I.S. Popenya

MEDICAL PSYCHOLOGY

Course of lectures for foreign students

И.С. Попеня

МЕДИЦИНСКАЯ ПСИХОЛОГИЯ

Курс лекций для иностранных студентов

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ

УЧРЕЖДЕНИЕ ОБРАЗОВАНИЯ

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В данном пособии изложены общие вопросы медицинской психологии, отражены основные психологические теории возникновения психических и поведенческих расстройств, рассмотрены психологические аспекты лечебного процесса, копинга с хроническими заболеваниями, приводится описание депрессивных и тревожных расстройств, основы психосоматики. Англоязычное пособие позволит облегчить изучение медицинской психологии студентам, проходящим обучение на английском языке. Изложенный материал соответствует тематическому плану лекций по дисциплине «Медицинская психология» для лечебного факультета.

Пособие предназначено для студентов факультета иностранных учащихся.

Ответственный за выпуск: первый проректор, доцент В.В. Воробьев

CONTENT:

Lecture 1
Introducing Medical Psychology. Psychological Models of Mental Disorders

Clinical psychology includes the scientific study and application of psychology for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction and to promote subjective well-being and personal development. Central to its practice are psychological assessment and psychotherapy, although clinical psychologists also engage in research, teaching, consultation. In many countries it is a regulated mental health profession.

The field is often considered to have begun in **1896** with the opening of the first psychological clinic at the University of Pennsylvania by **Lightner Witmer**. In the first half of the 20th century clinical psychology was focused on psychological assessment, with little attention given to treatment. This changed after the 1940s when World War II resulted in the need for a large increase in the number of trained clinicians. Clinical psychologists are now considered experts in providing psychotherapy, and generally train within four primary theoretical orientations— ***Psychodynamic, Humanistic, Cognitive Behavioral, and Systems or Family therapy.***

Clinical psychology may be confused with psychiatry, which generally has similar goals (e.g. the alleviation of mental distress), but psychiatry makes accent on the biological aspects of mental disorder, medical psychology – on psychological factors. As such, psychiatrists tend to focus on medication-based solutions, although some of them also provide psychotherapeutic services as well. In practice, clinical psychologists often work in multidisciplinary teams with other professionals such as psychiatrists, occupational therapists, and social workers to bring a multimodal approach to complex patient problems.

1. Assessment

An important area of expertise for many clinical psychologists is psychological assessment, and there are indications that as many as 91% of psychologists use in this core clinical practice. Such evaluation is usually done in service to gaining insight into and forming hypotheses about psychological or behavioral problems. As such, the results of such assessments are usually used to create generalized impressions (rather than diagnoses) in service to informing treatment planning. Methods include formal testing measures, interviews, reviewing past records, clinical observation, and physical examination.

There exist literally hundreds of various assessment tools, although only a few have been shown to have both high validity (i.e., test actually measures what it claims to measure) and reliability (i.e., consistency). These measures generally fall within one of several categories, including the following:

Intelligence & achievement tests. These tests are designed to measure certain specific kinds of cognitive functioning (often referred to as IQ) in comparison to a norming-group. These tests attempt to measure such traits as general knowledge, verbal skill, memory, attention, logical reasoning, and visual/spacial perception.

Personality tests. Tests of personality aim to describe patterns of behavior, thoughts, and feelings. They generally fall within two categories: objective and projective. Objective measures, such as the MMPI, are based on restricted answers—such as yes/no, true/false, or a rating scale—which allow for computation of scores that can be compared to a normative group. Projective tests, such as the Rorschach inkblot test, allow for open-ended answers, often based on ambiguous stimuli, presumably revealing non-conscious psychological dynamics.

Neuropsychological tests. Neuropsychological tests consist of specifically designed tasks used to measure psychological functions known to be linked to a particular brain structure or pathway. They are typically used to assess impairment after an injury or illness known to affect neurocognitive functioning, or when used in research, to contrast neuropsychological abilities across experimental groups.

