identify them, then go to *D*, disputing and questioning the evidence for them. At *E*, effective new philosophy, they can recognize and reinforce the notion no evidence exists for any psychopathological *must*, *ought* or *should* and distinguish them from healthy constructs, and subscribe to more constructive and self-helping philosophies. This new reasonable perspective leads to *F*, new feelings and behaviors appropriate to the *A* they are addressing in the exercise.

Main uses (indications)

Addictions

Anger and Related Disorders

Anxiety Disorders

Bipolar and Related Disorders

Challenges Related to Daily Living

- Social Skills and Assertiveness Deficits

- Career & Lifestyle Changes

- Procrastination

- Relationship Difficulties

Depressive Disorders

Disruptive, Impulse-Control and Conduct Disorders

Obsessive-Compulsive and Related Disorders

Personality Disorders

Trauma- and Stressor-Related Disorders

Efficacy

REBT and CBT in general have a substantial and strong research base to verify and support both their psychotherapeutic efficiency and their theoretical underpinnings. A great quantity of scientific empirical studies has proven REBT to be an effective and efficient treatment for many kinds of psychopathology, conditions and problems. A vast amount of outcome and experimental studies support the effectiveness of REBT and CBT. Recently, REBT randomized clinical trials have offered a positive view on the efficacy of REBT.

In general REBT is arguably one of the most investigated theories in the field of psychotherapy, and a large amount of clinical experience and a substantial body of modern psychological research have validated and substantiated many of REBTs theoretical assumptions on personality and psychotherapy

Comment from an expert and or quote from a famous psychotherapist (founder)

“There are three musts that hold us back: I must do well. You must treat me well. And the world must be easy.” Albert Ellis

“The best years of your life are the ones in which you decide your problems are your own. You do not blame them on your mother, the ecology, or the president. You realize that you control your own destiny.”

Albert Ellis

Comment from a trainee with some kind of experience (duration of the training, personal thoughts)

“My favorite metaphor, which I have learned in my REBT training, is the one comparing life and the chess game. No matter how many bad moves you have played and what important figures you have lost, you should concentrate on choosing your next move rationally. In REBT our main focus is to teach our clients new way of thinking, so they could play their life chess game in a victorious way in future. I also like the great emphasis on unconditional self acceptance, because I think that it is the most important keeper of mental health. It helped me through my 4 year REBT training and life challenges (activating events)”

Vladimir Djuric (Serbia, REBT psychotherapist under supervision)

Books, manual, videos, published online courses or international association

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For more detailed bibliography and information the official Albert Ellis Institute site <http://www.albertellis.org/>

Research possibilities

As evidence based psychotherapeutic method REBT offers many research possibilities which could be reached on research tab on the official site of Albert Ellis Institute

For each country: - Links to Societies

France

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Interpersonal Psychotherapy

Chapter written by João Borges Ferreira, Psychiatry Trainee from Psychiatric and Mental Health Department – Baixo Vouga Medical Center – Aveiro, Portugal.

Reviewed by Benjamin Lavigne, MD, Psychiatrist and Psychotherapist in Les Toises, Lausanne, Suisse, and IPT Supervisor in Centre de Recherches et d'Etudes Appliquées à la Thérapie InterPersonnelle (CREATIP), France.

Brief historic overview

What became interpersonal psychotherapy (IPT) was developed and tested in New England in a study designed in 1969, when the late Gerald L. Klerman, M.D., Myrna M. Weissman, Ph.D. and their colleagues added a psychotherapy condition to an 8-month randomised controlled trial for patients with major depressive disorder. IPT thus became part of the first clinical efficacy study of pharmacotherapy and psychotherapy for depression (Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). The study yielded a manualised, time-limited psychotherapy, initially called 'high contact' and then renamed IPT. IPT was based on the principles of a medical model, defining major depression as a diagnosable and treatable psychiatric illness, and on empirically derived interpersonal factors related to depression (Klerman, Weissman, Rounsaville, & Chevron, 1984).

As scientific evidence accumulated showing that IPT is a treatment that works for several disorders, investigators pursued opportunities to share their ideas about IPT research and training with each other. The earliest gatherings of IPT professionals were held in conjunction with meetings of the American Psychiatric Association in the late 1990's, organised by John Markowitz, M.D. In 2002, the International Society for Interpersonal Psychotherapy (ISIPT) was formally incorporated in Australia. The organisation moved to the United States in 2010. ISIPT's first formal elections were held in 2015. Holly Swartz, M.D. was ISIPT's first elected President, serving for a two-year term (2015-17), in accordance with newly ratified bylaws. In 2016, ISIPT was reincorporated in Brentwood, Tennessee. Since 2002, the activities of ISIPT have been directed toward furthering IPT research and training, and supporting the professional development of IPT practitioners.

Description

IPT is a time-limited, diagnosis-targeted, well-studied, manualised treatment for major depression and other psychiatric disorders. By improving their lives and providing symptomatic relief, therapists help patients to solve an interpersonal crisis. IPT helps patients to improve interpersonal situations by helping them to understand their emotions as social signals which leads them to mobilise social support. Its success in a series of research studies has led to its inclusion in numerous national and international treatment guidelines.

Diagnosis-targeted: IPT has demonstrated efficacy as an acute and as a maintenance treatment for major depression, and for patients from adolescence to old age; with social

rhythm regulation, as an adjunct to medication for bipolar disorder; for bulimia and binge-eating disorders; and, more recently in the field of research, for posttraumatic stress disorder (PTSD) and anxiety disorders.

Theoretical Rationale: IPT's development was influenced by the interpersonal school of psychology and its leaders such as Harry Stack Sullivan and Adolf Meyer. Sullivan argued that psychopathology arose in the context of conflict between an individual and his primary social unit. Meyer extended Sullivan's argument, drawing the distinction between the psychoanalytic focus on intra-psychic conflict as a primary locus of psychopathology versus an emphasis on interpersonal conflicts as the genesis of psychopathology in the interpersonal school. IPT also draws on the work of Frieda Fromm-Reichmann who emphasised the social roots of depression, Jerome Frank who articulated a sociocultural definition of psychotherapy, and attachment theorists such as John Bowlby.

Medical Model: IPT uses the medical model as a conceptual framework for patients' mood symptoms. In the context of initiating IPT, the therapist conducts a psychiatric history and diagnoses a current episode of major depression according to DSM 5 criteria. The IPT therapist likens the depressive episode to other medical illnesses ("no different than asthma or diabetes or pneumonia") and further explains that the patient has an inherited, biologic vulnerability to depression. Using the medical model as a framework, the IPT therapist stresses that it is not the patient's "fault" for developing depression—any more than it is someone's "fault" for developing pneumonia. Using a stress-diathesis model to explain the interaction between biological vulnerability and stressful life events, IPT further posits (and makes explicit to patients) that although individuals are not to blame for their illness, they are in an excellent position to help themselves recover from depression by attending to the interpersonal factors that may serve as triggers for the underlying biologic illness.

Key IPT Strategies

Time Limited: IPT was originally conceptualised to be delivered as 12-16 weekly, 45-50 minute, individual sessions. IPT has been tested in an even shorter, 8-session, brief format.

Interpersonal Inventory: The inventory is an extended psychosocial assessment. The therapist carefully reviews the important people in the patient's life and the quality of those relationships. The therapist seeks to understand the sources of social support, nature of confiding relationships, romantic attachments, interpersonal communication style, and relationship difficulties that may be a cause or consequence of the depressive episode. The therapist uses information from the interpersonal inventory to select the interpersonal problem area.

Interpersonal Problem Areas: In IPT, the therapist selects one of four interpersonal problem areas as the focus for treatment. The four IPT problem areas are:

Grief or Complicated Bereavement
Role Dispute
Role Transition
Interpersonal Deficits

Structured Treatment: IPT has three phases: beginning, middle, and end. The initial phase can last up to three, four sessions. During that time, the therapist has specific tasks (obtain a psychiatric history and interpersonal inventory, offer a case formulation). The middle phase is focused on resolving the chosen interpersonal problem area in order to improve mood symptoms. The final phase focuses on termination or a “good goodbye”(the last 3-4 sessions)

Main uses

- Major Depression
- Depression in adolescence
- Post-partum depression
- Depression in the geriatric population
- Depression in the medically ill population
- Recurrent Major Depression
- Bipolar disorder (adjunctive treatment)
- Bulimia
- Minor affective crisis
- PTSD

Efficacy

At this juncture, IPT had repeatedly demonstrated efficacy for major depression and might have begun to spread into clinical practice. Klerman, Weissman and their colleagues were more researchers than popularisers, however, and the death of Gerald Klerman in April 1992 further delayed the dissemination of IPT (Weissman, 2006). Thus, well into the 1990s, there were probably more published papers on IPT than IPT therapists. IPT was adapted for depressed patients with differing characteristics and depressive subtypes, such as adolescence (Mufson, Pollack Dorta, Moreau, & Weissman, 2004), post-partum (O’Hara, Stuart, Gorman, & Wenzel, 2000), geriatric (Reynolds et al., 1999), and the medically ill (Markowitz et al., 1998; Schulberg et al., 1996) patients with major depression; patients with dysthymic disorder (Browne et al., 2002; Markowitz, 1998) and subthreshold depression (Klerman et al., 1987; Mossey, Knott, Higgins, & Talerico, 1996); adjunctive treatment to pharmacotherapy for bipolar disorder (Frank et al., 2005; Swartz, Frank, Frankel, Novick, & Houck, 2009).

Lately, researchers began to test IPT for patients with diagnoses other than mood disorders: bulimia (e.g., Fairburn et al., 1995) and substance abuse (Carroll, Rounsaville, & Gawin, 1991; Rounsaville, Glazer, Wilber, Weissman, & Kleber, 1983).

In its most novel application, IPT was tested as a treatment for depression in Uganda in communities that had suffered from war, HIV and poverty as well as high rates of depression. Two controlled trials demonstrated the efficacy of group IPT for adults (Bolton et al., 2003) and adolescents (Bolton et al., 2007) in this setting. Recently, further research highlighted the

interest of interpersonal approach in treatment of posttraumatic stress disorders (Markowitz et al., 2015)

Comment from an expert and or quote from a famous psychotherapist

“While depression may be a genetic disorder, it has a strong environmental component. And, for a child, a parent's illness is a very strong environmental effect. You want to reduce that effect so that you can have a beneficial effect on the child”.

Myrna Weissman

“The field of psychiatry is the field of interpersonal relations, under any and all circumstances in which these relations exist”

Harry Stack Sullivan

Before IPT, he was a 20th century psychiatrist who stressed the importance of interpersonal connections and developed *interpersonal psychoanalysis*.

Comment from a trainee with some kind of experience

“IPT is a modern evidence-based psychotherapy, limited in time, with great and fast results which allows the psychotherapist and patients to have a real contract on the way of recovery”.

João Borges Ferreira

Psychiatry Trainee

Psychiatric and Mental Health Department – Baixo Vouga Medical Center – Aveiro, Portugal

Books, manual, videos, application, published online courses or international association

- Klerman, G., Weissman, M. (1984) *Interpersonal Psychotherapy of Depression*. Basic Books.
- Stuart, S., Robertson, M. (2012) *Interpersonal Psychotherapy: a clinician's guide*. Hodder Arnold Press.
- Markowitz, John (2017) *Interpersonal Psychotherapy for Posttraumatic Stress Disorder*. Oxford Press.
- Ravitz, P., Maunder, R. (2013) *Psychotherapy Essentials To Go: Interpersonal Psychotherapy for Depression*. Norton Professional Books. Include DVD with role plays.

