Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoomgov.com/j/1606358142
- **Phone:** 669-254-5252
- Enter the Webinar ID: 160 635 8142#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- Download or view the presentation materials. The evaluation survey opens at 11:59 a.m. the day of the presentation.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat to communicate with the WPPNT coordinator or to share information related to the presentation.

- Participate live to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2023.htm

Dynamic Supportive Psychotherapy:

Strategies and Techniques for Clinical Practice

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History of Psychotherapy

"Talking cure"

Freud & Psychoanalysis:

Free association, Transference, Insight

Problems with psychoanalysis

Evolution of Supportive Psychotherapy

Franz Alexander

Flexibility of the Therapist

Address ”real life” problems

Regulating the transference

Direct interviews

Process (comfort) vs Insight

The Corrective Emotional Experience

Supportive Psychotherapy Research:

Sexy, **innovative**, *exciting* psychotherapy

vs. Supportive psychotherapy (”treatment as usual”)

Bias in psychotherapy research

Treatment of Acute Stress Disorder: A Comparison of Cognitive - Behavioral Therapy and Supportive Counseling
Bryant, RA, et al. Journal of Clinical and Consulting psychology, 1998: Vol 6 (5); 862-866.

<u>Cognitive-behavioral group:</u>
Trauma education
Muscle relaxation techniques
Imaginal exposure to trauma
Cognitive restructuring
In vivo exposure to avoidance

<u>Supportive counseling group:</u>
Non-specific trauma education
Non-specific problem solving skills
"Unconditional support"
No talking about specific trauma

Menninger Psychotherapy Research Project*

Followed 42 patients in psychotherapy for 23 years

Psychoanalysis

vs.

Psychoanalytic therapy

vs.

Control (supportive psychotherapy)

*Wallerstein, RS. Forty-two lives in treatment: a study of psychoanalysis and psychotherapy. NY: Guilford Press 1986

*Wallerstein, RS. Psychoanalysis and psychotherapy: An historical perspective. Inter J Psychoanalysis 1989; 70: 563 –91.

Menninger Psychotherapy Research Project

- No differences between therapies
- Supportive elements were present in all therapies
- Defining change as “structural vs behavioral” not a useful concept

Wallerstein, RS. Psychoanalysis and psychotherapy: An historical perspective. Inter J Psychoanalysis 1989; 70: 563 –91.

McIntosh VW, et al. Three psychotherapies for anorexia nervosa: A randomized, controlled trial. American Journal of Psychiatry 2005; 162: 741 – 747.

Cognitive Behavioral	Interpersonal Therapy	Nonspecific Support
Psychoeducation	Life events	Education
CB skills training	Relationships	Care
Motivation training	Eating problems	Support
Homework	Grief	Praise
Thought restructuring	Interpersonal disputes	Reassurance
Relapse prevention	Interpersonal deficits	Advice
Recovery strategy	Role transitions	
	Depression links	

"*Contrary to our hypotheses, the patients who received nonspecific supportive clinical management had an outcome as good or better than the outcomes of those who received specialized psychotherapies…"*

"A key feature of nonspecific supportive clinical management may be the important nonspecific factors of psychotherapy: the ***therapeutic alliance, empathy, positive regard, and support*** *for a patient group greatly in need of these"*

McIntosh VW, et al. Three psychotherapies for anorexia nervosa: A randomized, controlled trial. American Journal of Psychiatry 2005; 162: 741 – 747. (page 745, 746)

Supportive Psychotherapy: Research Summary

Even when used as a “comparison group” or “treatment as usual in the community”, supportive psychotherapy often performs just as well as the treatment under study.

Supportive Psychotherapy: Efficacy

- Schizophrenia
- Bipolar Disorder/Depression
- PTSD
- Anxiety Disorders
- Personality Disorders
- Substance abuse/alcoholism
- Medical: breast cancer, back pain, ovarian cancer, diabetes, leukemia, heart disease, chronic bronchitis, emphysema, inflammatory bowel disease, and for hemodialysis patients

Freud: Psychodynamics and defense mechanisms

Denial
Splitting
Projection
Regression
Acting-out
Dissociation

Reaction Formation
Introjection
Conversion
Displacement
Idealization

Intellectualization
Rationalization
Sublimation
Fantasy
Humor

Repetition Compulsion: The propensity to repeat early life experiences, for good or ill

Psychodynamic formulation:

- What do they feel, act, and think now?
- What is their past, and how tied to their current life?
- What is the nature of their relationships?
- Biological, psychological, social, cultural elements
- Constantly evolving, not a fixed formula
- The patient as a character in a novel

Therapeutic Alliance

Therapeutic alliance is the collaborative, working relationship between patient and therapist toward common goals.

There is a positive correlation with therapeutic alliance and outcome of psychotherapy for all types of therapy.

Therapeutic alliance and outcome of psychotherapy. Ardito RB, Rabellino D. Frontiers in Psychology 2011 October, Volume 2 (270); 1 - 11

Therapeutic Alliance Predicts Symptomatic Improvement Session by Session. Linkoping F, Granstrom F, Homqvist R. Journal of Counseling Psychology 2013, Vol 60 (3), 317 - 328

Therapeutic Alliance: meta-analysis 1978-2017

"These results confirm the robustness of the positive relation between the alliance and outcome. This relation remains consistent across assessor perspectives, alliance and outcome measures, treatment approaches, patient characteristics, and countries."

