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(Continued)
LEARNING OBJECTIVES

This chapter is designed to enable you to:

- Outline different psychological specialties and their applications to medical settings.
- Understand the theoretical basis of psychological therapies.
- Describe cognitive behaviour therapy, third wave therapies, psychodynamic therapy, and counselling.
- Understand the use of psychotherapeutic techniques in clinical practice.

Mental illness is surprisingly common. It is estimated that 322 million people worldwide suffer from depressive disorders and 264 million from anxiety disorders – each of these figures represent about 4% of the global population (World Health Organisation, 2015). Less severe problems, such as mild or moderate symptoms of depression or anxiety, will be experienced by many more people at some point in their lives.

Psychological interventions have the potential to make a huge difference to individuals and society and are likely to play an increasing role in clinical practice. However, the range of psychological professionals and interventions can be confusing. Many professions are involved in psychotherapy, such as psychiatrists, psychologists, counsellors, mental health nurses, and psychotherapists. It is not always clear who does what. As with medicine, psychology includes many specialisms. These include: health psychology, clinical psychology, counselling psychology, occupational psychology, neuropsychology, and research. Table 19.1 summarises a range of psychological specialties. In practice, an individual’s work may span two or three specialisms: for example, a clinical psychologist may also work in a forensic setting.
### TABLE 19.1 Psychology specialities

<table>
<thead>
<tr>
<th>Specialty</th>
<th>What do they do?</th>
<th>Where do they work?</th>
<th>Typical training</th>
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<tbody>
<tr>
<td>Clinical psychologist</td>
<td>Assess and treat mental health problems such as depression, schizophrenia, and personality disorders</td>
<td>Health and social care settings like hospitals, community mental health teams, and health centres</td>
<td>Clinical doctorate degree, including work placements in mental health settings</td>
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<tr>
<td>Counselling psychologist</td>
<td>Assess and treat moderate mental health problems such as depression and anxiety</td>
<td>Wide variety of places such as hospitals, prison services, education, and industry</td>
<td>Undergraduate degree plus specialist diploma and sometimes a doctoral degree</td>
</tr>
<tr>
<td>Health psychologist</td>
<td>Health promotion, health services research, treats health problems such as obesity, smoking cessation, and pain management</td>
<td>Health and social care settings like hospitals, health centres, and other health-related organisations</td>
<td>Health psychology Master’s degree and often a doctoral degree</td>
</tr>
<tr>
<td>Forensic psychologist</td>
<td>Work in legal processes, criminal behaviour, and investigations, including rehabilitation work with offenders</td>
<td>Prison services, secure hospitals and rehabilitation, police and probation services</td>
<td>Forensic psychology Master’s degree and diploma, including work placements in forensic settings</td>
</tr>
<tr>
<td>Educational psychologist</td>
<td>Assess and provide remedial work for children with behavioural or learning difficulties</td>
<td>Schools, education departments, and local authorities</td>
<td>Educational doctoral or Master’s degree plus work placements in educational settings</td>
</tr>
<tr>
<td>Occupational psychologist</td>
<td>Work with individuals and organisations to increase the effectiveness of employees and organisations</td>
<td>Industry, commerce, and other large organisations</td>
<td>Occupational psychology Master’s degree plus work placements in occupational settings</td>
</tr>
<tr>
<td>Neuropsychologist</td>
<td>Assess and rehabilitate people with brain injury or disorders</td>
<td>Healthcare settings such as hospitals and neurological and community rehabilitation services</td>
<td>Doctoral degree (usually clinical, educational or health) plus diploma in neuropsychology</td>
</tr>
<tr>
<td>Sport and exercise psychologist</td>
<td>Work with athletes, sports people, and teams to enhance performance</td>
<td>Health services, professional sports teams and national governing bodies</td>
<td>Three-year training, including sport and exercise Master’s or doctoral degree, plus work placements in sport and exercise settings</td>
</tr>
</tbody>
</table>

In most countries psychology is regulated by organisations such as the European Federation of Psychologists’ Associations, or the American Psychological Association. These organisations monitor and regulate the content of psychological degrees and training in the same way that medicine is regulated by organisations such as the General
Medical Council (UK) or the Liaison Committee on Medical Education (USA). Psychologists need to be registered with the relevant organisation and apply for professional status in order to practice.

This chapter focuses on the use of psychotherapy in healthcare settings. First, it explains the main types of psychotherapy used to treat mental health problems. Then it looks more specifically at interventions for physical health problems, such as motivational interviewing to help people change their behaviour and the provision of support groups for people with cancer.

19.1 DIFFERENT APPROACHES TO PSYCHOTHERAPY

Here we shall use the term ‘psychotherapy’ very broadly to mean any form of therapy that involves talking and exploring psychological issues. The aim of psychotherapy is to resolve mental health problems and help a person thrive. Psychotherapy usually involves one-to-one sessions in which people talk through their problems. However, there are different types of psychotherapy, each with its own theoretical foundations. As a consequence, the content of psychotherapy can differ hugely and in addition to talking therapies may involve writing, drawing, imagery work, role-play, or homework.

The main theories on which psychotherapies are based include psychodynamic (Freudian) theory, humanistic and existential theory, behaviourism, and cognitive theory. Figure 19.1 shows how these theories have resulted in different approaches to psychotherapy, each with their own philosophical assumptions and techniques. For example, humanism assumes (i) that humans are essentially good, (ii) that we strive for personal growth and development, and (iii) that we have free will and can therefore make choices. The humanistic approach to therapy, which was very popular in the 1960s and 1970s, is founded on the principle that the therapist provides an unconditional positive regard: in other words, whatever a person has done will be understandable given that person’s experience. The focus in humanistic therapy is on the person’s unique experience, needs, and personal growth. The humanistic approach continues to be used in therapy today and is also evident in patient-centred medicine.

Modern psychotherapy draws on a range of theoretical approaches, including cognitive behaviour therapy (CBT), third wave CBT therapies, psychodynamic therapies, and counselling.

Psychotherapies often overlap with each other and thus are not always easy to classify. For example, cognitive analytic therapy (CAT) combines CBT and psychoanalytic principles in therapy. Interpersonal therapy focuses on relationship processes in depression and draws on psychodynamic principles, CBT techniques, and brief crisis intervention. Eye-movement desensitisation and reprocessing is a specific therapy used to treat post-traumatic stress disorder (PTSD): it is referred to as integrative but incorporates a lot of CBT principles. The next section will look in more detail at the most widely used psychotherapies in healthcare settings, namely CBT, psychodynamic therapy, and counselling.
19.1.1 COGNITIVE BEHAVIOUR THERAPY (CBT)

CBT is founded on behaviourism and cognitivism. CBT is not a single therapy but rather a group of therapies that are founded on shared core principles. Consequently, some argue that the term ‘cognitive and behaviour therapies’ is a more accurate label (Eagle & Worrell, 2018). These therapies have developed in three waves (Hayes, 2004). The first wave derived from behaviourism, which focuses on people’s behaviour and how it is learned and shaped by events. Behaviourism describes the processes through which people’s behaviour is shaped, including classical conditioning, operant conditioning, and modelling (outlined in Chapter 10). Behavioural therapy uses these processes to change maladaptive behavioural responses and substitute them with new adaptive behaviours. For example, phobias are often conditioned responses to an object that is associated with fear because of a negative or traumatic experience in the past. Behaviour therapy would involve trying to counter-condition this response through techniques like exposure to the feared object, systematic desensitisation to the object, relaxation training, modelling of adaptive behaviour, and reinforcement of adaptive behaviour. A well-known example of positive reinforcement is the use of reward charts and stickers with children to encourage good behaviours. Wearable technology that monitors health behaviours, such as exercise, can encourage behaviour modification using principles of behavioural monitoring and reinforcing healthy behaviour (Davision & Garcia, 2017).