- Weissman, M., Markowitz, J., Klerman, G. (2017) The guide to Interpersonal Psychotherapy: Updated and Expanded Edition.
- Site of Interpersonal and Social Rhythm Therapy (IPSRT) with online training - <https://www.ipsrt.org>.
- International Society of Interpersonal Psychotherapy (ISIPT) - <https://www.interpersonalpsychotherapy.org>.
- Interpersonal Psychotherapy Institute - <https://iptinstitute.com>.

Research possibilities

There are a lot of research possibilities: Columbia University, Pittsburgh University, and so on. Anyone can contact the ISIPT and ask for more information of research projects and funds. There are also a WHO project for IPT Group in Uganda and Group Interpersonal Therapy (IPT) for Depression manual in lower income countries (http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/)

Contacts worldwide:

ISIPT-Australasia

Situated in Christchurch headed by Associate Professor Sue Luty and Professor Marie Crowe.

Contact: sue.luty@otago.ac.nz OR marie.crowe@otago.ac.nz

ISIPT-Australia

Contact: Anthony Hillin
(NSW) ahillin@froggy.com.au

ISIPT-Brazil

UNIFESP – São Paulo/ Brazil

Contacts: Camila Tanabe Matsuzaka, MD
camila.tm@gmail.com

<http://provepsico.com.br>

ISIPT-France

In France there are two distinct yet closely collaborating French groups: CREATIP and La Teppe

ISIPT Germany

German Society for IPT; Freiburg, Germany
Contacts:

Prof. Dr. Elisabeth Schramm, Freiburg;
president: elisabeth.schramm@uniklinik-freiburg.de
Homepage: <http://www.dg-ipt.de/>

ISIPT Greece

Malama Institute for Psychological Applications
Contact: Anastasia Malama
233, Mesogeion Avenue, Neo Psychiko, 154 51, Athens, Greece
tel: (0030) 210 6742889
e-mail: malama@ipse.gr
www.ipse.gr , www.iptgreece.com

ISIPT-Italy

info@psicoterapiainterpersonale.it
here is an active group headed by Silvio Bellino

ISIPT-Israel

The Israeli chapter is coordinated by Dr. Sharon Ben-Rafael
Women's Mental Health Clinic
Tel Aviv Sourasky Medical Center

ISIPT-Japan

This local chapter is headed by Hiroko Mizushima

<http://www.ipt-japan.org/>
email: info@ipt-japan.org

ISIPT-North America
In North America there are many university-affiliated IPT training groups that have changed, and grown.

https://www.interpersonalpsychotherapy.org/wp-content/uploads/2016/09/NA_IPT_Training_Groups.pdf

ISIPT-Portugal
EME Saúde (Medical Clinic)
Rua Arq. Marques da Silva, n. 285, 1º C
PORTO
<http://emesaude.pt/departments/academia-de-psicoterapia-interpessoal-api/>

ISIPT-Spain

Contact: juan.garcia2@um.es

ISIPT-Sweden
Contact: www.interpersonellpsykoterapi.se
Malin Bäck IPT-terapeut –
relatera@me.com. tel: 070-5490329

ISIPT-Switzerland
The Swiss Association of Interpersonal therapy is based in Geneva mainly constituted of French speaking members.

Theodore Hovaguimian M.D.

ISIPT-Turkey
The Turkish IPT Association (KIPT DER) is led by Prof Nazan Aydin.

ISIPT-UK
Contact – Julia Fox-Clinch
South West (and Wales)
Clinical Specialist Eating Disorders Service,
The Brownhill Centre
St Pauls Medical Site
121 Swindon Road
Cheltenham
GL51 9EZ

Other useful websites

Online IPSRT Training Participate in free online training in Interpersonal and Social Rhythm Therapy (IPSRT): www.ipsrt.org
IPT Videos Obtain IPT training videos from the “IPT To Go”
books: <http://www.psychotherapy.net/video/interpersonal-psychotherapy-depression>

Are all psychotherapies equally effective?
Learn about the challenges of interpreting results from psychotherapy clinical trials: <https://www.youtube.com/watch?v=V3zVowrJAve>

Mindfulness therapy

Chapter written by Kremers Laura, psychiatry trainee in Amiens, France

Before reading this chapter, we invite you to sit down in a comfortable place, if possible in a quiet environment, and to take some time to turn your attention to the present moment, here and now.

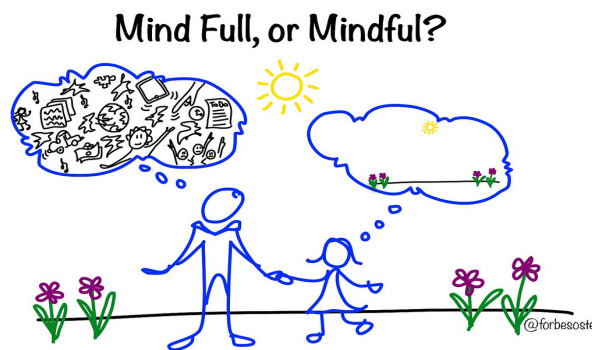
Do you recognize your breathing? If you want, take some time to observe it, without judging, just follow it calmly and peacefully. Breath in... breath out... without anything to prove, just observe and welcome warmly the different sensations and thoughts inside you.

If you have some time, try to become aware of the sounds around you, of the colours, of the sensations in your body, without thinking “Oh that's nice” or “Oh that's bad”, just by being kindly aware of them.

That's already a start into the wide range of Mindfulness exercises and applications!

Description

Mindfulness is the psychological process of bringing one's attention to the experiences occurring in the present moment, with compassion and without judgment. Being aware of the present moment calms down the ruminations and worries of the past and future, often observed in people suffering from anxiety or depression. It also helps to develop features such as compassion, concentration, acceptance and it lowers negative thoughts, emotions or behaviours such as auto-criticism, stress, impulsive behaviour etc. It's considered a third generation cognitive behavioural therapy.



Brief historic overview

Though it has its roots in Buddhist meditation, the secular practice of mindfulness has entered medical healing centers in part through the work of Jon Kabat-Zinn and his Mindfulness-Based Stress Reduction (MBSR) program, which he launched at the University of Massachusetts Medical School in 1979. Since that time, thousands of studies have documented the physical

and mental health benefits of mindfulness, inspiring countless programs to adapt the MBSR model for schools, prisons, hospitals and beyond.

Main uses and efficacy

Different programs based on Mindfulness exist and have shown their efficacy. You can find some of them here:

- MBSR : mindfulness based stress reduction. Helpful to people coping with stress, anxiety, depressive disorder,...
- MBCT: Mindfulness based cognitive therapy. Program developed at the end of '90 by Zindel Segal, Mark Williams and John Teasdale to prevent depressive relapse. Inspired by MBSR, with a focus on cognitive improvement.
- MBRP: Mindfulness based relapse prevention. Useful in the treatment of addictions.
- MBCT: Mindfulness based compassion and insight training
- MBDBT: Mindfulness-Based Dialectical Behavior Therapy, Used to help borderline patients.
- MBCP - Mindfulness-Based Childbirth and Parenting
- MBCT-C : MBCT for Children and MBSR-T : MBSR for Teens

But mindfulness can be used in many more fields (pain regulation, anorexia or bulimia, insomnia, hypertension, ...). Be just careful not to practice this exercises with people suffering from acute psychosis, manic episodes, or severe major depressive disorder with melancholic symptoms. Your patient should be mentally stable before starting.

The programs are often taught in an eight-week workshop given by certified trainers that entails weekly group meetings (two-hour classes), a one-day retreat (six-hour mindfulness practice) and some homework (45 minutes daily).

Mindfulness therapy has shown growing attention in research.

Did you know scientists can observe (thanks to EEG and fMRI) the anatomical and functional changes in the brain appearing after Mindfulness meditation? Moreover, scientific studies have shown that MBSR is associated with decreases in the habitual tendency to emotionally react to and ruminate about transitory thoughts and physical sensations (Teasdale et al. 2000; Ramel et al., 2004), stress, depression and anxiety symptoms (Segal et al., 2002; Evans et al., 2008) and distorted self-view (Goldin et al., 2009). MBSR is also associated with increases in behavioural self-regulation (Lykins and Baer, 2009), volitional orienting of attention (Jha et al., 2007) and emotion regulation (Goldin and Gross, 2010; Modinos et al., 2010).

Some examples of exercises used in nearly every program:

- Breath awareness: bring attention to each breath
- Body scan: bring attention to body parts, from the toes and up towards the head
- Sitting meditation: meditate in a seated posture
- Walking meditation: walk with attention and careful pacing
- Loving kindness meditation: send love and kindness to oneself and others
- Passing thoughts and emotions: notice and let go of thoughts and feelings
- Three-minute breathing: be aware (one minute), focus attention (one minute), and grow attention (one minute)

Comment from an expert and or quote from a famous psychotherapist

“Silence is for noise, what the shade is for light and what sleep is for awake : another essential side.”, Dr Christophe André

“Drink your tea slowly and reverently, as if it is the axis on which the world earth revolves – slowly, evenly, without rushing toward the future; live the actual moment. Only this moment is life.” Thich Nhat Hanh

“If we want to overcome suffering or discomfort, we should first admit their presence in us. We can't leave a place to which we didn't arrive first” Dr Christophe André

“In today's rush, we all think too much — seek too much — want too much — and forget about the joy of just being.” Eckhart Tolle

“What can't be avoided, should be welcomed” W. Shakespeare

“When I dance, I dance. When I sleep, I sleep. And when I'm walking alone outside in a beautiful orchard, if my thoughts are escaping some moment, I try to bring them back to the walk, the orchard, to the sweetness of this lonely moment with myself ” - Montaigne

Comment from a trainee with some kind of experience (duration of the training, personal thoughts)

“ Hi, I'm a psychiatry trainee in France. In the third year of our medicine studies, I was lucky enough to follow a research course and to develop a short research program. I went to a department for patients who cope with alcohol abuse and searched into article databases for

information about how to help them to prevent relapse. I found the MBRP program. It was great, because it combined the benefits I felt in my personal meditation practice, with the medical field. I followed the 8-weeks MBSR Program and since then, I'm fond of Mindfulness, and discovered how much patients are also interested in it. Sometimes, before a psychiatric interview, I take some time with them to do 5-min breathing exercise. It calms everyone down and the interview often becomes more interesting. Another exercise I like to practice, particularly with patients who are depressed and don't feel pleasure anymore, is mindful eating. Normally we do it with a dried grape but it also works really well with a piece of chocolate. Patients love it !”.

Kremers Laura, psychiatry trainee in Amiens

Books, manual, videos, published online courses or international association

- Some examples of **apps** : “ Headspace” (free), “Smiling mind” (free), “Stop, Breathe & Think” (free), “Mindfully me” (free), “Calm”, “Mindfulness training app” ...