Clinical observation. Clinical psychologists are also trained to gather data by observing behavior. The clinical interview is a vital part of assessment, even when using other formalized tools, which can employ either a structured or unstructured format. Such assessment looks at certain areas, such as general appearance and behavior, mood and affect, perception, comprehension orientation, insight, memory, and content of communication. One psychiatric example of a formal interview is the mental status examination, which is often used in psychiatry as a screening tool for treatment or further testing.

1.1. Diagnostic impressions

After assessment, clinical psychologists often provide a diagnostic impression. Many countries use the ***International Statistical Classification of Diseases and Related Health Problems (ICD-10)***, while the U.S. uses the ***Diagnostic and Statistical Manual of Mental Disorders (the DSM version IV-TR)***. Both assume medical concepts and terms, and state that there are categorical disorders that can be diagnosed by set lists of descriptive criteria. Most American HMO and insurance companies require a diagnosis from the DSM before they will approve payment for treatment.

The DSM uses a categorical medical model and views psychological problems in terms of discrete illnesses that can be defined by a minimum set of criteria—such as self-reported symptoms, intensity, behaviors, duration, onset, et cetera. There is a growing understanding that this model is not the only way to understand or describe psychological problems. As such, there is a debate in the field regarding alternative methods of diagnosing psychological problems.

British clinical psychologists do not tend to diagnose, but rather use formulation—an individualized map of the difficulties that the patient or client faces, encompassing predisposing, precipitating and maintaining factors.

2. Clinical theories and models of mental disorders and abnormal behavior
2.1. Biological model

The biological model of abnormal behaviour is also referred to as the organic model, the traditional medical model, or the disease model. In this model it is assumed that the various abnormal behaviours that people with a particular syndrome display are symptoms of a specific disease with a discrete cause, a unique course and prognosis, and for which a specific physical treatment will ultimately be identified. This model evolved within a medical tradition where there were numerous examples of physical conditions involving a syndrome of signs and symptoms that could be explained by a discrete cause, such as an infection or metabolic dysfunction. Syphilis is a good example of a condition where a discrete physical cause (syphilitic infection) causes a psychological syndrome (general paresis of the insane) and can be treated by specific physical methods (inoculation). In 1897 Richard von Krafft-Ebing (1840–1902), a German neurologist, following the work of Louis Pasteur (1822–1895), inoculated patients with general paresis. The success of this work gave force to the biological model of psychiatry. Not surprisingly, the biological model has been championed by psychiatry more than other mental health professions.

The diathesis-stress model is typical variant of the biological model. In this type of model it is assumed that psychiatric illnesses or psychological problems take place when people who are biologically open to such difficulties are exposed to particular stresses.

2.2. Biopsychosocial model

The biopsychosocial model is a general model or approach that posits that biological, psychological (thoughts, emotions, and behaviors), and social factors (abbreviated "BPS") all play a significant role in human functioning in the context of disease or illness. This is in contrast to the traditional, reductionist biomedical model of medicine that suggests every disease process can be explained in terms of an underlying deviation from normal function such as a pathogen, genetic or developmental abnormality, or injury. The concept is used in fields such as medicine, health psychology and sociology, and particularly in more specialist fields such as psychiatry, health psychology and clinical psychology. The biopsychosocial paradigm is also a technical term for the popular concept of the mind-body connection, which addresses more philosophical arguments between the biopsychosocial and biomedical models, rather than their empirical exploration and clinical application.

The "model" was theorised by psychiatrist George L. Engel. But no single definitive, irreducible model has been published. However, the general BPS model has guided formulation and testing of models within each professional field.

The biopsychosocial model of health is based on social-cognitive theory. The biopsychosocial model implies treatment of disease processes (e.g., type 2 diabetes, cancer, etc.) requires that the health care team address biological, psychological and social influences upon a patient's functioning. In a philosophical sense, the biopsychosocial model states that the workings of the body can affect the mind, and the workings of the mind can affect the body. This means both a direct interaction between mind and body as well as indirect effects through intermediate factors.