Behaviourism emphasises scientific, or empirical, testing. Behavioural therapy therefore includes carrying out behavioural experiments in which people test their views of what will happen under certain circumstances. Consider, for example, the case of a person who has social phobia and avoids social situations because they get highly anxious, assume that everyone notices and thinks they are odd. This can lead to a vicious cycle where social situations are avoided. The more these situations are avoided the more anxious the person will become about attending them. The person’s assumptions are not challenged or disproved because there is no opportunity for them to have a good experience of a social situation. This combination of negative assumptions and avoiding social events (avoidance behaviour) creates a negative cycle that perpetuates the phobia. In these circumstances, a behavioural experiment might be for the person to attend a social situation, monitor their anxiety (which should reduce over time), monitor how they act, and also notice how other people respond to them – whether positively or negatively. Another possibility might be to ask other people how they feel in social situations and whether they ever get anxious. This can normalise a certain degree of social anxiety. Behavioural experiments can reduce anxiety in many ways: the increased exposure to social situations can reduce anxiety through habituation, challenge negative beliefs, and break the negative cycle. We once heard of a therapist who went out and acted in bizarre ways in an attempt to show a person how little other people would notice!

It can be seen that behavioural experiments affect a person’s thoughts as well as their behaviour. From a cognitive viewpoint, behavioural experiments encourage people to become aware of underlying assumptions, specify and test them, and then revise their thoughts and behaviour accordingly. There is ongoing debate about whether behavioural
FIGURE 19.1  Main approaches to psychotherapy

**Psychoanalysis**  
Freud, Jung, Erikson  

**Humanism**  
Rogers, Maslow  
- Focus on an individual's personal experience, needs, and personal growth. Therapist provides unconditional positive regard, genuineness and empathy.

**Behaviourism**  
Skinner, etc  
- Focus on behaviour and factors that shape behaviour, such as classical conditioning, reinforcement, and modelling.

**Cognitivism**  
Beck, Ellis  
- Focus on how people interpret events and the meaning they attach to these events.

**Broad approach**

**Therapeutic techniques**

**Specific therapies**

- Interpersonal psychoanalysis
- Relational psychoanalysis
- Attachment-based psychotherapy

- Gestalt therapy
- Transactional analysis
- Counselling
- Solution-focused therapy

- Cognitive behavioural therapy
- Rational emotive behaviour therapy
- Acceptance and commitment therapy
- Dialectical behaviour therapy
- Schema-focused therapy

- Create a positive environment in which a person can work through difficulties in a supported manner. Help person to realise their needs.

- Change behaviour to be more adaptive through techniques such as exposure, modelling and behavioural experiments.

- Maladaptive thought processes and beliefs are identified and challenged. More adaptive beliefs and thought processes are developed.
experiments work mainly through behavioural or cognitive means (Ougrin, 2011; Salkovskis et al., 2006). Regardless of how they work, however, behavioural experiments can be powerful tools of change and are particularly effective for anxiety disorders. They are also useful when treating people with less cognitive ability, such as young children or people with learning difficulties. Case Study 19.1 gives an example of how cognitive and behavioural methods were used to treat a woman with PTSD after a difficult birth.

**CASE STUDY 19.1 CBT for postnatal PTSD**

Sarah is 35 years old, married, and has a 14-month-old daughter. Sarah had a termination of a pregnancy when she was 19 years old, which she kept a secret for 16 years because she thought people would judge her negatively.

Sarah’s labour was induced and there was confusion over when it would happen. Sarah panicked because she was unprepared and her husband was not there. The midwife was not sympathetic to Sarah’s high levels of anxiety. After a painful internal examination during which Sarah cried and asked the midwife to stop, the midwife said ‘If you think that’s painful, what are you going to be like giving birth?’ From this point onwards Sarah’s labour and delivery were characterised by pain, extreme distress, and fear of the midwife.

Sarah’s daughter was delivered by emergency caesarean section after a long labour during which Sarah thought she might die. Sarah started to feel the surgery half way through and was given morphine. She reported dissociating (feeling detached from herself and like the labour was unreal) and cannot remember anything for 12 hours after the delivery. She said the first few months after the birth ‘are a blur’ and it took her a year to bond with her daughter. The main themes of Sarah’s birth seemed to be feeling terrified, vulnerable, and out of control; high levels of confusion and dissociation; and confirmation of her belief that others will judge her and hurt her through her experience with the midwife.

After the birth Sarah suffered from postnatal depression, was prescribed antidepressants, and attended a support group. Sarah first attended CBT 14 months after giving birth. She was highly distressed, appeared to be reliving the birth experience, was crying and shaking. She had the full range of PTSD symptoms, including flashbacks, nightmares, and strong physical and emotional reactions to reminders of birth, feeling emotionally numb yet crying all the time. Her flashbacks were of seeing herself lying in the delivery room feeling helpless and terrified as the midwife came into the room.

Therapy consisted of various cognitive and behavioural techniques. Techniques used in treatment included:

(Continued)
HEALTHCARE PRACTICE

1. A behavioural experiment where an anonymous survey was carried out of people’s opinions of Sarah’s abortion to challenge her belief that others would judge her. The survey described the circumstances in which Sarah fell pregnant and had the abortion and asked people what they would think of her. People who did not know Sarah completed the survey and responses included pro-life and pro-abortion views. This dramatically changed Sarah’s beliefs about herself, the abortion, what others would think of her, and the importance she placed on others’ views.

2. Mild exposure in the form of reliving exercises. Sarah was asked to imagine the birth as if it were currently happening and talk through the events in detail.

3. Stronger exposure through visiting the labour ward with the therapist to help Sarah overcome her fear and avoidance.

4. Cognitive exercises to change Sarah’s appraisals of difficult events in the birth, such as using a role-play to act out confronting the midwife and reducing Sarah’s fear.

5. Visualisation exercises to rewrite her flashbacks. For example, she imagined the anaesthetist in the delivery room whom she felt comfortable and safe with, as opposed to the frightening midwife.

6. Positive reformulation to consolidate these changes in Sarah’s beliefs.

7. After ten sessions of CBT, Sarah’s PTSD symptoms had gone and her maladaptive beliefs about herself and others changed.

(Ayers et al., 2007)

The second wave of CBT derived from cognitivism, which views thoughts as being central to how we feel and behave. Cognitivism was the dominant paradigm in psychology for many years and the importance of cognition is apparent in many of the theories and research outlined in this book. The main cognitive theory of mental illness was proposed by Aaron Beck (1967), who argued that appraisal and the personal meaning of events are central in the development and maintenance of psychopathology. According to Beck, early experiences lead to sets of core beliefs or schema about ourselves, the world, and others. These beliefs are not necessarily rational because most of them are formed in childhood without the benefit of adult logic. Core beliefs can lead to maladaptive assumptions – sometimes referred to as ‘rules for living’.

Beck was particularly interested in depression. He argued that people become depressed when they have a depressogenic triad of negative beliefs about themselves (e.g. they are deficient in some way), others and the world (e.g. others don’t like them or treat them badly), and the future (e.g. negative expectations or hopelessness).

Evidence supports the existence of this depressogenic style of thinking; it has been observed in adults and children during depression (Beck & Perkins 2001; Braet et al., 2015). It has led to the cognitive content-specificity model which proposes that, although anxious and depressed people have maladaptive cognitions, the content of these differ for
each disorder. Following on from Beck’s work, it has been hypothesised that depressive cognitions are largely focused on negative beliefs about the self, the future, and loss, whereas anxious cognitions are largely focused on perceived danger or threat. There is some evidence to support this. For example, a study of anxiety and depression from childhood to early adulthood in over 1,600 pairs of twins found that anxiety sensitivity (fear of bodily sensations) was associated with anxiety but not depression (Brown et al., 2014). However, the same study found that social concerns (fear of publicly observable symptoms) were associated with both anxiety and depression, and so were not disorder-specific. The authors therefore concluded that there are both specific and shared thought patterns in anxiety and depression (Brown et al., 2014).