- You can find a huge amount of **books**, these are some examples, some are sold with a CD :

“ Sitting together : Essential Skills for mindfulness-Based Psychotherapy”, 2014, Susan M.Pollak, Thomas Pedulla and Ronald D. Siegel

→ “Mindfulness for beginners” , 2006, Jon Kabat-zinn

→ “The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness”, 2007, Williams, Taesdale, Segal and Kabat-zinn

→ “Wherever you go, there you are”, 1994, Jon Kabat-zinn

→ “The miracle of Mindfulness”, 1975, Thich Nhat Hanh

→ “Mindfulness for dummies”, 2014

- Some **websites** in English :

www.mindful.org

Mind and life institute : [www. Mindandlife.org](http://www.Mindandlife.org)

Annex - For each country:

France:

one very well known specialist: Dr

Christophe André

(www.christopheandre.com)

2 famous books : “méditer jour après jour:

25 lecons pour mieux vivre en pleine

conscience” (+ CD) and “méditer pour ne

plus déprimer” (+ CD)

Another interesting book: “Manger en pleine conscience: la méthode des sensations et des émotions” (+CD) written by Dr Jan Chosen Bays

Other interesting websites :

www.emergences.org rubrique “activités pleine conscience”

www.association-mindfulness.org

www.ressource-mindfulness.ch

www.aftcc.org

Belgium:

A well known specialist : Edel Maex,
l'hôpital ZNA Middelheim d'Anvers
2 good books: "Mindfulness: apprivoiser le
stress par la pleine conscience : un
programme d'entrainement en 8
semaines." and "Werken met mindfulness
Basisoefeningen", Edel Maex
a website for training : [www.mindfulness-
belgium.net](http://www.mindfulness-belgium.net)

United Kingdom:

A well known specialist: John Taesdale,
Mark Williams (www.mbct.co.uk)
websites: www.oxfordmindfulness.org and
www.bemindful.co.uk

Germany:

A well known specialist: Tania Singer
website: www.mbsr-verband.de

Spain :

website : <http://mindfulness-spain.com>

Switzerland:

A well known author :Alexandre Jollien "vivre
sans pourquoi", "Eloge de la faiblesse"
website: www.mbsr-verband.ch

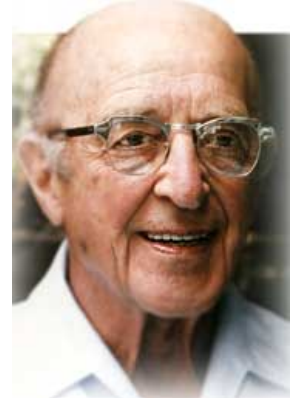
Canada: well known specialist : Zindel Segal

For other countries : you can find a link for a
national website on www.eamba.net
(*EAMBA : european network of Associations of
Mindfulness based approaches*).

Client-Centered Psychotherapy

Chapter written by Niel Merckx, Antwerp, Belgium

Also known as person-centered psychotherapy, Client-Centred Psychotherapy is a non-directive form of therapy based on the ideas of Carl Rogers (1902-1987). Rogers had a scientific and Christian background, which influenced his work. His method was different from the traditional psychodynamic model because he moved away from the expert role. By studying psychotherapy sessions (interesting fact: he was one of the first to research his results, the first to record sessions, to publish transcripts of his failures to encourage the study of what goes wrong, first to do follow-up studies of results), he believed the efficacy of treatment was mostly to be prescribed to what we now call the nonspecific factors. He focused on a nondirective, empathic approach that empowers and motivates the client in the therapeutic process. The core belief is that every human being strives for and has the capacity to fulfill his or her own potential. A therapist can guide a patient in this process. Far from being laissez faire, the therapist needs to help actively and empathetically clarify what the patient feels. He identified six necessary and sufficient conditions that are needed to produce personality changes in clients:



1. Two persons are in psychological **contact**.
2. The **client** is in a state of **incongruence**,
3. The **therapist** is **congruent** or integrated in the relationship.
4. The therapist experiences **unconditional positive regard** for the client.
5. The therapist experiences an **empathic understanding** of the client's internal frame of reference and endeavours to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree **perceived by the client**.

For the therapist this means in short he/she has to develop following conditions (aka the three core conditions): 1) Congruence, 2) Unconditional positive regard, 3) Empathy.

The nondirective approach (meaning: almost only using reflective listening) is now less strictly used and therapist will also give input and use specific interventions. Later developments and adaptations lead to therapies with a different emphasis:

Experiential:

Focusing by E. Gendlin

Emotion Focused Therapy by L.N. Rice and L. Geenberg

Interactional/Interpersonal by I.D. Yalom and Kusler

Existential by I.D. Yalom and M. Cooper

Indications

Covers mostly problems of the neurotic range (depression, anxiety or panic) but has been used for all types of disorders. Especially useful for ineffective self-structure organisation or perceived discrepancies in self. Can be used at all ages and all levels of intelligence. Passive patients urging the therapist to take control or incapable of managing themselves will not feel helped by this kind of therapy.

Efficacy

There are several RCTs providing evidence for the effectiveness of client-centered psychotherapy in numerous pathologies. But the body of evidence is less extensive and some studies have difficulty withholding under the strict scrutiny of methodology.

Gibbard I, Hanley T. (2008). A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care. *Counselling and Psychotherapy Research*, December 2008; 8(4): 215-222.

Elliott R, Freire B. (2009). Person-centred/experiential therapies are highly effective: summary of the 2008 meta-analysis. *British Association for the Person-Centred Approach*. 2009

Stiles W.B., Barkha, M., Mellor-Clark, J., Connell, J. (2007). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies as practiced in UK primary care routine practice: replication in a larger sample. *Psychological Medicine*.

Training

A recognized psychotherapy training now takes 4 years and includes supervision and undergoing therapy yourself.

Quotes:

Rogers

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

“The good life is a process, not a state of being. It is a direction not a destination.”

Greenberg

“Emotion is not opposed to reason. Emotions guide and manage thought in fundamental ways and complement the deficiencies of thinking.”

Comment from a trainee with some kind of experience (duration of the training, personal thoughts):

“The most useful aspect of this psychotherapy for a trainee is that it really focuses on the basic characteristics you need as a psychotherapist or even psychiatrist to have effective treatment. Without the core conditions as stipulated by Rogers, you will not be able to reach a patient through psychotherapy. The client-centered approach strongly trains therapists in the properties needed for a good therapeutic working alliance and a context that makes change possible.”

Niel, Belgium, 3th year in training of a client-centered therapy

Books

[On Becoming a Person](#): A Therapist's View of Psychotherapy - Carl Rogers

Videos, published online courses:

Youtube: [Carl Rogers Counsels an Individual on Hurt and Anger](#) (1977)

Youtube: Leslie Greenberg Emotion Focused Therapy (videos 2015-2017)

International associations

World Association for Person-Centered and Experiential Psychotherapy and Counseling

([WAPCEPC](#))

Network of the European Associations for Person-Centred and Experiential Psychotherapy and Counselling - [PCE Europe](#)

Image: http://www.buscabiografias.com/img/people/Carl_Rogers.jpg

Psychoeducation

Chapter written by Tania Abreu, Porto, Portugal and Thomas Gargot, Paris, France

The aims of psychoeducation are to expand patients' understanding of their psychiatric disorder, in order to improve coping strategies and to reduce stigma.

Description

By educating people about their psychiatric illness, patients and their families better understand their psychiatric disorder, which leads to destigmatisation. They are able to manage their symptoms more easily, recognise early signs of relapse, and know the effects of treatment and methods of rehabilitation. Psychoeducation promotes an acceptance of a disease and adherence to treatment. Some psychological strategies (like communication skills and relaxation) are also taught, helping patients deal with the problems caused by the disease and to improve their relationships with others, like relatives and professionals.

Different programs exist for several disorders and are usually organised by a multidisciplinary team with nurses, psychologists, psychiatrists and members of patient associations. Sessions follow a structured plan with specific objectives. Psychoeducation can be organized for individual or in groups.

More than just a lecture, Psychoeducation promotes patients' empowerment, help them to be more active in the management of their disorder. A theoretical knowledge is not the sufficient. For instance, role plays can be organized. A special focus will be given to experience sharing between patients, since a good coping strategy is always more credible when it comes from a patient than from a mental health professional.

Indications

Any chronic disorder could be the target of psychoeducation program. They are mainly developed for bipolar disorders, schizophrenia and Attention Deficit Hyperactivity disorder (ADHD).

The patients need to be previously stabilised with medication. All of them could benefit from this approach, but some studies suggest that younger age, shorter illness period, higher levels of education and a less external locus of control are positive predictors of participation and cooperation in the sessions.

There are also some programs that target patients' family members, especially in case of schizophrenia or ADHD. These programs help the family members to have a better understanding, attitude and communication toward their relative.

Brief Historic Overview

Over the years, the investment in psychological interventions for bipolar disorder (BD) and schizophrenia was scarce. This was due to several factors: the strong biological component; high heritability; the reluctance for the psychotherapist (often a psychologist) to manage severe

mental illnesses with necessary medications; the lack of psychotherapeutic training amongst psychiatrists.

Meanwhile, these perspectives began to change. It was accepted that pharmacotherapy is not enough, something that had already been demonstrated in other mental illnesses. It was recognized that not only biological factors but also psychological and social factors are predictors of the disease's course.

The roots of Psychoeducation for BD came from the 1970's pharmacological treatment monitoring. They quickly offered some information and mutual support. Afterwards, Psychoeducation groups focused on giving information emerged. In the mid-1990's, a new model was developed, including not only information but also stressing the empowerment of the patient regarding the treatment and recognition of relapses.

The content of psychoeducation programmes could be implemented in books (bibliotherapy) or in online programmes (components of electronic-CBT for instance).

Description

Three phases are described:

- Preparation: the working alliance with the therapist is good, the diagnosis has been explained to the patient, the doctor is informed and supports the psychoeducation program, the subject is motivated to follow the program.
- Elaborate an educative diagnostic: what are the demands and need of the subject, what is disabling for the person and what sources of support are possible to use
- Realise the psychoeducation: choose the content, plan the meetings, obtain peer support
- Evaluate the sessions: what was learned, and what are the psychological consequences and the possibility of implementation.

For instance, different Psychoeducation programs have been developed for BD. The majority found in the literature consist of group Psychoeducation directed to BD patients or to families and caregivers. Combining Psychoeducation with other psychosocial interventions is common. The Barcelona Psychoeducation Program (BPP) was proposed by Francesc Colom and Eduard Vieta and consists of 21 weekly group sessions. The authors recommend that the groups should have between 10 to 12 patients, balanced in sex and age. The sessions address awareness of the disorder (definition, causal and predisposing factors, symptoms in different episodes, evolution and prognosis); treatment adherence (mood stabilizers, antimanic drugs, antidepressants, plasma levels of mood stabilizers, pregnancy and genetic counselling, psychosocial therapies, risks associated with treatment dropout); avoiding substance abuse; early detection of new episodes and to what to do if a new phase is detected; regular habits and stress management (lifestyle regularity, stress-control techniques and problem solving strategies). A manual containing all the information needed to implement a group, including a description of every session, procedures, useful tips, patient materials and assignments.

Different topics discussed:

- Neurobiology and Neuropsychology of the disease; eg. the mood swing and the importance of sleep, the lack of motivation and insight associated with schizophrenia
- Different kinds of treatments, efficacy and side effects
- Early detection of relapse symptoms
- Life styles and hygiene to prevent relapse (sport, sleeping routines, relaxation techniques)
- Information and destigmatisation about the illness
- Decrease emotional burden of the family, how family can set limits
- How to have a positive approach, how to reinforce a relative, how to be grateful: to be Positive about Precise Small Steps
- Improvement communication in the family and with professionals
- How to get help from professional and patients associations

Efficacy

This intervention, the Barcelona Psychoeducation Program (BPP), showed efficacy in preventing recurrences and has been replicated several times it, since the first published randomized controlled trial, in 2003.

Psychoeducation improved medication adherence, reduced manic symptoms and increased global functioning.

Results are more controversial regarding the reduction of relapse rates: some studies concluded that Psychoeducation reduced both poles relapse rates; other concluded that it had no effect on depressive relapses. In addition, a quite recent meta-analysis concluded that only interventions for family members affected relapse rates.

Overall, Psychoeducation has revealed itself to be a very useful tool in the treatment of BD, whether it is used in combination with pharmacotherapy only or also in with other psychosocial interventions.