There are also theories that the state of mind directly affects the immune system, and there are many carefully-planned studies that show this to be the case (psychoneuroimmunology). Psychosocial factors can cause a biological effect by predisposing the patient to risk factors. An example is that depression by itself may not cause liver problems, but a depressed person may be more likely to have alcohol problems, thus liver damage. Perhaps it is this increased risk-taking that leads to an increased possibility of disease. Most of the diseases referred to in BPS discussion tend to be such behaviourally-moderated illnesses which have known high risk factors, or so-called "biopsychosocial illnesses/disorders". An example of this is type 2 diabetes, which with the growing frequency of fatness and physical inactivity, is on course to become a worldwide pandemic (e.g., approximately 20 million Americans are estimated to have diabetes, with 90% to 95% considered type 2).

It is important to note that the biopsychosocial model does not give a simple, testable model to explain the interactions or causal influences by each of the components (biological, psychological, or social). Rather, the model has been a general structure to direct theoretical and empirical exploration, which has a great deal of research since Engel's 1977 article. One of the areas that has been greatly influenced is the formulation and testing of social-cognitive models of health behavior over the past 30 years. While no single model has taken priority, a large body of empirical literature has identified social-cognitive variables that appear to influence in healthy behaviors and adhere to prescribed medical regimens, such as self-effectiveness, in chronic diseases such as type 2 diabetes, cardiovascular disease, etc.

2.3. Psychoanalytic model
2.3.1. Assumptions

The psychoanalytic or psychodynamic model assumes that abnormal behaviour patterns are symptoms of underlying unconscious conflict or psychopathology. As a child develops, according to classical psychoanalytic theory, primitive sexual and aggressive drives of the unconscious **'id'** become gradually controlled by the rational **'ego'**. The ego is guided by an internalization of society's standards: the **'superego'**. However, intrapsychic conflict is unavoidable. Conflict occurs between the *sexual* and *aggressive* impulses of the id and societal standards as reflected in the superego. Such conflict is managed unconsciously by using various defence mechanisms, the function of which is to keep the not allowed sexual and aggressive impulses from consciousness. For example, a man who is angry at his boss at work may sing praises to him, thus using the defence of reaction formation. However, *defences are compromises between the forces of the id and superego* and often carry costly side-effects. For example, the man who is angry at his boss may finally develop chest pains and anxiety, as a result of repressing rather than acknowledging the anger felt towards the superior. In addition, the psychoanalytic model argues that relationship styles learned early in life are transferred in later life to other relationships, notably relationships with authority figures, sexual partners and psychotherapists. These relationship styles or **'transference phenomena'** as they are called in psychoanalysis

are coloured in part by feelings aroused and partly resolved during the *Oedipus complex phase (for boys) or Electra complex phase (for girls)*. These developmental phases refer to the psychoanalytic hypothesis that children in early life desire their opposite-sex parent and feel aggression towards the parent of their own gender. However, these sexual and aggressive impulses are repressed and the child finally identifies with the parent of the same gender for fear of the consequences of acting them out. In later life, patients, such as the man with chest pains referred to earlier, experience feelings towards significant others and deal with them in a manner similar to that which occurred during the oedipal phase of development. So the man with chest pains experienced aggression towards his boss, and later towards his psychotherapist in a similar fashion, and with this using reaction formation in a manner similar to that with which he handled the oedipal triangle as a child. Psychoanalysis and psychoanalytic psychotherapy provide a context within which patients can experience transference towards a psychotherapist and then through interpretation gain insight into the transference and related defences which cause their psychopathology. The analyst or therapist and client meet often according to a strict schedule. The patient reports in an uncensored way his or her contents of consciousness. Eventually the client develops transference and the analyst interprets this repeatedly over time until the patient has gained insight into the transference and related defences and worked through related unresolved feelings. At the same time the patient's symptoms decrease. In order to be able to practice psychoanalysis, therapists must undergo their own analysis so that they have a first-hand understanding of the process, and so that they will recognize transference feelings that they have towards patients (countertransference). Traditionally strict selection criteria are used for psychoanalysis and typically YAVIS (young, adult, verbal, intelligent and single) patients only have been deemed suitable. However, this has changed in recent years with developments like object relations approaches to conditions such as borderline personality disorder.