CBT is used to treat a wide range of psychological problems, not only depression. Cognitive theories have been developed for different psychological disorders such as depression (Beck, 1967), panic (Clark, 1986), anxiety (Wells, 1997, 2010), PTSD (Brewin & Holmes, 2003), and personality disorders (Young et al., 2004). These theories and the evidence for content-specificity have informed the development of cognitive therapy protocols for different psychological disorders. The defining features of CBT are given in Box 19.1. CBT is now being applied to an increasing range of mental and physical disorders and is also developing to incorporate different techniques based on mindfulness meditation, and acceptance. These are collectively referred to as the third wave therapies and are outlined in the next section.

However, the underlying theory can be applied to most of us, even when we are functioning well. Consider, for example, a person whose core beliefs include that they are unlovable and that other people will judge them, which could stem from having overly judgemental or unloving parents. This person might compensate for these core beliefs by having rules for living such as:

‘If I do everything perfectly then people will love me.’

‘If I do what people want they will not criticise me.’

‘I must not show negative emotions or people will judge me.’

These rules can help the person to function well and feel good about themselves as long as they adhere to these high standards. However, keeping up these standards will put them under considerable strain and make them vulnerable if something happens to make them think they’ve failed, such as not doing well in an exam or being made redundant from work. Under these circumstances it is possible they will develop depression because they have violated their rules and so activated their underlying belief that they are unlovable.

One difficulty in cognitive therapy is that people are not consciously aware of their own core beliefs and rules for living. However, these beliefs are usually reflected in the moment-to-moment automatic thoughts they have, especially in difficult situations. Thus CBT involves monitoring automatic thoughts
to help uncover a person’s rules and core beliefs. These are put together in a formulation, which can be written or diagrammatic. The formulation is then used as a guide for the therapist and person to understand the problem and work out ways to test and challenge existing beliefs and build new, more adaptive beliefs. Testing beliefs can be done using cognitive and behavioural methods. Cognitive methods include guided discovery or Socratic questioning, where the therapist helps the person examine and question their existing beliefs by considering evidence of whether or not they are correct. Case Study 19.1 illustrates the testing of beliefs using cognitive and behavioural methods. The formulation for the woman featured in this case study is shown in Figure 19.2.

**ACTIVITY 19.1**

- Think about the last time you felt upset or angry and write down the following:
  - What was the situation or trigger?
  - What thoughts went through your mind (automatic thoughts)?
  - How did these thoughts influence how you felt?
  - Can you identify any of your rules (assumptions) that might have been broken?

**BOX 19.1 Core features of CBT**

1. It is a collaborative relationship between the therapist and the client.
2. The client is educated about the CBT approach so that they can become their own ‘therapist’.
3. The focus is on the present problem – ‘here and now’.
4. Structured sessions with content (an agenda) are agreed between the therapist and the client at the beginning of each session.
5. It is goal directed, with aims for therapy being stated at the beginning and work in therapy is directed toward achieving these aims.
6. It is short-term therapy, typically between six and 24 sessions.
7. It is an examination of maladaptive beliefs.
8. Maladaptive beliefs are cognitively challenged through Socratic questioning.
9. Behavioural experiments are used to test maladaptive beliefs (empirical approach).
10. General and specific formulations are used to guide understanding and change.

There is little doubt that CBT is a popular and effective treatment for a variety of conditions. It is now the recommended treatment for many psychological disorders, including depression, PTSD, generalised anxiety disorder, panic, and obsessive compulsive disorder (National Institute for Health and Care Excellence (NICE), 2011). The widespread use of CBT is based on evidence that it is an effective treatment for these disorders. Reviews of
CBT for anxiety disorders show that it is better than wait-list or placebo controls and as effective as pharmacological treatment in reducing anxiety, depression, and increasing quality of life (Mitte, 2005; Olatunji et al., 2010). In addition, CBT has lower dropout rates than pharmacological treatment (Mitte, 2005).

CBT is also increasingly used as an adjunct to treatments of chronic illnesses. Reviews of randomised controlled trials have generally found positive effects of CBT treatment for illnesses as diverse as chronic fatigue (Price et al., 2008), fibromyalgia (Bernardy et al., 2013), traumatic brain injury (Soo & Tate, 2007), sleep problems (Montgomery & Dennis, 2003), and asthma (Kew et al., 2016). However, the assessment of the effects of CBT is often limited to psychological outcomes, such as quality of life and measures of distress, rather than to physical functioning.

The popularity of CBT means it is now in danger of being applied in a blanket fashion to areas where there is inconsistent evidence of its efficacy. For example, there are instances where CBT appears helpful but does not result in clinically significant change, such as with child sexual abuse (MacDonald et al., 2012) or domestically abusive men.
There is also evidence that other therapies can be just as effective as CBT, or more so (Stoffers et al., 2012). A more considered view might be to recognise that CBT works very well for some disorders where it can lead to an improvement in some outcomes, but that it is by no means a panacea.

19.1.2 THIRD WAVE CBT THERAPIES

The most recent developments in CBT have been referred to, collectively, as third wave cognitive and behavioural therapies (Hayes, 2004). These therapies focus less on challenging the content of thoughts and more on the relationship that an individual has with their thoughts and emotions. Techniques such as acceptance, mindfulness, and cognitive defusion help a person to accept their thoughts and emotional responses and not see them as all-defining or permanent. This prevents psychological symptoms being made worse by negative appraisals of thoughts and emotions. There is also a focus on life values and spirituality in many third wave therapies.

Various third wave therapies have been developed. A review identified 17 therapies classified in the literature as ‘third wave’ (Dimidjian et al., 2016). Those most widely cited were Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), and mindfulness, which are described below. Other third wave therapies include functional analytic psychotherapy, behavioural activation, compassion-focused therapy, metacognitive therapy, and integrative behavioural couples therapy.

Mindfulness is based on meditative practices which have been used for centuries. In its contemporary form, mindfulness has been defined as bringing non-judgemental awareness to an object of attention, being receptive, and in the present moment (Kristeller, 2018). Mindfulness interventions involve regular meditation to practise raising awareness of factors such as breathing, bodily sensations, or thoughts and emotions. Specific techniques, such as guided meditation, walking meditation, body scan meditation, or mindful eating, can be incorporated into a range of different psychotherapeutic approaches. These techniques involve focusing on a particular task (e.g. walking or eating meditation) or different parts of the body (e.g. body scan meditation) in order to be in the present moment, to notice and pay attention to what we are doing or feeling.

There are also stand-alone mindfulness therapies which have been widely applied and evaluated. The most commonly known are Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 1990) and Mindfulness-Based Cognitive Therapy (MBCT) (Segal et al., 2002). Both these therapies consist of eight weekly sessions of mindfulness meditation with daily mindfulness practice in between to teach people mindfulness skills with the goal of reducing stress or depression. The therapist or instructor provides psychoeducation about mindfulness and emotions, guides mindfulness practice in person or via audio-recordings, and provides specific content relevant to the intervention (e.g. risk factors for stress or depression).

Many mindfulness interventions have been developed for specific health problems or illnesses with mixed evidence for efficacy. Interventions have been developed for changing...
health behaviours such as smoking (Maglione et al., 2017) or obesity (Ruffault et al., 2016); for symptoms such as chronic pain (Hilton et al., 2016); for psychological disorders such as attention deficit/hyperactivity disorder (Mitchell et al., 2015) or psychosis (Aust & Bradshaw, 2017); for physical illnesses such as breast cancer (Zhang et al., 2016) and respiratory disorders (Harrison et al., 2016); and for groups of people such as carers (e.g. Rayan & Ahmad, 2017) and healthcare professionals (Burton et al., 2017).

Mindfulness interventions have been widely evaluated with evidence that they are effective compared to wait-list controls or treatment as usual. A review of 47 randomised controlled trials found that mindfulness meditation programmes, such as MBSR and MBCT, result in small to moderate improvements in anxiety, depression, and pain (Goyal et al., 2014) but there was poor or insufficient evidence of effects on positive mood or stress-related behaviours, such as substance use, eating habits, sleep, or weight. Mindfulness interventions are not more effective than other active treatments, such as behavioural therapies or exercise (Goyal et al., 2014). However, there is interesting evidence emerging about physiological responses to mindfulness interventions (see Research Box 19.1).