Psychoeducation for schizophrenia improves compliance (Number Needed to Treat, NNT = 11). Relapse is decrease (NNT=9) and readmission NNT=5. Psychoeducation promotes better social and global functioning (Xia et al, Psychoeducation for schizophrenia. Cochrane Database Syst Rev, 2011)

Research Possibilities:

Research in this area is mainly by evaluating patients before and after the group and then in follow-ups. It is important to replicate results but also to consider new areas to include in a Psychoeducation program in order to be more complete and holistic, including life style education (exercise, food) and cognitive remediation, etc. Import work is ongoing about how families cope with the burden of severe mental illnesses. Treatment adherence is very discussed in psychoeducation group and could be increased with such programs.

Materials:

Psychoeducation Manual for Bipolar Disorder

Authors: Francesc Colom and Eduard Vieta

Cambridge University Press, 2006

The Bipolar Disorder Survival Guide – What You and Your Family Need to Know

Author: David J. Miklowitz

Guilford Press, 2010

<http://psycheducation.org>

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/bipolardisorder.aspx>

Profamille programme in France for parents of patients with schizophrenia

<http://profamille-clusteridf.blog4ever.com/actualites-profamille-idf>

Barkley program for parents of child with ADHD

Cognitive Remediation Therapy

Chapter written by Mariangela Corbo, Annunzio- Chieti (Italy) and Tania Abreu, Porto, Portugal

Cognitive Remediation Therapy (CRT) is a behavioral training based intervention that aims to improve cognitive processes and psychosocial functioning.

Brief Historic Overview

The first records of rehabilitation programs appeared during World War I. The objective was to rehabilitate soldiers with traumatic brain injuries. These techniques were further developed during World War II.

Around 1943, the rehabilitation ideas were extended to psychiatric disabilities. Furthermore, with the deinstitutionalization movement and the community mental health development in the 1950's and 1960's, the interest in preventing disability in severe psychiatric diseases also flourished.

Attending to the growing evidence of the last decades about the prevalence and impact of cognitive deficits in severe mental illness, the interest in cognitive remediation was stimulated. Relevant studies on schizophrenia started to appear in 1980's, namely, studies with the Wisconsin Card Sorting Test (which tests executive functioning). These studies proved not only that the executive function is diminished in schizophrenia but also that it can be enhanced.

Since then, cognitive remediation techniques have been developed to improve several cognitive areas and a variety of programs have been created.

Description

CRT consists of several nonpharmacological methods focused on improving cognitive processes in people with severe mental disorders. These methods can promote functional improvement, not only by reducing learning limitations, but also by increasing individual confidence.

There are different types of CRT programs: individual or group sessions guided by a therapist, using mainly paper and pen; computerized programs (self-guided or guided by a therapist); and online programs.

The exercises target one or several specific cognitive functions. Sessions consist in repeating series of tasks, beginning at a basic level and gradually increasing difficulty throughout the program, based on principles of errorless learning and targeted reinforcement. The tasks are diverse, using games and neurocognitive tests, for example, memory exercises, motor dexterity tasks, visual reading exercises, etc. Besides the repetition of tasks, it promotes the patient capacity to think about the different ways of solving a task as well as to be aware of its own difficulties.

The vast majority of programs and studies are directed to Schizophrenia. A few examples:

Integrated Psychological Therapy for Schizophrenia (IPT) (Brenner *et al*, 1992): it is a group program, administered in five modules (cognitive differentiation, social perception, verbal communication, social skills and interpersonal problem solving). The program integrates cognitive and psychosocial interventions;

Cognitive Enhancement Therapy (CET) (Hogarty and Flesher, 1999): this program combines cognitive training by computer with group social cognition training. The objectives are to adequately assess stimuli and social contexts and to enhance thinking flexibility.

Neurocognitive Enhancement Therapy (NET) (Bell *et al*, 2001): it is a computer-based program, focused on vocational rehabilitation.

Neuropsychological Educational Approach to Rehabilitation (NEAR) (Medalia *et al* 2002): it was developed within educational psychology and uses training techniques that are intrinsically motivating. Different cognitive skills are trained by individualized computer exercises, within group sessions.

Cognitive Remediation Therapy (CRT) (Wykes and Reeder, 2005): initially developed in Australia by Ann Delahunty and reformulated by Til Wykes in the United Kingdom. The main objective is to increase the capacity and efficiency of cognitive functions, through information processing strategies. It consists of three modules: cognitive shift, memory and planning. The program is applied individually, using mainly paper and pencil tasks.

Cognitive remediation is usually used in combination with pharmacotherapy. Also, if combined with vocational rehabilitation, the effects can be enhanced. For each patient, an interdisciplinary team must define a structured plan. It's utterly important that the rehabilitation program is adapted to the individual.

Indications

During the last decade, CRT has been used mostly for disorders commonly associated with persistent symptoms, cognitive impairment and long-term disability, such as attention deficit disorder, brain injury, and schizophrenia spectrum disorders.

Emerging evidence suggests that CRT is also an effective intervention for mood disorders and that these treatment effects translate into improvements in cognitive performance and possibly functioning.

CRT has recently been developed for children and adolescents with anorexia nervosa. It focuses on decreasing rigid cognitions and behaviours, as well as increasing central coherence.

Younger age, higher education level, shorter length of stay, and lower PANSS Negative and Disorganized factors predict a positive response to cognitive remediation.

Efficacy

CRT, associated with psychopharmacological therapy resulted in significant improvements in global cognition, particularly in terms of verbal memory, executive functioning, and working memory. In the context of psychiatric rehabilitation, resulted in improving vocational and social functioning.

Although negative symptoms have not been considered a primary target for CRT, recent research suggested that CRT might also have a positive effect on negative symptoms.

A cognitive remediation program transferring learning skills into the real world is useful to increase the quality of working life in persons with severe mental illness and cognitive dysfunction who want to work competitively.

After therapy, increased activations are observed in various brain regions mainly in frontal - especially prefrontal - and also in occipital and anterior cingulate regions during working memory and executive tasks. Several studies provide evidence of an improved functional connectivity after cognitive training, suggesting a neuroplastic effect of therapy through mechanisms of functional reorganization.

Cognitive remediation may be particularly effective in people in the early course of illness or prior to the onset of illness due to the better neuroplasticity in people who are younger and have not yet experienced the consequences of long-term psychosis.

Research possibilities

A growing literature using neuroimaging techniques showed that cognitive remediation paradigms engage neural targets.

From a different perspective, some changes in serum levels of brain derived neurotrophic factor (BDNF) have been described. However, the status of BDNF as a biomarker of cognitive recovery is possibly premature. Some studies suggested a role of genes affecting dopamine modulation on outcomes of cognitive remediation.

Unfortunately, different programs, imaging tasks, and techniques may explain the heterogeneity of observed outcomes. Future studies would need to specify the effect of cognitive training depending on those variables.

Materials:

<http://www.cognitive-remediation.com/>

<https://www.rehacom.co.uk>

<http://www.programme-recos.ch>

<http://www.braincare.ie/our-programs/cr-psychiatry>

<https://www.happyneuronpro.com/en/>

Book: Cognitive Remediation Therapy for Schizophrenia: Theory and Practice
Professor Til Wykes and Dr. Clare Reeder
Routledge, 2006

Training:

<http://www.kcl.ac.uk/ioppn/news/events/2017/July/Cognitive-Remediation-Therapy-Training.aspx>

Psychoanalysis

Chapter written by Roberts Klotins, Longdon, UK, Nikitas Arnaoutoglou, Oxford, UK



What it is about

Compared to other medical specialties, such as Orthopaedics or Radiology, the diagnosis and treatment in Psychiatry is less straightforward: blood tests and radiographs can be helpful for our patients, but the diagnosis comes from the history and mental state examination. Some of our patients will be helped by medications; however as we know from our experience in community clinics or seeing a suicidal patient at the Emergency Department, for other patients a more complicated care plan will be needed. But these are our patients, and it is important for us to find treatments to help to relieve their suffering. Many of us choose Psychiatry in part to understand something about how psychic illness and health operate. Psychoanalysis is one such way of understanding; perhaps the one where looking into the human mind through language and emotional contact has been developed the most. A lot of subsequent speech-based therapies are in one way or another based on psychoanalytic understanding.

In this chapter, we will try to show, from our experiences, the essentials of psychoanalysis. We will try to convey why one might choose to make use of weekly contact with a therapist or an analyst and we will open this with a brief look into a session.

Personal Experience

It is Thursday, 8:30 pm. I am still at work. I must hurry up, my session starts in thirty minutes! Am I going to meet any traffic? The same scenario every time, three times per week. Same time for each session, and they last exactly 50 minutes. Last time I was 5 minutes late, so it lasted forty-five minutes. I finally get there; fortunately, I'm on time. He opens the door. We shake hands and walk into the room. I lay on to the couch. This room has been my sanctuary for the last 6 months, and I consider myself a beginner. I mostly do the talking, he rarely intervenes. I have so many things to say to myself. He hardly says anything. He usually repeats some of my words, asks or rephrases me. But I remember most of his interventions. Probably I will remember them for the rest of my life. He knows when to talk. He read me like a book from the first two introductory sessions. He must have a lot of patience. I think he likes me.

Now I am looking at the ceiling. Oh, that ceiling! I know every single detail of it. I also know by heart all the books that stand on that bookshelf. I cannot believe that there are times that I

forget his face. Mostly during the sessions. Is that part of this technique? Normally I cannot see him, he sits behind me.

Then something comes up and I restart the talking. I have so many things on my mind. How could I have forgotten them? Well, maybe they were not that important. Or were they? Well, we will see. If I remember them or they appear in the next session maybe they were. Time flies and the session finishes. I didn't cry this time. They say that a successful session always involves a bit of crying. My head feels heavy, but the feeling in my chest is like a feather. How does he do that? I hope I learn to understand myself better and I don't repeat the same mistakes. I am starting to believe that this is my wisest life investment.

I don't always feel different after a psychoanalysis session. But sometimes I feel a very peculiar and unmistakable sense of the world being more alive; I can smell the various faint smells - such as the new leaves, the oncoming rain or the summer breeze much better than I otherwise could. It signifies an emotional breakthrough in the session, I think to myself.

What is psychoanalysis

In order to understand psychoanalysis, we should understand the concept of **free association**. In real life, free association can be like blurting random words or thoughts that enter your head. It is similar to the game that we used to play when we were children: One says a word and the other responds with the first thing that pops into his mind. This applies also to psychoanalysis. The main difference between the two, is that the patient in his ceaseless talking manages to respond to his own ideas, thoughts, fears, impulses, drives and emotions - something that couldn't happen when he was fully alert and functioning in everyday life mode. He gains access to his unconscious by digging deeper and deeper into the layers of his psyche. He finds answers to his own problems, but he is not always right. In order to safely guide him through this long journey of self-discovery, his analyst is present through the intervention. Many believe that being a psychoanalyst is a simple task that could be easily performed by a good friend or a family member: in reality this is a highly demanding job, that requires a vast set of personal skills, qualities, enduring training, supervision and many years of the therapist's own personal analysis.

Psychoanalysis was originally developed by Sigmund Freud in the beginning of the previous century as a **clinical method** for treating neurological patients with symptoms for which there was no neurological explanation, commonly known then as hysteria. It evolved to a much broader way of helping other kinds of patients and to an understanding of the human mind, taking the existence of **the unconscious** as the key premise. It was a radical innovation for Freud's time, but today there would hardly be a neuroscientist, or a mental health professional who would not acknowledge that a lot of what happens in our brain happens unconsciously. Despite many attempts to define psychoanalysis as a philosophy or general theory, psychoanalysis has remained a clinical method and in that sense, it is not something that can be learned from books.