2.3.2. Achievements

The most outstanding achievement of the psychoanalytic model is the discovery of the unconscious. Freud drew together a set of ideas from a wide range of sources and crystallized them in the idea of the unconscious, not as a passive repository of irretrievable memories but as an active set of psychological processes. According to the psychoanalytic model of the unconscious, people can make themselves forget things or keep them outside understanding.

Second, psychoanalysis gave sense to apparently meaningless behavior. For example, Freud showed how, in phobias, fears of one stimulus (e.g. one's father) could be displaced onto other stimuli (e.g. horses). He also showed how unconscious processes which explained psychological disorders could also explain strange everyday behavior.

Third, psychoanalysis introduced the ideas of transference and countertransference into the practice of psychotherapy. This idea that people have a limited number of relationship-maps, which they learn early in life and transfer onto

significant others in adulthood, has been supported by recent empirical work on continuity in patterns of attachment from childhood to adulthood.

Fourth, psychoanalysis established the place of the 'talking cure' in ordinary mental health practice. It also provided a model of the development of private long-term treatment of patients with psychological difficulties.

Finally, Freud provided a model for developing a theory of personality and therapy which spawned a wide range of neo-Freudian derivatives including those of - *Jung, Adler, Horney, Stack-Sullivan, Reich, Fairburn, Klein, Erikson* and many others.

2.4. Cognitive-behavioral model
2.4.1. Assumptions

The cognitive behavioral tradition incorporates a range of psychotherapeutic theories and practices, *including behavior therapy, behavior modification, cognitive therapy and cognitive-behavior therapy*, all of which have their roots in learning theories. Within the cognitive behavioral tradition, it is assumed that abnormal behavior is a set of habits. Psychological disorders are clusters of learned behaviors, cognitions and affective states. Within the broad cognitive behavioral tradition it is assumed that *abnormal behavior is learned through the same processes as normal behavior*. These processes include **operant** and **classical conditioning**, **imitation** and **Insight**. Therapy involves coaching clients in such a way that they learn to replace abnormal with normal behavior patterns. This coaching process is based on the principles of learning theory. So the small constituent habits that make up large clusters of behavior, cognition and affect are identified through careful interviewing and observation. The experience, co-occurring beliefs, and consequences associated with individual habits are identified. Treatment programs include interventions that alter antecedents which signal the onset of abnormal behaviors; interventions that challenge non-adaptive beliefs and styles of information processing that accompany abnormal behavior; and interventions that change the consequences of behavior so that normal alternatives to abnormal behavior patterns are reinforced. In the behavioral treatment of depression, antecedents of low mood may be altered through inviting clients to schedule pleasant events regularly throughout their day. In the cognitive therapy of depression, anxiety and personality disorders, clients are coached in how to identify and challenge negative automatic thoughts and to identify the use of cognitive distortions. Imitation and operant procedures may be used to help individuals with skills deficits learn social, communication and problem-solving skills. Skills training is regularly used when working with people who have schizophrenia and their families.

Treatment programs also include procedures based on classical conditioning. For example, with systematic desensitization for people who have phobias, increasingly threatening stimuli are paired with the experience of relaxation. Another example of a classical conditioning-based intervention is the use of urine alarm programs for night-time enuresis in which bedwetting is paired with the sound of an alarm. Through this procedure, the child learns eventually to awaken when the

bladder is full. Within the cognitive behavioral tradition, specific treatment programs are developed for specific symptoms and detailed assessment of the impact of treatment on abnormal behaviors targeted in treatment is routinely made. This tradition is championed by clinical psychologists.