**Acceptance and Commitment Therapy (ACT)** (Hayes et al., 1999) incorporates mindfulness and other techniques to help people accept events, thoughts, and feelings that are outside our control and instead identify personal values and commit to acting on these. ACT rests on the assumption that trying to avoid or get rid of symptoms perpetuates negative emotions and suffering – hence the focus on accepting these symptoms and commitment to living a valued life. The core principles of ACT are shown in Box 19.2. The evidence for ACT is similar to that for mindfulness in that it appears to be an effective treatment but no more effective than standard CBT. A meta-analysis of 60 randomised controlled trials of ACT for stress, physical, and psychological disorders found a small effect of ACT compared to wait-list controls or treatment as usual (Ost, 2014). The evidence suggested ACT was most effective for chronic pain and tinnitus, and possibly effective for psychological disorders and stress. However, ACT was not significantly better than other forms of cognitive or behavioural therapy (Ost, 2014).

**Dialectical Behaviour Therapy (DBT)** (Linehan, 2014) was originally developed as a treatment for suicidal people and then tailored for people with borderline personality disorder. Since then, it has been used as a treatment for a range of psychological and behavioural problems. DBT uses standard CBT techniques for emotion regulation along with mindfulness and acceptance. DBT has four components: (i) individual therapy to address problem behaviours, set goals for quality of life, and work toward them; (ii) group sessions to teach core skills of mindfulness, emotion regulation, tolerance of distress, and interpersonal skills; (iii) a therapist consultation team to support therapists providing DBT; and (iv) telephone coaching to help people apply skills in their daily life. As with other third wave therapies, reviews of the evidence suggest DBT is more effective than usual treatment for borderline personality disorder and suicidality (Stoffers et al., 2012), and eating disorders (Lenz et al., 2014). However, DBT is not necessarily more effective than other psychotherapies. Although DBT has been used to treat other conditions, such as depression, anxiety, and intellectual disabilities, there is not yet enough evidence on which to draw conclusions (McNair et al., 2016).
**RESEARCH BOX 19.1  Effects of mindfulness-based interventions on biomarkers in people who are healthy or have cancer**

**Background**
A previous review and meta-analysis found that mindfulness-based interventions have a small beneficial effect on cortisol levels in healthy adults [Sanada et al., 2016]. This systematic review looked at the effect of mindfulness-based interventions on biomarkers (cytokines, neuropeptides, and C-reactive protein [CRP]) in healthy people and people with cancer.

**Method and findings**
A search of the literature between 1980 and 2016 found 13 research studies with a total of 1,110 participants: seven studies with healthy subjects (n=750) and six studies of people with various types of cancer (n=360). Results showed mindfulness-based interventions had no effect on cytokines in healthy people but were associated with a reduction in pro-inflammatory cytokines and possibly an increase in anti-inflammatory cytokines in people with cancer. In healthy people, mindfulness interventions were associated with increased levels of the neuropeptide insulin-like growth factor (IGF-1) as well as short-term increases in neuropeptide Y, which is associated with more beneficial responses to acute stress.

**Significance**
The authors suggest that the changes in biomarkers observed in healthy adults after mindfulness interventions might offer protection against acute stress. Changes observed in cancer patients might indicate a change from a depressive/carcinogenic profile to a more normal one. However, given the complexity and different contexts of the immune system, additional evidence is necessary to confirm the impact of mindfulness interventions on biomarkers.

Third wave therapies such as mindfulness, ACT and DBT share a number of similarities. Common characteristics are the focus on mindfulness, acceptance, and cognitive defusion. There is substantial evidence that these third wave therapies are effective. A review of meta-analyses conducted for common third wave therapies (including those described here) concluded they have ‘at least moderate to large effects’ for treatment of anxiety, depression, eating disorders, borderline personality disorder, and suicidal behaviours compared to wait-list controls or treatment as usual (Dimidjian et al., 2016). For example, a review of psychological therapies for depression found that third wave therapies and standard CBT approaches were equally effective and acceptable treatments (Hunot et al., 2013). Third wave therapies therefore provide a useful extension of cognitive and behavioural therapies to include new techniques and approaches that are as effective as standard CBT, but not necessarily more effective.

**BOX 19.2 Core features of ACT**

ACT frequently uses six core principles to help people develop psychological flexibility:

1. **Cognitive defusion**: helping people to realise that their thoughts, emotions, and memories are not necessarily true or define them.
2. **Acceptance**: helping people to allow their thoughts and feelings to come and go rather than struggling with them.
3. **Present moment**: helping people to be aware of the here and now, and to experience it with openness, interest, and receptiveness.
4. **Observing the self**: helping people to develop a transcendent sense of self and a continuity of consciousness that is unchanging.
5. **Values**: helping people to discover what is most important to them.
6. **Committed action**: helping people to set goals according to their core values and acting on them.

**19.1.3 PSYCHODYNAMIC THERAPY**

Psychodynamic therapy is based on Freud’s theory of the psyche and psychopathology. The central idea is that we have a dynamic unconscious – hence the term psychodynamic therapy. This dynamic unconscious involves a continuous conflict between drives and impulses on the one hand, and our ego and social constraints on the other hand. Conflict, suppression, and a building up of psychological defences then influence our behaviour, thoughts, and feelings which can lead to psychopathology.
Psychodynamic theory has been extensively developed and refined and there are now many different types of psychodynamic therapy. These include interpersonal psychoanalysis, relational psychoanalysis, and attachment-based psychotherapy. Carlyle (2007) outlines three common principles in psychodynamic therapies. The first is the importance of early childhood experience. Modern psychodynamic theory incorporates work on early attachments (Bowlby, 1958), which indicates that the relationship a child has with their primary caregiver between the ages of six months and 3 years of age is fundamental in forming a person’s early experience and their expectations of social relationships (see Chapter 8). Attachment is not the only important early experience. Research suggests that playing helps children to learn about the rules for appropriate behaviour and social roles. It also helps them to test their own abilities and regulate their emotions. For example, a child play-fighting with a parent will learn about acceptable and unacceptable levels of aggression.

Psychodynamic theory puts forward two processes by which early experiences affect development. These are introjection, where the child internalises aspects of their parents or other significant people into themselves. The other process is projection, where people project aspects of their own internal world onto others. The most well-known example of projection is when you view another person negatively because they do something or represent something you dislike about yourself. For example, a father may react angrily when his son does not achieve top grades at school because the father is frustrated by his own lack of achievement and success. The father is therefore projecting a part of himself that he dislikes onto his son and reacting strongly because of this.

Psychopathology in adults is therefore thought to result from early experiences being negative in some way, such as having neglectful or over-intrusive parents or a childhood that involved trauma, loss, or separation. The negative experience then results in adults who have difficulties coping with life or relationships. As a result, the second common principle in psychodynamic therapies is the importance of relationships, particularly the therapeutic relationship. The therapeutic relationship is thought of as a regular, contained space for people to work through and understand their difficulties. This means psychodynamic therapy is regular and intensive – often happening more than once a week for more than a year – to provide the patient with a frequent and predictable time in their life to deal with their difficulties.

Through regular contact, the therapist starts to symbolise a parent for the patient. The therapeutic relationship therefore becomes a ‘stage’ on which interpersonal difficulties are played out. This is known as transference, where the way the patient views and relates to the therapist is thought to represent their underlying issues or interpersonal difficulties with parents or other significant people. A psychodynamic therapist therefore remains as neutral as possible and is not supposed to bring their own characteristics or feelings into therapy. This aspect of psychodynamic therapy is summed up by the (often untrue) stereotype of the therapist who says nothing while the person lies on the couch and talks.

The third common principle in psychodynamic therapies is the importance of personal defences, which are the ways in which people avoid difficult or painful thoughts. There
are many different types of defences, including denial, repression, humour, rationalisation, escapism, and regression. Like coping strategies, defences are not necessarily maladaptive. For example, a person who has to have complicated surgery may well deny or repress thoughts of possible complications or a painful recovery, which will minimise the threat of surgery and reduce their anxiety beforehand. The defining features of psychodynamic therapy are given in Box 19.3. Case Study 19.2 illustrates the psychodynamic treatment of sexual dysfunction.