In broad terms one can say that the psychoanalyst is attempting to hear something of the unconscious knowledge of the patient and convey that understanding to the patient. This is not done in a didactic way. Rather the patient establishes an emotional connection with the analyst - that we call **transference** - that serves to convey the knowledge of the self-back to the patient

- often in a way that both the patient and the analyst had not thought about. The analyst typically listens a lot, in a posture that Freud called of *floating attention*, one that focuses more on the shape of the patient's discourse (the enchainment of ideas, hesitations, interruptions in their verbalisation) than on the actual content of the "story" being told, and draws attention (or voluntarily abstains to) to the salient points in the patient's stream of thoughts. This can be done via *interpretations* - reflections on what the patient has conveyed, based on the analyst's listening. Frequently, these interpretations are not immediate, they arise from the free association of the content of previous sessions. However, interpretations are only half of the story and they are much easier to write about than what is often referred to as *contact* in supervision. What is meant here is that an interpretation takes place on the background of a therapeutic (transferential) relationship and a precise context.

Practical aspects

Psychoanalysis can be defined by the way it is conducted and how it is taught. We will discuss from our perspectives things that we have experienced and found useful to be known before embarking on personal analysis or training in psychoanalysis.

Experiencing analysis - the frame of the classical "cure"

The analytic session happens once a day and it lasts 50 minutes; usually the analyst will have at least 5 to 10-minute break between the sessions. In Lacanian tradition, the session may be ended before the 50 minutes have passed, if the analyst has detected a particular insight on the part of the patient. Lacanian psychoanalysis has a frequency of at least three times a week, but in many countries for the treatment to be called analysis it has to proceed four or five times a week. Most often the patient lies on the couch and the analyst sits on a chair behind the patient's head. In this way there is no visual contact - a deliberate component of the method as oftentimes we take clues from the other's facial expressions when talking, hence the patient's flow of thought would be less affected by the analyst who is out of the visual field. The sessions are fixed in time - if my Tuesday's session is at 19:20 it remains so. *Changes in this are very rare* and have to have a serious reason. The general principle is that during this particular hour the analyst is available to the patient in the consultation room. Among other things it means if I cannot make to the session, I still have to pay for it!

One needs to speak freely; that is to say associate freely. However, in practice one finds that there are bits and pieces that one does not want to talk about - this is an element of what can be called *resistance*. Trust in the analyst and in the process may take time to develop. Trust is needed as the key part of the analyst's job is to help the patient to talk about things that are difficult.

Apart from the classic analytical cure framework there are a lot of patients (usually the case for psychiatric trainees) undergoing psychoanalysis in less time consuming settings (bi-weekly sessions, for example) and in a face-to-face modality.

Learning analysis

One becomes an International Psychoanalytic Association (IPA) recognised analyst via undertaking a training administered by an IPA component society. There are three recognised training models (IPA 2017) and they all include these parts:

Theoretical learning is usually done via seminars that are based on reading certain important psychoanalytic papers. Less commonly there can also be lectures but learning has to include individual reading. It may include also a year of once weekly infant observation - this component lies between theoretical and clinical learning.

Personal analysis. One cannot expect to become an analyst (or a psychodynamic psychotherapist for that matter) without experiencing the process as a patient. Often it is a requirement for entering a training scheme that you have at least a year of personal analysis. Personal analysis has to be done with a trained analyst. This is the most expensive part of the training.

Supervised clinical experience. That would mean at least 2 patients treated at the same frequency one is undertaking the personal analysis at. Supervision is once a week and the supervisor has to be recognised by the training institution. One usually has to pay for supervision - the cost of a supervision session is similar to what one pays for an analytic session. In some countries, IPA component societies administer training on a three times weekly basis, in some the frequency can be not less than four to five times weekly. It is also possible to undertake training on a three times weekly basis (this is often called intensive psychotherapy training) and then, if in your practice see patients on four to five times weekly for several years; if you train this way - you could qualify as an analyst after a one-and-a-half-year course and supervision (BPA 2017). This can be called an advanced training scheme as it is meant for therapists who are well versed in intensive work.

Psychoanalysis can also be learned and transmitted by societies that are not affiliated to the IPA. Usually these societies do not meet the IPA criteria because of the duration and frequency of the sessions. This was historically the case of the SFP (Société Française de Psychanalyse); they were considered ineligible for membership while Jacques Lacan did his teaching. It has not stopped him from becoming one of the biggest developers of psychoanalysis after Freud, or from him continuing the development of the latter's work.

Evidence base

Firstly, in terms of outcome data, there is a large body of research in psychodynamic approaches. Secondly, as the technological era in neurosciences has recently advanced, people are better at understanding how the brain works and quite a few findings are congruent with psychoanalytic findings. For many years, the effectiveness of all the psychotherapies was questioned, mainly by empiricists. Many regarded psychoanalysis as a pseudoscience, due to the fact that its effect was not easily measurable, there was little in terms of validated assessment scales, there was lack of quantitative evidence and the end result of the therapy was primarily based on testimonials. In the early 90's, the use of assessment scales in other psychotherapies (e.g. CBT) gave the scientific base psychological therapies needed. Recent studies have shown that in mood or anxiety disorders, psychoanalysis had greater effect when compared to shorter term psychotherapies in the 5-year follow-up (Knekt et al. 2011).

Psychoanalysis is not effective for obsessive-compulsive disorder, post-traumatic stress disorder, bulimia nervosa, cocaine dependence or psychosis (Fonagy 2015). There is strong evidence that psychoanalysis can be effective in borderline personality disorder and other personality disorders (Gabbard 2000). An interesting overview of evidence base can be found in the article 'The efficacy of psychodynamic psychotherapy' (Shedler 2010).

Lastly, by linking neuroscience with theory, many studies show links to Freud's theories (Ouss-Ryngaert and Golse 2010), brain networks and conscious part of ego (Rizzolatti, Semi, and Fabbri-Destro 2014) as well as the presence of the unconscious in decision making (Bode et al. 2011). In general, although neuroscientists find positive correlations, there are difficulties to provide scientific validity as a result of the diversity in research methodology and psychoanalytic approaches (Marini et al. 2016). This is often the case with complex ideas: we cannot be 100% certain about many of life's important questions.

Further, one needs to think about the very individual approach of psychoanalysis; to what extent really can group based statistics applied to the development of psychoanalytic theory and treatment of a particular patient? If at this point in time we tend to rely only on evidence that can be expressed in numbers, and we try to convert the human experience into numbers, such as using any Likert type scale - is that experience adequately reflected in the numbers we have obtained, or are we allaying our anxiety about lack of numbers and will we miss something more important? These might seem to be theoretical questions, however they clearly are not when we are trying to help our patients. If explaining numbers were the treatment, life would be far easier and our speciality would become more like Orthopaedic Surgery.

Types of psychoanalytic approaches

You may notice that there is not a central textbook of psychoanalysis. There are theoretical orientations that accentuate different aspects of theory. If we start chronologically, there is **Ego Psychology** - which focuses mainly on the conflicts between the demands and drives of the intrapsychic agencies id, ego and superego, and defences employed against anxieties stirred up by those conflicts. The **Object Relations school** emphasizes the importance of internalized relationships between people, the prototype being the relationship between the mother (the object) and the infant (the self). **Self Psychology** looks more at how external relationships help maintain one's self-esteem and self-cohesion. **Attachment theory** focuses on the impact of the caregiver's capacity to observe and respond in an attuned way thus shaping the development of the child (Gabbard 2005). Then major directions not to be forgotten are **Jung's Analytical Psychology** - a split from Freud's psychomiscanalysis long time ago and French **Lacanian analysis** that is closely based on Freud and semiotic aspects of language. History of development of psychoanalysis might perhaps be best appreciated through essays showing development of national associations in the book "100 Years of the IPA" (Loewenberg and Thompson 2011).

Freud began the journey of psychoanalysis as an attempt of neurological understanding of patmiscients, but in a few years the impossibility of this task became clear. Today there are interesting developments correlating the findings of neuroscience with the clinical and

theoretical findings of psychoanalysis. A group of researchers and analysts has called the movement **Neuropsychanalysis** (NPSA 2017).

Neuropsychanalysis may hold a particular appeal to doctors - our medical training gives us more understanding of the workings of human biology. It is to be noted that neuropsychanalysis is not a clinical method as such. One does not treat patients through explaining psychoanalytic or other theories; it is rather part of the background knowledge for the analyst that may help to understand the patient better and thus, perhaps, to find the right words at the right moment to help the patient to become aware of something and change.

Is it worth it?

The short answer is yes, but it depends on one's perspective. The analyst has to grapple with universal aspects of human existence. That often includes not quite knowing for sure what to do; it certainly has a failure rate, but its success can be very fulfilling. It enriches one's life immensely, but it can be seen as quite an exclusive approach for the obvious reasons of time and money investment. However psychodynamic therapies are all based on psychoanalytic methodology therefore you could reasonably see analysis as a high-end method of the psychotherapy spectrum and an engine for their further development.

I personally think that the way psychoanalysis works is by making one's thinking more complex, more able to see and feel what has not been possible before. If our premise is that part of the thinking process is unconscious, yet impacts strongly on what we do, we may include feelings or feeling motivated thinking processes among those affected by analysis. In a simple way, the idea behind this is that in order to talk we have to think and feel, and what we think and feel is related to what we do.

Psychoanalysis is hard work - both for the patient and the analyst, but the reward is the enrichment of life for both.

A Visual Example

If you would like to get a visual representation of what it might be like to be on the analyst's couch you can look at this video. I should warn you - it is a bit schematic and does not by far convey the gamut of experience that psychoanalysis really is, but Gabbard psychoanalysis enactment video still is a serviceable visual illustration:

https://www.youtube.com/watch?v=oS_L8efaJ-E

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Institutional Psychotherapy

Chapter written Kim Doan, psychologist, Paris; David de Freitas, Brussels, Belgium; and Thomas Gargot, Paris, France



La Borde clinic, Loir-et-Cher, France

Brief historic overview

Institutional psychotherapy (IP) is a humanistic model of psychiatric care, which was developed in France, during the 1950s in reaction to the organisation of asylums developed in France from the 19th century, and the concentration camp experience of WWII. First trialled by Tosquelles as a "*therapeutic community*" in Saint-Alban, IP was put into practice by Oury and Guattari in several private psychiatric clinics (La Borde, La Chesnaie and Saumery).

During the following 1960s and 1970s, the IP movement spread throughout numerous psychiatric clinics in the world, before transforming the French mental health landscape in the 1980s, leading to hospital decentralisation and sectorisation in networks of in- and outpatient structures.

Description

Based both on psychoanalytic theory and on communitarian principles, IP counters the two main sources of alienation for the individual: the alienation of mental illness and the alienation inherent to social organisation. Consequently, *care* is not only applied to the patients, but to the institution itself.

Treating the institution as an organism that participates in the social aspect of mental illness requires a permanent analysis of the institutional organisation and relationships. In other words, the institution itself is considered to have a group unconscious which can be grasped and which determines the therapeutic action.

(1) Open-door policy

In an IP clinic, patients are free to move around, and even to leave the institution if they are so inclined. This policy is aimed to bring the patients out of their isolation and of their repetition compulsion, by constantly enabling them new social connections and new forms of subjectivity.

The result is a homelike and convivial clinical setting, providing all sorts of meetings, committees, workshops, occupational and leisure activities that keep the social life alive and diverse and in which psychiatric patients cease to feel stigmatised, foreign to others and to themselves.