The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis.
Flückiger C, Del Re AC, Wampold BE, Horvath AO
Psychotherapy 2018, Vol. 55, No. 4, 316–340

Therapeutic Alliance: Therapist attributes

Empathy- ability to understand why a person feels, thinks and acts the way they do

Flexibility- meeting the patient where they are at

Nurturance- ability to be nurturant

Behavior of the therapist:

- The therapeutic environment (office)
- Be yourself!
- “Friendly” not “friends”
- Time spent in positive therapeutic alliance = “money in the bank”
- Turbulence in therapeutic alliance = opportunity for corrective emotional experience

Behavior of the therapist: Taking care of the patient

- How well do they handle strong emotions?
- Do they compensate well after intense sessions?
- Do they tend to “act-out”?
- What is their history of coping?
- Do they have healthy ways to cope?
- Do they abuse substances (alcohol, drugs) to cope?
- Do they have tendencies to harm self or others when distressed?

Behavior of the therapist:

- How much to “open up” vs how much to “cover up”?
- Methods to “cover up” and coping skills
- Methods to “open up”
- Pacing and time management in session!
- The “nudge”
- Therapist as ringmaster

Behavior of the therapist: Therapist disclosure

- Therapist disclosure:
  - Is the patient seeking the information, or is it therapist driven?
  - Is giving the information for the benefit of patient or therapist?
- Simple disclosure: training experience, degrees, expertise
- Moderate disclosure: spirituality, marital status, children
- Intimate disclosure: sexuality, prior mental illness, trauma

Behavior of the therapist: Relationship boundaries

- Overlapping roles: no personal gain, financial or sexual relationship should exist outside of the therapy.
- Friendship?
- Romantic relationship - never

Behavior of the therapist: importance of self-acceptance

Hendin H, Haas AP, Maltsberger JT, Szanto K, Rabinowicz H
Factors contributing to therapists' distress after the suicide of a patient
American Journal of Psychiatry 2004; 161: 1442 – 1446

"The less distressed therapists, compared to those who were severely distressed, had a greater capacity to view their misfortunes as learning opportunities rather than as occasions for self-reproach"

Behavior of the therapist: therapist health

- Mental health of therapist correlated with therapy effectiveness
- Boundary techniques during work day and when “on-call”
- Compassion fatigue
- ***Supervision !!!***
- Psychotherapy (self-discovery)
- Humor*

Transference and Countertransference:

- Transference (Freud): Unconscious feelings of the patient, based on past genetic relationships, that get projected onto the therapist
- Countertransference (Freud): Unconscious feelings of the therapist, based on past genetic relationships, that get projected onto the patient
- Broader definition: Any feeling, unconscious or conscious, that is identifiable to both patient and therapist

  (toward each other)

Countertransference stages:

Stage 1. Denial

Stage 2. Reluctant acceptance

Stage 3. Acceptance

Stage 4. Embracement

Countertransference: "Red Flags"

- Believing that your relationship with the patient is "special", and not subject to the usual rules of professional conduct. This can also include believing "I am the only one" who can help the patient.
- Doing something with the patient outside of the normal therapeutic activity (something that you do not do with any other patient). For example, walking them to their car, becoming friends on social network, or giving them your personal phone number.
- Dreaming about the patient, especially if this occurs more than once.
- Daydreaming excessively while in the therapy session, being mentally "outside of the room" for extended periods of time.

Countertransference: "Red Flags"

- Dreading seeing the patient's name on your schedule or hoping for their cancellation. Alternatively, looking forward to the session, especially to tell the patient something about your life.
- Having intense feelings about the patient or therapy session that stay with you well beyond the therapy hour. This can include having frequent fantasies about the patient.
- Keeping something from the therapy secret or hidden from psychotherapy supervision.
- Initiating contact with the patient outside of customary procedures.

Trauma changes a person

Trauma outcome:

The nature of the person + the nature of the stressor

Working with trauma:

- Assume the symptoms make sense (are not “crazy”)
- Symptoms provide safety in some way
- Symptoms were adaptive at one time
- Symptoms prepare the person to withstand further trauma
- Education about PTSD (including flashbacks and “ripple” effects)

Supportive Psychotherapy for PTSD

- Good therapeutic alliance (correlated with successful PTSD treatment)
- Safety and coping measures
- ”Grounding” techniques
- Problem solving techniques
- “After hours” techniques for grounding, social support, medications

Supportive Psychotherapy for PTSD

- Discussing the trauma (or not)
- Pacing
- EMDR* (Eye-Movement Desensitization and Reprocessing)

*Shapiro, F. Eye Movement desensitization: A new treatment for post-traumatic stress disorder. Journal of Behavior Therapy and Experimental Psychiatry. 1989: 10 (3); 211 – 217

Termination

- What is premature termination?
- Does psychotherapy need an ending?
- How much time to allow for termination?
- Is it okay for therapist and patient to stay in touch?