The emphasis on unconscious processes means psychodynamic theory is difficult to test scientifically and it has been criticised for this. However, advances in neuroscience and research using imaging, such as fMRI, have demonstrated that unconscious neural activity in the brain often pre-empts our voluntary action (Bonn, 2013). Because of various criticisms and the lack of consistent evidence, psychodynamic therapy is not as commonly recommended in guidelines for the treatment of mental health disorders as CBT. Proponents of the psychodynamic approach argue that this dismissal of psychoanalysis by treatment guidelines is premature and unjustified (Smith, 2007). Reviews of the research into the effectiveness of psychoanalysis for disorders such as personality disorders, anxiety, and depression have reached different conclusions. Some find that psychodynamic therapy is ineffective (Roth & Fonagy, 2004), but others conclude it is effective (Driessen et al., 2015; Leichsenring, 2005). However, this might reflect the variability of disorders and contexts in which it has been applied. Two notable reviews concluded that psychodynamic psychotherapy is effective. A Cochrane review of randomised controlled trials of short-term psychodynamic psychotherapy concluded that there is evidence for ‘modest to large gains’ for common disorders such as anxiety, depression, and interpersonal problems (Abbass et al., 2014). Another review and meta-analysis of the effect of psychodynamic therapy over time concluded that psychodynamic therapy is as effective as other types of psychotherapy for a range of outcomes (Kivlighan et al., 2015).

**BOX 19.3 Core features of psychodynamic therapy**

1. It is based on the assumption that we have a dynamic unconscious.
2. It is focused on the past, particularly early childhood experience and conflict, and on the suppression or psychological defences that have resulted.
3. The therapist remains neutral so transference can occur and the underlying issues can be explored.
4. The focus is on interpersonal relationships and how these are influenced by childhood experience, subsequent defences, projection, etc.
5. Maladaptive personal defences are explored.
6. It is an intensive therapy, typically comprising one or more sessions a week for at least a year.
CASE STUDY 19.2  Psychodynamic therapy for sexual dysfunction

Laura is 38 and suffers from dyspareunia (pain on intercourse) and an inability to have sexual intercourse. Dan suffers from dyspepsia (indigestion) and backache. His mother died when he was five.

Laura and Dan had a son who died of a hereditary brain disorder at 15 months. When he died Laura was pregnant and this baby also died of the same disorder when 10 months old. The following year Laura had an ectopic pregnancy and chose to be sterilised.

At the funeral of their first child Laura said she felt ‘numb’ and her family sent her shopping to distract her. Laura and Dan went on to foster and adopt two children. Their sexual dysfunction started after the death of their first child.

Psychodynamic therapy

Laura and Dan’s symptoms were interpreted as physical manifestations of the distress caused by the loss of their children and fertility. Their problems were therefore thought to be due to unresolved loss and bereavement. Dan and Laura were seen individually and as a couple by the same therapist for a year.

The therapist described Laura as ‘wooden and lifeless’ when discussing her experiences. This was interpreted as a defence mechanism where Laura was no longer in touch with her feelings but projected them onto others so that they felt distress. The fostering, adoption, and work with disabled children was her way of escaping from the pain of bereavement.

The therapist explored Dan’s relationship with his mother, who died when he was 5 years old. The therapist suggested his marriage was an attempt to replace the relationship he had with his mother. Dan therefore felt rivalry with his own children while they were alive because they took away Laura’s attention. When the babies died he felt responsible and guilty so reacted very negatively to Laura’s distress because it reminded him of this. Laura’s dyspareunia and inability to have intercourse may therefore have been an angry attempt at retribution because he did not allow her to grieve.

Following this insight the couple was able to have intercourse again. After Laura had an orgasm she broke down and said it was as if she was ‘crying from the deepest depths of herself’. She reported recovering mental images of her babies when they were dead, whereas previously she could only picture them alive. By the end of therapy Dan’s symptoms had disappeared and Laura’s dyspareunia was intermittent but tolerable. The couple was sexually active and reported that their marriage had improved greatly.

(Adapted from Lewis & Casement, 1986)
19.1.4 COUNSELLING

Counselling is an integrative approach that draws on various psychotherapeutic techniques so there is considerable variety, which makes counselling difficult to summarise. However, there are three core principles. The first is that it is client-focused. The needs of the client are put first and the aim of counselling is to increase or protect the person’s psychological well-being (Farsides, 2009).

The second principle is that counselling is non-directive and the emphasis is on the person exploring, clarifying, and solving their problems. The role of the counsellor is to facilitate this process (Bor & Allen, 2007). The third core principle is that counselling aims to provide a safe and accepting environment in which the person can explore and reflect on their difficulties. This is partly based on the principle of providing people with unconditional positive regard to facilitate self-acceptance and feelings of self-worth. For example, parents and society place expectations on us about performance, achievement, and what is seen as successful or worthwhile. This means many people might only feel worthwhile if they reach expectations and perform well in these areas. A counsellor might explore this with a person while at the same time accepting them regardless of their achievements or failures. This provides the person with an insight into their behaviour and feelings at the same time as allowing them to experience a relationship where they are liked and accepted for who they are.

Counselling tends to be used with mild or moderate anxiety and depression, or with people who are in difficult circumstances, or crises. Counselling is also increasingly used in healthcare settings to help people adjust and cope with difficult events, such as a diagnosis of HIV, coronary heart disease, a late miscarriage or stillbirth, or to help people make difficult decisions, such as during infertility treatment or genetic testing (Bor & Eriksen, 2018). For example, in the UK, counsellors are often employed in primary care settings so that doctors can refer people to them immediately, without having to refer to secondary care teams in hospitals or community mental health teams. The defining features of counselling are given in Box 19.4.

Currently, evidence for the efficacy of counselling is limited. This is partly because it is difficult to define a ‘standard’ approach to counselling so research has focused on evaluating more clearly outlined therapies like CBT. Research into counselling is often methodologically limited by factors such as counselling being poorly defined or not compared to other forms of therapy. However, where evidence is available it suggests that counselling is evaluated positively by participants and can improve some outcomes in the short term. For example, a review of counselling in primary care settings for psychological and psychosocial problems concluded that this was more effective than usual care in the
HeAl THCAre PrACTICe short term. However, over the long term counselling was no more effective than usual care (Bower et al., 2011). Similarly, a review of telephone counselling for carers of people with dementia concluded that it led to reduced symptoms of depression in carers but that the evidence for other outcomes was limited (Lins et al., 2014).

**BOX 19.4 Core features of counselling**

1. The therapist provides unconditional positive regard and accepts the person for who they are.
2. The therapist is non-judgemental and provides a safe space in which the person can work through their problems.
3. The needs of the client are primary.
4. The person explores their problems and solutions and the therapist facilitates this.
5. Sessions are directed toward the overall aim of improving a person’s psychological wellbeing.
6. An integrative or eclectic approach is taken toward therapeutic techniques. These are drawn from various psychotherapeutic approaches, such as CBT and psychodynamic therapy.
7. It is a short-term therapy, typically consisting of between six and 16 sessions.

**19.2 WHICH THERAPY IS BEST?**

The issue of whether one type of therapy is better than another is contentious. There is evidence to suggest that various different psychotherapies are effective treatments for depression and anxiety disorders. Richardson (2006) argues that ‘where one therapy appears to have an advantage over others in terms of empirical research this is usually because the others have failed to accumulate the relevant evidence’. It may be that different therapies are equally effective for some disorders and there is emerging evidence that this may be the case. For example, a review of 257 meta-analyses of the effect of psychotherapy on a range of outcomes showed that the majority (80%) reported a significant effect on outcomes. The authors concluded that the most convincing evidence for the efficacy of psychotherapy were for: CBT, meditation, cognitive remediation, counselling, and mixed psychotherapy (Dragioti et al., 2017). Similarly, a study of more than 5,600 people who had had CBT, person-centred therapy, or psychodynamic therapy found that all three therapies resulted in an improvement and were equally effective (Stiles et al., 2008).