(2) Dissociated transference & constellation meeting

IP arises from the ambition of making psychoanalytic psychotherapy *possible* in the treatment of schizophrenia while taking into consideration the fragmentary structure of the psychotic *self*. Hence the concept of *dissociated transference* (Oury), which accounts for how the schizophrenic patient *institutes* a *constellation* of partial investments with several *people, objects* and *spaces*, as opposed to classic dual patient-therapist transference.

Consequently, the function of the *constellation meeting* (Tosquelles) is to gather these pieces of transference from caregivers and to collectively elaborate towards *meaning*. It's all about telling a story out of a patient's trajectory in time and space and therefore actively building up one's "lost" identity.

(3) Transversality

Having a certain status (doctor, nurse, patient, gardener, etc.) does not confine you to a fixed role or function. Getting rid of uniforms and blouses embodies this basic rule in IP and allows the therapeutic process to pass between levels. Plus, the utmost importance is given to context-based decision-making, in order to overcome an alienating pyramidal organisation and favor one's own initiative.

Another illustration of transversality is the communitarian organization of tasks within *the grid*, a double-entry chart which helps rotating the daily assignments between caregivers and the service personnel, so that each staff member alternates between different kinds of activities, be it talk groups, doing the dishes or helping patients take their showers.

(4) Therapeutic club

Self-managed by both patients and caregivers, financially independent from the clinic, the therapeutic club is a non-hierarchical and non-profit organization where patients and caregivers can mix and mingle daily. It is central to life at the clinic, as it sets up stimulating creative and professional activities for the entire community. In addition to this cultural and social role, the club publishes a newspaper and serves as a forum for discussing problems or making requests during its weekly general meeting, as the patients are allowed to have a say on the conditions of their stay and their care.

By putting caregivers and patients on an equal footing, caregivers and patients, by giving them equal responsibilities in handling the administrative and financial matters, by allowing them to function within a social bond, the therapeutic club allows patients to truly *belong* to a community from which they were often denied access due to their mental condition.

Indications

Although historically linked to schizophrenia, IP is not meant to be exclusively applied to psychotic patients. On the contrary, IP takes the unconventional approach of mixing patients and their pathologies, showing that a mixture of different pathologies and different age groups can mobilize potentially therapeutic vectors in patients.

Efficacy

Different studies in France and abroad have underlined that the patients' participation in their everyday life changes drastically the way they experience their mental disorders. However, it must be emphasized that treatment in institutional psychotherapy demands time! IP takes into account the chronicity of schizophrenia and therefore organises psychiatric care throughout a necessarily long timespan.

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Quotes from founders & experts

"Institutional psychotherapy is perhaps best defined as the attempt to fight, every day, against that which can turn the collective whole towards a concentrationist or segregationist structure", Jean Oury¹ (1970), co-founder of institutional psychotherapy and founder of La Borde clinic.

"By allowing patients to participate in the daily making of their institutional life, the therapeutic club makes it possible for them to rebuild a "better-organized inner home-body-psyche", with well-ordered thoughts and rules of life that are compatible with those of others", Antoine Fontaine, psychiatrist, psychoanalyst & director of Saumery clinic.

Comments from trainees

"I loved to experience the organisation of institutional psychotherapy that shows the relevance of confidence that a psychiatrist can give to their teams and patients. It is much easier to find relevant tools in patients' everyday life to work on: their autonomy, self-esteem, motivations and values. It can be a challenge to manage with shared decisions, but it makes everybody much more engaged and creative", Thomas Gargot, psychiatry intern at Saumery clinic.

"Training in institutional psychotherapy made me realize how the majority of the clinical settings I had known were lacking in freedom of initiative for caregivers and patients alike and gave me several cues for more lucid, harmonious and effective teamwork. While visiting La Borde clinic, I realized how "psychotherapy" emerges through small gestures, events and

¹ Oury J. (1970), *La psychothérapie institutionnelle de Saint-Alban à La Borde*, Poitiers: Archives IMEC.

interactions as long as one takes the time to notice them and make them part of one's daily work and mission." David de Freitas, psychiatry intern in Brussels, 1-year training in institutional psychotherapy.

Training

- 1-year University Diploma "*Psychothérapie institutionnelle & psychiatrie de secteur*", Université Paris 7 Diderot : [http://www.ep.univ-paris-diderot.fr/formation-continue/les-
formations/diplomes-universite/psychotherapie-institutionnelle/http://www.ep.univ-paris-
diderot.fr/formation-continue/les-formations/diplomes-universite/psychotherapie-
institutionnelle/](http://www.ep.univ-paris-diderot.fr/formation-continue/les-formations/diplomes-universite/psychotherapie-institutionnelle/http://www.ep.univ-paris-diderot.fr/formation-continue/les-formations/diplomes-universite/psychotherapie-institutionnelle/)
- 1-year University Certificate "*Psychothérapie institutionnelle*", Université Catholique de Louvain : <http://www.uclouvain.be/397027><http://www.uclouvain.be/397027>
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Movies

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Institutional psychotherapy throughout the world:

- o **France:**
- o Clinique de La Borde, Cour Cheverny.
- o Clinique de Saumery, Huisseau-sur-Cosson.
- o Clinique de La Chesnaie, Chailles.
- o Centre Psychothérapique, Saint-Martin de Vignogoul.

- o Institut Psychothérapique, Le Pin-en-Mauges.
- o Centre Antonin Artaud, Reims.
- o CHRU - Psychiatrie de l'Enfant & de l'Adolescent, Lille.
- o Centre de Santé Mentale Angevin, Sainte-Gemmes-sur Loire
- o Centre Hospitalier Roger Prévot, Moisselles.
- o Institut Marcel Rivière, La Verrière.
- o Établissement Public de Santé de Ville-Évrard, Aubervilliers.
- o Centre Hospitalier Ferdinand Grall, Landerneau.
- o Centre Hospitalier Édouard Toulouse, Marseille.
- o Hôpital Psychiatrique Le Grandvalier, Pontarlier.
- o Centre Hospitalier de Montfavet, Avignon.
- o

Belgium:

- o KaPP - Clinique Saint-Luc, Bruxelles.
- o La Devinière, Charleroi.
- o Hôpital de Jour Universitaire La Clé, Liège.
- o La Traversière, Nivelles.

Greece:

- o Aghia Sofia Children's University Hospital, Athens

Events : The TRUC organize a joint meeting every year between the different clubs in France
<http://pagedutruc.unblog.fr/>

Psychodrama

Chapter written by Milos Lazarevic, MD, psychiatry trainee, PhD student of neurosciences, RE&CBT counsellor -Belgrade, Serbia. miloslazarevic@yahoo.com

Brief historic overview

Psychodrama is a method of psychotherapy developed in the mid-1930s by psychiatrist Jacob Levy Moreno (1889– 1974) born of Sephardic Jewish parents in Bucharest, Romania. (Blatner, 2005) (Davies, 1988) From the age of four, Moreno lived in Vienna. (Davies, 1988) The experiments in which he encouraged individuals to work on their emotional problems by acting them out in a controlled and supportive group setting, were the outcome of his life-long enthusiastic commitment to the creative arts, in particular poetry, philosophy and theatre, and an equally powerful determination to study social behaviour. (Davies, 1988) Moreno said that his “most important beginning was in the gardens of Vienna” where as a medical student he learned psychodrama from watching children play, encouraging them to take action to challenge their circumstances, sometimes also involving parents



Figure 2

in the process. (Haworth, 2005) Later he initiated discussion groups among the prostitutes of the “red light” district of the city and noted how these groups exhibited autonomy and structure, and how the collective dynamic interacted with the individuals’ need for self-expression and recognition. (Davies, 1988) Upon qualifying as a doctor, Moreno found himself in charge of patients in a refugee camp for three years during which time his informal observations of group structure led him to suggest to the authorities principles that should be used actively in organising the community. Between 1921 and 1923 he worked with a group of young actors in Vienna using improvisation to dramatize current events in the “Theatre of Spontaneity” (Das Steigreftheater). He took up residence in USA in 1925. His classic work *Who Shall Survive? Foundations of Sociometry, Group Psychotherapy, and Psychodrama*, was published in 1934 and in 1936 the Moreno Sanatorium at Bacon, New York was set up. (Davies, 1988)

Description

The objective of psychodrama was, from its inception, to construct a therapeutic setting that uses life as a model, to integrate into the setting all the modalities of living – beginning with the universals of time, space, reality, and the cosmos – and moving down to all the details and nuances of life. (Moreno, 1972) Definition of time, space, reality and cosmos universals as Moreno defined them is out of scope of this chapter. It is so far left to your imagination.

The method is applicable mainly in groups, but with modifications can also be used in family therapy and with individuals. (Blatner, 2005)

The psychodrama session has three parts: the warm-up, the action and the sharing.

The warm-up serves to produce an atmosphere of creative possibility. It makes it possible for people to feel freer to trust the group, and to present their problems in an atmosphere of love, caring and creativity. Group discussion may be an expedient catalyst to get the

group into action. (Karp, 2005) The therapist then invites a client (later to become protagonist) to enact some aspect of the problem with the help of the therapist (in psychodrama called the director), and other group members (in the group setting). (Blatner, 2005)

The action part starts when the director of psychodrama group selects the protagonist – person that will bring out the internal drama, so that the drama within becomes the drama outside oneself. The director, with the protagonist, sets out to create scenes that give examples of the problem in the present, past or future with an eye to a possible behavioural pattern. Within the action there are five main tools or instruments that distinguish the method of psychodrama from other group methods: (Karp, 2005)

The stage provides the actor with a living space which is multidimensional and flexible to the maximum; (Moreno 1953:81 cited in Karp, 2005). If a conversation takes place in the kitchen, we set out the tables and chairs and give imaginative space to a window, sink, door, fridge, and other objects. Constructing the reality of an individual's space helps the person to really be there and warms them up to produce the feelings that do or do not exist in that space. (Karp, 2005)

The subject or actor (protagonist) is asked to be himself on the stage, to portray his own private life; (Moreno 1953:81 cited in Karp, 2005). The protagonist simply states an aspect of life s/he wants to work on: my fear of death, my relationship with my daughter, my authority problem at work. The director, with the protagonist, sets out to create scenes that give examples of the problem in the present, past or future with an eye to a possible behavioural pattern. (Karp, 2005)

The audience (group members) is a sounding board of public opinion as well as the subject itself—it becomes healed by taking part; (Moreno 1953:81 cited in Karp, 2005) There are many societal roles represented in any given group.

The auxiliary egos (group member that took some role) have a double significance; they are extensions of the director, exploratory and guiding, and extensions of the subject, portraying the actual or imagined. (Moreno 1953:81) cited in (Karp, 2005)

The director is a trained person who helps to guide the action. (Karp, 2005) The director has three functions: producer, counsellor and analyst. (Moreno 1953:81 cited in Karp, 2005)

Figure 2 Stage of Moreno's 'therapeutic theatre' in Beacon, New York. 'There are three concentric levels to the stage', Moreno writes, 'with a fourth level provided by the balcony. These levels permit great scope for movement and the expression of distances as well as providing means for the indicating of differences in psychological stages of the actors' (Moreno 1937, pp. 16 Å 17) cited in (Lezaun, Muniesa, & Vikkelsø, 2013)



Sharing is a time for group catharsis and integration. It was meant as a 'loveback' rather than a feedback, discouraging analysis of the event and encouraging identifications. Points of most involvement by individual group members are identified, and each member finds out how he or she is like or unlike the protagonist. People are much more alike than different in behavioural responses. Often, as in Greek drama, the audience member is purged by watching the enactment of another's life story. The sharing is meant to capture this learning process and allow the group members to purge themselves of emotions or insights gained. (Karp, 2005)

Some techniques used in psychodrama the way Moreno presented them are: therapeutic soliloquy, self-presentation, self-realization, hallucinatory psychodrama, double, multiple double, mirror, role reversal, future projection, dream presentation, improvisation, didactic psychodrama, family psychodrama. (Moreno, 1972)

Main uses (indications)

Kellerman stated that psychodrama, whether behaviouristic, psychoanalytic or existential-humanistic can make a contribution either on its own or as an adjunct to many branches of psychotherapy. He has emphasised that the method should be used with individuals who have adequate ego-strength, psychological-mindedness and a capacity for adaptive regression. (Kellermann, 1992) cited in (Karp, 2005). It is rather individuals' capacity for the method or for being a part of the group than a categorical diagnosis that make the indication for the use of psychodrama with patients.