2.4.2. Achievements

The cognitive behavioral tradition has made a number of important contributions to the understanding and treatment of psychological difficulties.

First, this tradition has led to the development of a brief, effective approach to therapy which is applicable to a wide range of patients. Typically cognitive behavior therapy is short, ranging from 1 to 30 sessions, depending upon the nature and severity of the problems.

Second, the cognitive behavioral tradition has shown empirically that its treatment strategies are effective, so they facilitates evidence-based practice. More than any other approach to treating psychological difficulties, the cognitive behavioral tradition has generated an colossal volume of empirical research to test the effectiveness of a wide variety of treatment programs for a broad range of problems in adults and children.

Third, the cognitive behavioral model has led to the development of specific psychological treatment packages for specific types of problems. For example, exposure-based treatments have been developed for anxiety disorders, and cognitive therapy has been developed for mood disorders.

Fourth, methodological and scientific strictness has characterized cognitive behavioral research on psychological problems and their treatment.

2.5. Family systems model
2.5.1. Assumptions

The family systems model assumes that psychological problems are maintained by patterns of interaction and belief systems within the family and the wider social system of the patient. Historical, contextual and constitutional factors may predispose family members to engage in these interaction patterns and adopt these belief systems. The many family therapy schools within this tradition may be classified in terms of their central focus of therapeutic concern and in particular with respect to their emphasis on:

1) problem-maintaining behavior patterns;
2) problematic and constraining belief systems;
3) historical, contextual and constitutional predisposing factors.

With respect to the first theme, some family therapy schools underline the role of cyclic patterns of family interaction in the maintenance of problem behavior, and advocate practices which aim to interrupt these patterns of interaction. Schools that fall into this category include strategic therapy (Madanes, 1991); structural therapy (Colapinto,1991); and functional family therapy (Barton and Alexander, 1981).

With respect to the second theme, some schools of family therapy point to the centrality of belief systems and narratives which subserve repetitive interaction

patterns that maintain presenting problems. Practices that make possible the appearance of new belief-systems and narratives which liberate family members from problem-maintaining interaction patterns are espoused by these schools. Schools that fall into this category include the Milan school (Campbell *et al.*, 1991); solution-focused family therapy (Wetchler,1996); and narrative therapy (Freedman and Combs, 1996).

With respect to the third theme, a number of family therapy traditions underline the role of historical, contextual and constitutional factors in predisposing family members to adopt particular belief systems and engage in particular problematic interaction patterns. Such schools advocate using practices that specifically address these historical, contextual and constitutional predisposing factors, including working with members of the complete family and wider social network as well as coaching individuals to manage historical, contextual and constitutional constraints. This category contains transgenerational family therapy (Friedman, 1991); psychoanalytic family therapy traditions (Scharff, 1995); experiential family therapy (Wetchler and Piercy, 1996); multisystemic consultation, which includes reference to the wider system (Henggeler *et al.*, 1998), and psychoeducational approaches (McFarlane, 1991).

2.5.2. Achievements

Family therapy has made an important contribution to the understanding and treatment of abnormal behavior.

First, in a field dominated by essentially individualistic models of practice, it has highlighted the role of the patient's social context in the etiology and treatment of psychological difficulties.

Second, family systems therapy is a brief, reasonable form of treatment well suited to public health services. It is highly. Where different family members have problems they may all be treated by the same therapist or team.

Third, empirical research shows that family systems therapies are effective with a wide range of problems in children and adults.

Fourth, systems theory can offer an integrative framework for comprehending not just the role of social factors but also those of biological and intrapsychic factors in the understanding and treatment of psychological difficulties.

Fifth, in clinical practice, an integrative approach to family systems therapy is particularly useful in managing complex cases in which multiple family members have multiple problems, since often these are interconnected, a point missed by individualistic conceptualizations of abnormal behavior.