This suggests that non-specific factors, such as the therapeutic relationship or placebo effect, may play an important role in the effectiveness of psychotherapy. The importance of a good relationship between the person and therapist is well established, and evidence shows that it leads to better outcomes, regardless of the type of psychotherapy (Department of Health, 2001). Whether therapy also works through a placebo effect is less widely considered, though Kirsch (2007) has suggested that this is the case because
Psychotherapy involves no active physiological substances and instead relies on a person’s expectations, experience of therapy, and beliefs about therapy to treat illness. So what can we conclude from this? There is little doubt that psychotherapy is effective in the treatment of mental health. Which type of psychotherapy is best is likely to vary for different psychological problems and individuals. Although the current guidelines favour CBT and third wave therapies, this position may change as the evidence accumulates for counselling and psychodynamic approaches. It would be nice to think that in the future psychotherapy will move away from a ‘winner takes all’ mentality where one type of therapy has to prove itself as being better than all the others and will integrate those approaches and techniques that are shown to be effective under different circumstances. This is already evident in counselling, which draws on techniques from many different approaches to therapy.

Summary

- There are many different types of psychotherapy.
- Therapies have developed from theories of psychoanalysis, humanism, behaviourism, and cognitivism.
- Dominant approaches to therapy at present are CBT, third wave cognitive therapies, psychodynamic therapy, and counselling.
- CBT is a structured, short-term therapy that focuses on the present problem and changes maladaptive beliefs and behaviour.
- Third wave cognitive therapies focus on the relationship people have with their thoughts and changing this through techniques such as mindfulness meditation, acceptance, and cognitive defusion.
- Psychodynamic therapy is an intensive, long-term therapy that focuses on a person’s early childhood experience, interpersonal relationships, and unconscious conflicts.
- Counselling is a short-term therapy that can consist of one approach to therapy, such as psychoanalysis, but is often more integrative or eclectic.
- There is some indication that different types of therapy may be equally effective for some disorders. This may be due to the importance of non-specific factors such as the therapeutic relationship or a placebo effect.

19.3 Psychological Interventions in Medical Settings

Psychological interventions in medical settings extend beyond psychotherapy. They do not purely aim to resolve mental health problems but also include any intervention to promote physical or mental health in medical settings. This includes health promotion, pain
management, self-management in chronic illnesses, crisis intervention, stress management, and support groups. Descriptions of some of these interventions are given in Table 19.2. Examples and case studies of these interventions can be found throughout the chapters in this book.

There is general support for the effectiveness of psychological interventions for promoting health and wellbeing, although this varies according to the type of intervention and target group. Interventions can be broadly grouped into:

- Those that aim to change health behaviours.
- Those that aim to help people cope with difficult or stressful circumstances.
- Those that target particular symptoms or illnesses, such as pain management.

### TABLE 19.2 Psychological interventions in medical settings

<table>
<thead>
<tr>
<th>Psychological intervention</th>
<th>Aims</th>
<th>What it consists of</th>
<th>Use</th>
<th>See example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Assess an individual's psychosocial needs</td>
<td>Interview and questionnaires to assess people's needs and mental state</td>
<td>For severe or chronic illnesses that require multidisciplinary management</td>
<td>Chapter 4</td>
</tr>
<tr>
<td>Pain management</td>
<td>Help people manage their pain to increase activity levels and wellbeing</td>
<td>Education about pain, CBT techniques such as monitoring activity and pain, setting goals, empowering people</td>
<td>For chronic pain of any kind, e.g. back pain, pelvic pain, arthritis, etc.</td>
<td></td>
</tr>
<tr>
<td>Motivational interviewing</td>
<td>Help people to change risky health behaviours</td>
<td>Exploring and understanding a person's current beliefs and behaviour, facilitating change through developing the discrepancy between a person's values and current behaviour, and building confidence that change is possible</td>
<td>For smoking, alcohol use, other drug addictions, eating disorders and depression</td>
<td>Chapter 2</td>
</tr>
<tr>
<td>Self-management</td>
<td>Help people manage their illness or recovery, including adherence to medication, rehabilitation and facilitating psychological wellbeing</td>
<td>Examining beliefs about illness, illness behaviour, and emotions, and facilitating change to promote good self-management of illness</td>
<td>For chronic illnesses, e.g. multiple sclerosis, diabetes, heart disease, asthma, irritable bowel syndrome, arthritis, etc.</td>
<td>Chapter 4</td>
</tr>
<tr>
<td>Psychological intervention</td>
<td>Aims</td>
<td>What it consists of</td>
<td>Use</td>
<td>See example</td>
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<tr>
<td>Health promotion</td>
<td>Promote health and positive health behaviours and reduce risky health behaviours</td>
<td>Education and promotion of health through information and interventions to reduce risky behaviours</td>
<td>With the normal population, e.g. people attending primary care, antenatal clinics, sexual health clinics, and smoking cessation</td>
<td>Chapter 5</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>Support people in times of crisis and help them adjust and cope</td>
<td>Supporting people to work through what has happened and encourage positive adjustment</td>
<td>After a diagnosis of a serious illness such as cancer, heart disease, multiple sclerosis, etc., and in palliative care</td>
<td>Chapters 6, 11 &amp; 12</td>
</tr>
<tr>
<td>Stress management</td>
<td>Help people to manage stress effectively</td>
<td>Education about stress: understanding and breaking down stress, appraisal processes and responses, and exploring more adaptive ways to cope</td>
<td>When stress may exacerbate conditions such as heart disease, premenstrual tension, and for healthcare professionals in high stress jobs</td>
<td>Chapter 3</td>
</tr>
<tr>
<td>Support groups</td>
<td>Encourage contact with, and support from, other people in similar circumstances</td>
<td>Small groups of people with similar problems, which are usually facilitated by a healthcare professional</td>
<td>With groups such as people with cancer, heart disease, or following stillbirth</td>
<td>Chapter 11</td>
</tr>
<tr>
<td>Bereavement counselling</td>
<td>Help people cope with and come to terms with their loss</td>
<td>Individual or couple counselling to help people mourn their loss and find ways to cope</td>
<td>For the loss or bereavement of a significant other, e.g. a stillbirth, relatives of people who are dying</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>Neuropsychological rehabilitation</td>
<td>Assess, treat and rehabilitate people with a brain injury to reduce disability and increase quality of life</td>
<td>Examination of cognitive, behavioural, emotional, and social function, and rehabilitation through various techniques, e.g. goal setting, skill training, and increasing awareness</td>
<td>Following brain injury or neurodegenerative diseases such as dementia</td>
<td>Chapter 16</td>
</tr>
</tbody>
</table>
19.3.1 INTERVENTIONS FOR CHANGING BEHAVIOUR

Interventions to change health behaviours include health education, health promotion, and motivational interviewing. Health promotion is a broad area, ranging from national advertising campaigns to group interventions with people who have a particular illness. Its effectiveness varies according to the method chosen and the people targeted. Providing blanket information to everyone is less effective than targeting information. Evidence has clearly shown that educational interventions are more effective if they are relevant to the people they target, are individualised, can provide feedback on people’s learning, facilitate change by explaining how people can take action, can help people to develop the required skills to change, and can reinforce the desired behaviour (Kok, 2007). This has informed health promotion and there are many advertising campaigns targeting specific groups, such as those in Figure 19.3.

Motivational interviewing is used to change risky behaviour and promote healthy behaviour. Motivational interviewing was developed as a treatment for substance misuse, where people often have positive and negative attitudes toward the problem behaviour. It is a form of directive counselling that helps patients to explore their reasons for a behaviour and their ambivalence toward a problem behaviour and to try to resolve it. Motivational interviewing is more focused and goal-directed than normal counselling, although the emphasis here is not on persuading someone to change but on helping them to develop their own motivation to change. This is done through (i) empathising with the situation the person is in, (ii) avoiding argumentation or persuasion, (iii) examining the discrepancy between what the person wants to do and what they are actually doing, (iv) examining resistance, and (v) bolstering the person’s self-efficacy (Miller, 1995). An example of motivational interviewing is given in Chapter 2 (see Case Study 2.2).