Psychodrama can also be applied in many non-clinical contexts, schools, businesses, spiritual development programs, etc. (Blatner, 2005)

Efficacy

Studies of Holmes et al. (1994) and Leutz (1985) proposed that psychodrama may be helpful for a wide variety of disorders including: relational, neurotic, psychotic and psychosomatic problems (Holmes et al. 1994; Leutz: 1985) cited in (Karp, 2005).

The Cochrane Database of Systematic Reviews conducted a review that included all randomised controlled trials that compared drama therapy, psychodrama and related approaches with standard care or other psychosocial interventions for schizophrenia. Although they concluded that randomised studies are possible in this field and should continue to be under evaluation, benefits, or harms, are unclear. (Ruddy & Dent-Brown, 2007)

A meta-analysis conducted by Kipper and Ritchie on the basis of 25 experimentally designed studies showed an overall effect that points to a large improvement effect similar to or better than that commonly reported for group psychotherapy in general. The techniques of role reversal and doubling emerged as the most effective interventions. (A. Kipper & Ritchie, 2003) Although the authors concluded that their findings appear to shed a positive light on the validity of psychodramatic techniques, and they should be researched further and integrated into psychotherapy practice. The Centre for Reviews and Dissemination stressed that the limited reporting of the included studies and methods used mean that these findings may not be reliable. (CRD, n.d.)

Future well designated studies considering effects of psychodrama are needed.

Comment from an expert and or quote from a famous psychotherapist (founder)

In 1972 Moreno wrote:

“The author met Sigmund Freud for the first time in 1912, while working at the Psychiatric Clinic in the University of Vienna. Dr. Freud ended one of his lectures with his analysis of a telepathic dream. As the students filed out of the lecture hall, he asked the author what he was doing. “Well, Dr. Freud, I start where you leave off. You meet people in the artificial setting of your office. I meet them on the street and in their homes, in their natural surroundings. You analyse their dreams. I try to give them the courage to dream again. I teach people how to play God” Dr. Freud looked at the author as if puzzled” (Moreno, 1972)

Comment from a trainee with some kind of experience

“The theatrical aspect of psychodrama and the way in which unconscious and psychological become live and visible is what made me to start a psychodrama training. Training in psychodrama consists of personal experience in group, hours in theory, and practice under supervision which all together lasts approximately 2000 hours or 5 years to complete” Milos Lazarevic

Books, manual, videos, application, published online courses or international association

Federation of European Psychodrama Training Organisations (<http://www.fepto.com/>) - The Federation wishes to support the development of psychodrama training in Europe, and the Mediterranean countries, by promoting scientific and social exchanges between trainers and training institutes, to establish minimal training standards, to give ethical guidelines and to promote research.

Bibliography of Psychodrama © Inception to Now (<http://pdbib.org/>) - is an attempt to compile an exhaustive list of citations of scientific works on psychodrama since its creation by J. L. Moreno. It now contains *more than six thousand entries*.

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Research possibilities

The Federation of European Psychodrama Training Organisations (FEPTO) aims at enhancing research in all areas of professional practice in psychodrama. For more information visit <http://www.fepto.com/>

Image credits (link of websites or references of books or articles)

Figure 1 – Cleveland Psychodrama Institute. Retrieved from http://clevelandpsychodrama.com/what_is_psychodrama
Figure 2 - Lezaun, J., Muniesa, F., & Vikkelsø, S. (2013). PROVOCATIVE CONTAINMENT AND THE DRIFT OF SOCIAL-SCIENTIFIC REALISM. *Journal of Cultural Economy*, 6(3), 278–293. <http://doi.org/10.1080/17530350.2012.739972>

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Family Therapy

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Brief historic overview

For centuries, formal interventions to help families have been used. However, the roots of Family Therapy as a distinct professional practice as a branch of psychotherapy, were established in the early 1900s with the emergence of the child guidance movement (1909) and marriage counselling (1920s). Psychoanalytic treatment was applied in parallel confidential sessions with spouses and provided the theoretical foundation for early family and marital investigations. The formal development of Family Therapy dates from 1940's and early 1950s, with the foundation of the American Association of Marriage Counsellors in 1942 and with the contributions of many groups and individual clinicians (Ackerman; Bowen; Bell; Bateson; Haley; Milan Group – Italy and others). In addition to these practitioners, a number of other important figures had improved the development of Family Therapy (Whitaker; Minuchin; Boszormenyi-Nagy; Watzlawick and others). Initially, there was a strong influence from psychoanalysis, social psychiatry, learning and behaviour therapy. There were many movements around the theoretical role that considered the family as a system and not only as an aggregation of individuals. These movements such as the Palo Alto USA group through the work of the anthropologist Gregory Bateson and colleagues - Jay Haley, Donald Jackson, Paul Watzlawick and others introduced theories from cybernetics and general systems into psychotherapy, focusing on the role of communication. This group was also influenced by Erikson and his innovative use of strategies for change such as paradoxical directives.

By the mid 1960s several Family Therapy schools had emerged, such as MRI (Mental Research Institute, Palo Alto- USA), Brief Therapy, Strategic Therapy, Structural Family Therapy (Minuchin) and the Milan Systems Model. Independently, there emerged various Intergerational Therapies (Murray Bowen, James Framo and others), Psychodynamic Family Therapy and Multiple-family Group Therapy. The late 1960s-70s saw the development of Network Therapy and Behavioural Marital Therapy. By the late 1970s there were demarcations between schools like feminism and post-modernist approaches that reflected the political and cultural environment at that time which derived into various “post-systems” constructivism and social constructionist theories (1980s-1990s). Multicultural, intercultural and integrative approaches are being nowadays developed.

These days, there is a tendency on the part of family therapists to apply eclectic techniques from several areas and to do partnerships with other health professionals seeking the accumulated knowledge to adapt to many different contexts of the patients. The Family Therapy Model is one of the most utilized models in the US and Europe.

Description

Family therapy, also referred to as couple and family therapy, marriage and family therapy, family and systemic psychotherapy and family counselling, is a branch of psychotherapy designed to identify family patterns that contribute to a behaviour

disorder or mental illness and help family members to solve the identified problem. Family therapy involves discussion and problem-solving sessions with the family. Some of these sessions may be as a group, in couples, or one on one. In family therapy, the web of interpersonal relationships is examined and, ideally, communication is strengthened within the family. "Family" is defined by the modern family therapist as anyone who plays a long-term supportive role in one's life, which may not mean blood relations or family members in the same household. Family relationships are viewed as important for good mental health, regardless of whether all family members are participating in the therapy (Laney Cline King in <https://healthypsych.com>)

What distinguishes family therapy from individual counseling is its perspective or framework, not how many people are present at the therapy session. This type of counselling views problems as patterns or systems that need adjusting, as opposed to viewing problems as residing in the person, which is why family therapy is often referred to as a "strengths based treatment."

Family Therapy aims to be:

Inclusive and considerate of the needs of each member of the family and/or other key relationships (systems) in people's lives

Recognise and build on peoples' strengths and relational resources

Work in partnership 'with' families and others, not 'on' them

Sensitive to diverse family forms and relationships, beliefs and cultures

Enable people to talk, together or individually, often about difficult or distressing issues, in ways that respect their experiences, invite engagement and support recovery.

Adapted from <http://www.aft.org.uk>

Main uses (indications)

Family Therapy is indicated when there is a stressful conflict in a family, with or without symptomatic behaviours in one or more family members. More recently is recognized the use of Family Therapy in the treatment of major psychiatric disorders such as schizophrenia, depression, alcoholism, conduct disorders and somatoform disorders – in these groups of disorders, the interventions are mostly psychoeducational and combined with other treatments. Psychodynamic Family Therapy is used for interventions with narcissistic and borderline personality disorders.

Other common reasons for seeking Family Therapy include:

When a child is having a problem such as with school, substance abuse, or disordered eating

A major trauma or change that impacts the entire family (i.e. relocation to a new house, natural disaster, incarceration of a family member)

Unexpected or traumatic loss of a family member

Adjustment to a new family member in the home (i.e. birth of a sibling, adoption, foster children, a grandparent entering the home)

Domestic violence

Divorce

Parent Conflict

Adapted from <https://healthypsych.com/family-therapy/>

Efficacy

The efficacy and effectiveness research related to Family Therapy has demonstrated good experimental outcomes. In addition, reductions in health care use have been documented, especially for high utilisers of health care, after participating in Family Therapy. In most cases, Family Therapy has produced results better than no-treatment control groups and results as good as, if not better than, other forms of psychotherapy. Given that Family Therapy has been shown to be effective in numerous research reviews and that including it in health care systems does not seem to increase health care costs, now may be the time to begin to educate policy makers and begin to offer this form of care to families who desire to receive it (Crane, R., Morgan, T. - *The efficacy and effectiveness of family therapy*, January 2007).

Reasons to ensure and expand provision of Family Therapy include:

(Stratton, P (2005). Report On The Evidence Base Of Systemic Family Therapy. Association for Family Therapy)

- . There is very substantial supportive evidence for its effectiveness from diverse research and clinical experience.
- . Trained family therapists draw on a good range of approaches with clear theoretical rationales.
- . Current models of Family Therapy pay explicit attention to issues of culture, ethnicity, gender, discrimination and wider physical and societal contexts.
- . Properly trained family therapists have transferable skills in relation to team working, consultation, organisation etc.
- . Family therapists can support other professionals in their work with families.