Evidence shows that motivational interviewing can be highly effective. A review of 72 clinical trials of using motivational interviewing across a wide range of behaviours showed it is very effective in the short term. In the long term, change was most likely when motivational interviewing was used in addition to a standard treatment (Hettema et al., 2005). It is therefore a useful approach for healthcare practitioners to use to help people change behaviours, such as substance abuse and non-adherence to treatments.

19.3.2 INTERVENTIONS FOR STRESSFUL OR DIFFICULT CIRCUMSTANCES

Interventions to help people cope with stressful or difficult circumstances include stress management, critical incident debriefing, crisis intervention, bereavement counselling, and support groups. Stress management has been used with occupational groups, patient groups, and health professionals. It is based on our understanding of the processes of stress and coping (see Chapter 3) and helps people identify the factors contributing to their
stress and to find more adaptive ways to cope. In healthcare settings, stress management has most often been provided for people with cancer or heart disease. In this context, stress management reduces anxiety, depression, perceived pain, and increases quality of life for people. However, it may have no effect on the course of illness or morbidity (Kenny, 2007).

Critical incident debriefing was initially developed to help emergency service workers cope with the traumatic events they attended, such as disasters, homicide, or road traffic accidents. Debriefing was carried out in groups and this approach was rapidly applied to a range of traumatic situations. However, evidence has shown that debriefing is not effective and in some cases can make people worse. As a result, many guidelines recommend against using it. Despite this, debriefing is still used in some settings in varying forms. For example, 78% of hospitals in the UK offer some form of midwife-led debriefing to women after difficult or traumatic birth experiences (Ayers et al., 2006). However, the content of midwife-led debriefing is different from critical incident debriefing so these services are usually referred to by other names, such as ‘birth afterthoughts’.

FIGURE 19.3  Targeted health promotion: anti-smoking campaign. © Nick Geoergiou
Debriefing shares some similarities with crisis intervention and bereavement intervention in that all of these try to ameliorate a situation rather than prevent it happening in the first place. Crisis intervention is used in situations where there has been threat of harm or violence, such as terrorist attacks, violent crime, domestic violence, or suicide attempts. It draws on a range of psychological theories and techniques to support people through a critical period (Roberts, 2005). Evidence for crisis intervention in medical settings suggests it reduces anxiety and PTSD, but is less effective for reducing depression (Stapleton et al., 2006). In addition, crisis intervention is more effective when it involves more than one session and is carried out by an experienced therapist (Stapleton et al., 2006).

Bereavement intervention is used following the death of a significant other, such as a spouse, parent, or child. Bereavement interventions vary according to which theoretical view is taken of bereavement. The psychodynamic view focuses on unresolved conflicts or issues with the deceased. Stage theories of bereavement emphasise the different stages a person needs to go through, such as numbness, yearning, despair, and recovery (Payne et al., 1999). Stress theories of bereavement emphasise the stress of bereavement and the loss of resources to cope. Support theories emphasise the loss of social support and the disruption of support networks.

A review of bereavement intervention considered the different theoretical viewpoints and whether these can account for the evidence that (i) men are more affected by the death of a spouse than women; and (ii) that how the person dies affects the nature of grief – for example, an unexpected death is likely to result in more severe grief than an expected death. The review concluded that these facts were best accounted for by stress or support theories of bereavement (Kato & Mann, 1999). However, this and other reviews of the evidence suggest that bereavement interventions as a whole may be limited in their impact. Although they improve short-term outcomes compared to no treatment, these differences are not observed in the longer term, which might be because grief tends to reduce naturally over time in those who have no treatment (Currier et al., 2008). There is also evidence that suggests bereavement interventions are only really effective for high-risk individuals – for example, in cases where the death was unexpected, where there was a high level of dependency in the relationship, or where the person had a history of psychological problems (Currier et al., 2008; Jordan & Neimeyer, 2003).
Psychotherapy techniques and clinical practice

• Recognise that individuals come to you with their own emotional baggage, core beliefs, past experience, and relationship history.
• Do not underestimate the effects of a good practitioner–patient relationship and placebo.
• Give people unconditional positive regard to improve the practitioner–patient relationship and the person’s psychological wellbeing.
• Be on the person’s side, understand their experience, and work with them to encourage change.
• Remember that helping people to ‘face their fear’ is essentially a form of exposure and so can be an effective treatment for anxiety.
• Help people to distance themselves from negative thoughts – e.g. to accept the thoughts and think of them as a wave that will just wash over them and recede.

19.3.3 INTERVENTIONS FOR SPECIFIC ILLNESSES OR SYMPTOMS

Interventions targeted at specific illnesses or symptoms are wide-ranging and include self-management interventions, support groups for people with particular problems or illnesses, pain management, and neuropsychological rehabilitation.

Self-management interventions draw on the theories outlined in Chapters 4 and 5 to help people manage their illness or rehabilitation effectively, with the aim of improving their psychological and physical wellbeing. Specific self-management interventions have been designed for many illnesses, such as arthritis, asthma, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), headache, and back pain (Mulligan & Newman, 2018). Generic self-management programmes for chronic disease have also been developed (Lorig et al., 2001). Most self-management programmes involve five core components to increase people’s skills at managing their illness. These are: problem solving, decision making, how to find and use resources, forming partnerships with healthcare professionals, and taking action (Lorig & Holman, 2003).

Evidence shows self-management interventions are effective in the short term and can improve health behaviours and the management of an illness, such as adherence to medication. Self-management interventions can also lead to improved physical and emotional wellbeing. For example, a review of 969 randomised controlled trials of self-management interventions for different conditions found strong evidence that self-management interventions for diabetes improve blood glucose control; self-management interventions for rheumatoid arthritis lead to improved disability and psychological wellbeing; and self-management interventions for asthma reduce hospital admissions and emergency healthcare
services (Taylor et al., 2014). However, these effects are not always maintained over the long term (Mulligan & Newman, 2018).

Support group interventions are based on substantial evidence that social support is associated with better health and wellbeing and that, conversely, social isolation is a risk for many illnesses. Support interventions usually consist of a group of up to 12 people with similar problems or circumstances who meet eight to ten times. Groups can be facilitated by a health professional or be patient-led. Support groups aim to increase the support available to people, increase education and the sharing of knowledge about relevant circumstances, and increase the sharing and modelling of positive coping strategies.

The popularity of support groups in medical settings was boosted by a study that showed that women with breast cancer who attended a support group lived on average 18 months longer than those who did not attend a support group (Spiegel et al., 1989). Since then the evidence has been less consistent: although support groups usually improve psychological wellbeing and quality of life, they do not have a consistent impact on morbidity or mortality (Gottlieb, 2007). It is possible this is because they work better for some people than others. For example, if a person has a poor social network and does not express their emotions or cope particularly well, then a support group can be very helpful by increasing their social network, helping them talk about their feelings, and letting them see other group members modelling better ways of coping. Conversely, a person with many close friends and family members supporting them may not benefit from a support group.

There are many other interventions for specific illnesses. Evidence shows that pain management programmes based on CBT can lead to short-term reductions in pain, disability, negative mood, and catastrophising compared to usual treatment (Williams et al., 2012; see also Chapter 4). Neuropsychological rehabilitation uses a wide range of psychological theory to treat and rehabilitate people with neuropsychological problems, such as brain injury (see Chapter 16). Families are usually highly involved in this process. Technologies, such as computer programs, virtual reality training, electronic reminders, and memory aids, are rapidly being developed to help people adapt and function in the community (Wilson, 2007). Research into the effectiveness of neuropsychological rehabilitation has focused on specific techniques. For example, there is evidence that memory rehabilitation and specific attention skills training can be effective, but that general attention training is not (Rohling et al., 2009).

Summary

- Psychological interventions in medical settings include health promotion, interventions for stressful or difficult circumstances, and interventions for specific illnesses or groups of people.
- These interventions are wide-ranging and draw on a range of psychological theories and techniques.

(Continued)
19.4 TECHNOLOGY AND PSYCHOLOGICAL INTERVENTION

The cost and limited availability of psychological services in many countries means there is increasing use of technology to support or deliver psychological interventions. The advantages to this are that treatment is accessible, convenient, and can be provided over a wide geographical area. People sometimes refer to the three ‘A’s of the internet: availability, accessibility, and affordability. Online interventions may also provide a fourth ‘A’, anonymity, which can reduce barriers to accessing treatment, such as the stigma associated with various illnesses.

Tailored psychological interventions are increasingly accessible through the web, smartphones, and tablets. Online resources are available to treat illnesses, such as computerised therapy for anxiety and depression. Technology can also be used to facilitate support groups through online forums, email discussion groups, and social media. People generally rate online groups positively but there is a lack of high-quality evidence for the effectiveness of online groups (Griffiths et al., 2009). Technology-assisted programs are also available to assist people in lifestyle change or therapy, such as exercise trackers, mood trackers, and meditation apps.

Technology-mediated psychotherapy programmes are usually self-directed, where people work through a series of modules in their own time. Some are supported by a healthcare professional who oversees people’s progress via telephone, email, or messaging. Programmes are available for a range of common psychological problems, such as insomnia, stress, depression, anxiety, phobias, etc. (see Clinical notes 19.2). Most are based on CBT or third wave cognitive therapy techniques, which are relatively easily adapted for this medium. There is now substantial evidence that online and computerised programs can be an effective treatment for less severe affective disorders. Reviews and meta-analyses show that web-based treatments for stress, depression, and anxiety disorders are more effective than no treatment or placebo controls, and in some cases are as effective as face-to-face psychotherapy treatment (Andrews et al., 2010; Heber et al., 2017; Mayo-Wilson & Montgomery, 2013; Olthuis et al., 2016).
For example, *Beating the Blues* is a therapy programme developed for moderate depression. It has been used in primary care settings and is also available online. The programme involves individuals watching an introductory videotape and then carrying out eight sessions of one hour each with homework between each session. At the end of each session a printed summary of the session is provided for the person and can be shared with the healthcare professional supporting the programme. People can then meet with their healthcare professional to check on their progress and medication if this is needed. Evidence suggests that this programme is more effective than GP treatment alone at reducing moderate anxiety and depression, facilitating social adjustment and a return to work (Proudfoot et al., 2003, 2004).

The advantages and potential efficacy of programmes delivered through technology means this is a rapidly expanding area. However, not all programmes have evidence of efficacy from methodologically rigorous trials (Ashford et al., 2016). Web-based interventions have also been developed to help people manage long-term physical health conditions such as diabetes (Hofmann et al., 2016), and to encourage more healthy behaviours. However, programmes available via the web vary in quality and content. It is clear from reviews that some web-based programmes are more effective than others, and that not all of them are founded on validated theories of psychological disorder or behaviour change (Murray, 2012). Similarly, there are huge numbers of health apps available, but many of them do not have a theoretical basis or evidence of efficacy. Apps that do have a theoretical basis, such as self-monitoring for behaviour change, have been positively evaluated but the evidence is currently limited to feasibility and pilot studies (Payne et al., 2015). It is therefore important that people are directed to programmes with some evidence of effectiveness.

More recent developments include the use of games and virtual reality to monitor or improve health. Games such as *Wii Fit* promote physical activity and have been used as a part of neuropsychological rehabilitation, e.g. with people who have had a stroke as part of rehabilitation to regain mobility. Although improvements are similar to those observed after conventional rehabilitation, people were less likely to drop out from the *Wii Fit* programme (Cheok et al., 2015). Games have also been developed for specific health issues. These can be to help patients, such as *Bobby got a Burn*, which prepares children for standard medical procedures, or *iSpectrum*, which aims to improve social interaction skills in people with autism or Asperger’s syndrome. Games have also been developed to help healthcare students. A scoping review in 2014 identified a wide range of games to help students learn procedures in surgery, radiology, dentistry, nursing, cardiology, dietitians, and first aid (Ricciardi & Tommaso de Paolis, 2014).

Virtual reality programs enable various situations to be simulated and therefore have potential applications in psychological interventions such as neuropsychological rehabilitation and psychotherapy for anxiety disorders. Virtual reality has been used in rehabilitation for conditions such as Parkinson’s (Dockx et al., 2016), stroke (Laver et al., 2015), brain injury (Shin & Kim, 2015) and cerebral palsy (Ravi et al., 2016), with some evidence that it is a promising method in terms of increasing mobility and motor skills. Virtual reality programs are also used as part of exposure treatment for anxiety disorders. As mentioned earlier, an effective behavioural treatment for fears and phobias is to expose people to the
feared object until their anxiety reduces. Obviously, being exposed to fearful situations can be very challenging for people, so virtual reality is a useful medium through which to ‘expose’ someone to their feared object or situation but where the person knows it is not real. Virtual exposure has been used as part of treatment for a range of problems, including fear of flying, dental phobia, spider phobia, social anxiety, and PTSD. Several reviews show that virtual reality exposure is an acceptable and effective treatment for phobias and anxiety disorders (Botella et al., 2015). For example, a review of 14 randomised controlled trials of virtual reality exposure for phobias found it resulted in improved outcomes and that improvements are similar to those observed after real-life exposure (Morina et al., 2015).

**CONCLUSION**

In this chapter we have looked at different types of psychotherapy and the theories underlying them. First we looked at cognitive behaviour therapy and third wave therapies such as mindfulness, ACT and DBT. Then we looked at different approaches of psychodynamic therapy and counselling. There is now extensive evidence that psychotherapy is more effective than no treatment for common affective disorders. However, at this stage there is little conclusive evidence that one therapy is more effective than another. Nonspecific factors, such as the relationship between the therapist and client, are likely to be important in the efficacy of psychotherapy. In the future psychotherapies may therefore move away from focusing on one particular approach to using techniques that are shown to be effective under different circumstances.

Psychological interventions in medical settings draw on psychotherapy and health behaviour change techniques to promote physical and mental health. These interventions may aim to (i) reduce negative health behaviours, such as health promotion and motivational interviewing; (ii) help people cope with stressful circumstances, such as stress management, debriefing, crisis intervention and bereavement interventions; or
(iii) target specific illnesses or symptoms, such as pain, self-management of chronic illnesses, or neurological rehabilitation. The evidence for the effectiveness of such interventions is mixed – probably due to the wide range of interventions and target populations. For example, there is good evidence that motivational interviewing and self-management programmes are effective, but little evidence bereavement interventions are effective unless targeted at high-risk individuals.

Technology is increasingly used to deliver computerised or app-based psychotherapy. These are usually based on CBT and third wave cognitive therapy techniques, which lend themselves well to self-directed psychotherapy. There is substantial evidence computerised psychotherapy is effective for less severe affective disorders, such as depression and anxiety. Recent developments also include use of games and virtual reality to improve psychological and physical health in specific groups, such as people with phobias or neurological disorders.

**FURTHER READING**


**REVISION QUESTIONS**

1. Describe third wave cognitive therapies and illustrate this with an example.

2. Describe the core features of cognitive behaviour therapy (CBT).
3. Outline the cognitive theory of depression and discuss the role of the depressogenic triad of negative beliefs.

4. Briefly compare and contrast behavioural and cognitive techniques for treating psychological problems.

5. What is a formulation and what is its role in psychotherapy?

6. Briefly outline the three core principles of psychodynamic therapy.

7. Describe the five core features of counselling.

8. Outline three psychological interventions used in medical settings and discuss whether these are effective.

9. What is unconditional positive regard and from which theory or theories does it originate?

10. Outline three psychological specialties and discuss their potential application to healthcare.