Most Important Models of Family Therapy Summary

Theoretical Model	Theorists	Summary	Technics
Bowenian Family Systems Therapy	Murray Bowen, Betty Carter, Michael Kerr, Thomas Fogarty, Edwin Friedman, James Framo	Also known as "Intergenerational Family Therapy", may be considered a main bridge from psychodynamically oriented views to systems perspectives. The concept of multigenerational transmission and each generation moves toward a lower level of differentiation. Family members are led to achieve a balance of internal and external differentiation causing anxiety, triangulation, and emotional cutoff.	Detriangulation, emotional cutoff, differentiation of self, genogram.
Strategic Therapy	Jay Haley, Cloe Madanes	The symptoms of dysfunction are aimed to maintain homeostasis in the family hierarchy, as it transitions through several stages of the family's life cycle. They are primarily committed to changing behavior rather than insight, and are famous for creative interventions.	Directives, paradoxical injunctions, reframing, metaphoric tasks, restraining
Milan Systemic	Luigi Boscolo,	This group shifted the focus of treatment	Hypothesising, circular

Family Therapy	Gianfranco Cecchin, Mara Selvini Palazzoli, Giuliana Prata	away from observing interactive sequences and patterns, and toward questioning family belief systems. Therapeutically, they moved away from creating strategies to help families change their behavior. Based on Gregory Bateson's cybernetics, they challenge erroneous family beliefs and reworks the family's linguistic assumptions.	questioning, neutrality, counterparadox
Collaborative Language Systems Therapy	Harry Goolishian, Harlene Anderson, Tom Andersen, Lynn Hoffman, Peggy Penn	Collaborative therapists help families reorganize their perceived problems through a transparent dialogue about inner thoughts with a "not-knowing" stance. The therapist and the family work together, using their own knowledge and understanding the issues, to conceptualize and illuminate the client's problems.	Dialogical conversation, not knowing, curiosity, reflecting teams
Narrative Therapy	Michael White, David Epston	Separates the person from the problem and encourages people to rely on their own skill sets to minimize the problems that exist in their lives. Personal experiences are transformed into stories to establish their identity as a social and political constructs based on individual knowledge.	Deconstruction, externalising problems, mapping, asking permission
Solution Focused Therapy	Kim Insoo Berg, Steve de Shazer, William O'Hanlon, Michelle Weiner-Davis, Paul Watzlawick	The focus is on future using a goal-directed approach centered on solutions, rather than on the problems. The conversation is directed toward developing and achieving the client's vision of solutions.	Future focus, beginner's mind, miracle question, goal setting, scaling
Structural Family Therapy	Salvador Minuchin, Harry Aponte, Charles Fishman, Jorge Colapinto	The therapist join the family to win their confidence and circumvent resistance. Family problems arise from maladaptive boundaries and subsystems that are created within the overall family system of rules and rituals that led their interactions.	Joining, family mapping, hypothesising, reenactments, reframing, unbalancing
Experiential Family Therapy	Carl Whitaker, Virginia Satir, David Kieth, Thomas Malone, August Napier	From Gestalt foundations, Experiential therapy is rooted in the notion that the cause of family problems is the emotional suppression that create problems within the family system. The therapist is encouraged to be authentic and spontaneous worried less about the problem and more about the process of the experience.	Battling, redefining symptoms, affective confrontation, co-therapy,
Social Network Therapy	Ross Speck, Carlos Sluzki, Mony Elkaim, Jaakko Seikkula	"Social networks affect positively or negatively a person's health, and a person's health affects, in turn, the network's availability"(Sluzki, 2010). Explores the patterns and characteristics of social networks that maintain health and help prevent illness.	Ecomap, Retribalisation, Network Assembly, Open dialogue

Comment from an expert and or quote from a famous psychotherapist:

"I describe family values as responsibility towards others, increase of tolerance, compromise, support, flexibility. And essentially the things I call the silent song of life - the continuous process of mutual accommodation without which life is impossible".

Salvador Minuchin

Comment from a trainee with some kind of experience:

"All psychiatry residents would improve their clinical practice by learning Systemic and Family Therapy, especially serving children and adults across the lifecycle. Clinicians learn how to apply comprehensive assessment and treatment for individuals, couples and families representing the needs of our diverse community. It leads us to help families discover their strengths and resources to solve problems including depression, anxiety, adolescence behaviour problems, family conflict, grief and loss, or to cope with health concerns. More than a therapy, it's a way to deal with and prevent mental disorders."

Rita Almeida Leite, Psychiatry Trainee from *Psychiatric and Mental Health Department – Baixo Vouga Medical Center – Aveiro, Portugal*

Books, manual, videos, application, published online courses or international association

It's impossible to name all important authors since there are so many great works in this area. To state some of them:

- Bateson, Gregory (1972) *Steps to an Ecology of Mind*
- Watzlawick (1967) *Pragmatics of Human Communication*
- Minuchin, S., & Fishman, H.C. (1981) *Family Therapy Techniques*
- Haley, J. (1987) *Problem-Solving Therapy*
- Selvini-Palazzoli, M., Boscolo L., Cecchin, G. & Prata, G. (1988) *Paradox and Counterparadox: A New Model in the Therapy of the Family in Schizophrenic Transaction*
- de Shazer, S. (1991) *Putting difference to work*. New York: Norton.
- Ackerman, N. (1966) *Treating the Troubled Family*.
- Sluzki, C. (1976) *Double-Bind: The Foundation of the Communication Approach to the Family*
- Whitaker, C. & Bumberry, W.M. (1988) *Dancing with the Family*.

Research possibilities and Courses

There are many possibilities for training and research around the world. All information is provided on local and international Family Therapy Associations which websites are listed below in the annex. A summary of current evidence, research and training is available via the UK's Association of Family Therapy on

<http://www.aft.org.uk/training/view/academic-and-research-training.html>

Bibliography:

Sholevar, G., Scwoeri, L. (2003) Textbook of family and couples therapy: Clinical Applications. American Psychiatric Publishing, 1st Edition

Guttman, H.A. (1991). Systems Theory, Cybernetics, and Epistemology. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy*. Vol. 2. NY: Brunner/Mazel

Crane, R., Morgan, T. - *The efficacy and effectiveness of Family Therapy*, January 2007

<https://healthpsych.com/family-therapy/>

<http://www.aft.org.uk>

Links to Societies

Europe: <http://www.europeanfamilytherapy.eu>

International: <http://www.ifta-familytherapy.org>

Family Therapy Associations outside Europe:

American Association for Marriage and Family Therapy - <http://www.aamft.org/iMIS15/AAMFT/>

American Family Therapy Academy - <http://www.afta.org>

Australian Association of Family Therapy - <https://www.aaft.asn.au>

FAMSA-Family and Marriage Association of South Africa -

<http://mzansiitsolutions.co.za/famsaorg/?q=node/48>

Asian Academy of Family Therapy - <http://acafamilytherapy.org/wordpress/>

Journals:

American Journal of Family Therapy

Cahiers critiques de Thérapie Familiale et de pratique de réseaux

Ecologia Della Mente

European Research Journal for Qualitative

Research in Psychotherapy

Familiendynamik

Family Learning

Family Process

Family Relations

Family Systems Medicine

Human Systems: the Journal of Therapy,

Consultation and Management

Hungarian Journal of Psychotherapy

Interazioni

International Journal of Group Psychotherapy

Journal of Family Psychotherapy

Journal of Family Therapy

Journal of Feminist Family Therapy

Journal of Marital and Family Therapy

Kontext

Mediazione Familiare Sistemica

Metalogos: Systemic Approaches and

Psychotherapy

Mosaico

Perheterapia

Psicobiiettivo

Psychotherapie im Dialog

Revue de psychologie et de travail social

Rivista di psicoterapia relazionale

Systeemtherapie

Systeme

Systemic Thinking & Psychotherapy

Thérapie Familiale

Zeitschrift für Systemische Therapie und

Beratung

Supportive psychotherapy

Chapter written by Ekin Sönmez, Istanbul, Turkey

Supportive psychotherapy is by far the most commonly used method of psychotherapy around the world. It is one of the most commonly trained forms of psychotherapy, training or residency programs in Europe, US, Canada and Australia include supportive psychotherapy – or at least its techniques.

Supportive psychotherapy actually takes place in almost every psychiatric clinical setting to a degree. Therefore it is advisable to start deepening your therapeutic skills and practical experience with supportive psychotherapy.

Description & Brief Historic Overview

As the author of one of the founding books in the field and the owner of the most cited definition, **Pinsker** defines it as a “dyadic treatment and use direct measures to ameliorate symptoms and maintain, restore or improve self-esteem, ego functions and adaptive skills”. The empirical utilisation of supportive techniques in treatment has been present for at least two centuries now – but the development of what we today call supportive psychotherapy can be traced through the approaches of Freud’s successors in the second half of 20th century and their differences from his original psychoanalytical technique. Once called the “Cinderella of Psychotherapies”, there has always been a debate if it is a form of psychotherapy in its own right or a compilation of techniques. A great review on the history (spoiler: dates back to ancient Greeks!) and development of supportive psychotherapy can be found in the book “Clinical Manual of Supportive Psychotherapy” by **Novalis** and colleagues.

Indications & Efficacy

Supportive techniques can be employed in a spectrum of therapies ranging from counseling to rather expressive approaches. The advantage is you could move through the spectrum depending on the needs and capacity of the patient. It can be implemented in hospital settings, for chronically ill patients to restore daily functioning or to help patients resolve crises. The techniques may change over the course of the therapy – depending on patient’s progress.

Although it is implemented in various settings, research specifically investigating the effect of supportive psychotherapy is scarce. What is researched is mainly supportive techniques. Yet, one inspiring research that you would benefit from taking a look is the Psychotherapy Research Project of the Menninger Foundation.

How you can train for it?

Theoretical and technical aspects carry influences from psychodynamic, interpersonal and cognitive behavioral therapy approaches – this can allow you to have a broader perspective. It is even mentioned that supportive psychotherapy provides effective treatment for the broadest range of clinical problems. If you are curious, then you can enjoy many valuable works in both fields and find out about different techniques. In their illustrated guide,

Winston and colleagues say that beginner therapists, who cannot yet attempt expressive psychotherapy, can provide good supportive-expressive treatment.

It will require long hours of theoretical learning and following patients with a supervisor. In more structured training programs, theoretical training generally lasts for one year, simultaneously with or followed by another year of practical training. The reward is - it allows you to work with a wide range of patients and problems.

It is not only about knowing the techniques, but also having the correct attitude. You'll need regular supervisions, group supervisions are also helpful. It is not strictly required for you to have your own psychotherapy, but as this form of psychorthotherapy contains psychodynamic elements and in general, sitting on the other chair is recommended.

Essential Textbooks on Supportive Psychotherapy:

1. Learning Supportive Psychotherapy: An Illustrated Guide, by Winston, Rosenthal and Pinsker:

This is a book and DVD in which you can find very useful examples of interviews with the patient.

2. A Primer of Supportive Psychotherapy, by Pinsker

Quite old, but provides essential, easy to understand information on the technique.

3. Dynamic Supportive Psychotherapy

A fifty-pages handbook with basics. Of course, only a handbook will never be enough, but good for daily use, eg. Reading from your tablet

4. Instruction to Supportive Psychotherapy, by Winston, Rosenthal and Pinsker

Patient-therapist dialogues and case-vignettes, on course and interventions of supportive psychotherapy

5. Of course, theoretical psychodynamic literature, different approaches (drive theory, object relations theory, ego psychology, attachment, etc.) are all worth reading to increase your competence. Try to read some of the classical books during your training, which would introduce you the context and the historical development of therapies- but keep in mind most of them may not be taken as an updated source of knowledge.

Don't miss these articles:

1. The Nuts and Bolts of Supportive Psychotherapy
2. 5 keys to good results with supportive psychotherapy

“What is supportive psychotherapy? The term has been widely used, poorly and variously defined, and often disparaged. It can mean anything and nothing; yet also, when carefully defined and applied, it can describe a potent treatment that ... lies at the core of all good psychotherapy.”

*John C. Markowitz
M.D., Professor of Clinical
Psychiatry, Columbia University
College of Physicians &
Surgeons; Research Psychiatrist,
New York State Psychiatric
Institute New York, NY*

Who We Are

The European Federation of Psychiatric Trainees (EFPT) is an independent, non-profit making umbrella organization for European national psychiatric trainees' associations.

The EFPT is officially recognized by the European Union of Medical Specialists (UEMS). The Federation serves the European trainees in all branches of psychiatry.

Since its foundation in 1993 in Utrecht, The Netherlands, the EFPT has sustained a steady growth and currently successfully represents thousands of psychiatric trainees from more than 34 European countries.



Shaping the future of psychiatry

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EFPT full member and observer member countries 2016-17



EFPT 2016 member countries in black, observer countries in grey