2.6. The Humanistic Approach

The **humanistic** approach employed philosophy, existentialism, and theories of human growth and potential to understand human behavior and offer strategies for psychological treatment. The humanistic approach focused on the patient's experience or phenomenology of their concerns and offered warmth, empathy, and unconditional positive regard in psychotherapeutic interactions. During the 1950s and

1960s (during an age of anxiety following World War II and during the Cold War), the humanistic approach to psychological treatment gained widespread acceptance. Frustrated with the limitations of the psychodynamic and behavioral approaches regarding treatment process, outcome, and both client and therapist satisfaction, as well as the perceived negative psychodynamic and behavioral views of human nature (e.g., the psychodynamic emphasis on neuroses as well as infantile and primitive needs; the behavioral focus on governing behavior through external reinforcement), many mental health professionals began to incorporate the more optimistic and embracing views purported by the humanistic school of thought. The humanistic approach became known as the *third force* in psychology following the psychodynamic and behavioral approaches.

The humanistic approach was strongly influenced by philosophy as well as the existential approach to psychotherapy. The existential approach became especially popular after the atrocities of World War I and most especially in response to Nazi Germany during World War II. The existential approach had its roots in European philosophy in the works of Kierkegaard, Nietzsche, Sartre, Buber, and Heidegger among others. This approach focused, for example, on the human need to seek and define meaning in life. American writers such as psychologist Rollo May and psychiatrist Irvin Yalom helped to delineate and popularize the existential approach to humanistic therapy in the United States. Psychoanalytic writers such as Hans Kohut, Otto Kernberg, and Merton Gil have integrated some of the humanistic perspective into their writing as well. Leading humanistic psychotherapists and theorists such as Carl Rogers, Abraham Maslow, Frederick Perls, Victor Frankl, and others all uniquely contributed to the development of the humanistic approaches to professional psychotherapy. Whereas each offered a somewhat different approach, their commonalities are notable and together comprise the humanistic school. These commonalities include the commitment to the phenomenological model that emphasizes that humans are able to be consciously reflective and have the ability to experience self-determination and freedom. Thus, therapists must be able to fully understand a person's perception of internal and external reality in order to not only better understand their feelings and behavior but also offer assistance. Another commonality included the notion that humans strive toward growth and are not, for example, trying to maintain homeostasis by satisfying various primitive needs and conflicts. The humanistic approach also championed a belief in free will and regarded human behavior as not just a by-product of early childhood experiences or merely conditioned responses to the external environment. Finally, the humanistic approach is person-centered with maximum respect for the individual and his or her experiences.

The client-centered and phenomenological approach of Carl Rogers became the most influential humanistic therapy. While Rogers was trained in the more traditional psychodynamic approach, he rejected it to provide a compelling alternative with the clientcentered approach. The approach emphasizes therapist empathy, unconditional positive regard, congruence, intensive active listening, and support to help individuals and groups reach their full human potential. Rogers felt

that humans naturally strive toward their potential and that psychotherapy was a catalyst that could assist them in this endeavor.

Lecture 2
The Psychology of Treatment

Medical psychology (related to Clinical Health Psychology, Psychosomatic Medicine, and Behavioral Medicine') is a branch of clinical psychology where clinicians have trained in the biological aspects of mental illness in relation to physical illness, and are usually qualified to prescribe medication; this last aspect varies from country to country. It adopts the biopsychosocial approach to medicine, which revolves around the idea that both the body and mind are indivisible and that disease and illness are not identical. Continuing with this line of thought, all diseases whether of the mind or of the physical body must be treated as if they have both been affected. The aim of Medical Psychology is to apply knowledge from all branches of social, psychological, and biological medicine in the prevention, assessment, and treatment of all forms of physical illness and the adaptation to illness; specific behavioral, psychotherapeutic, and pharmaceutical methods are used to help the person respond to illness and prevent further illness through matching coping and management skills to the person's abilities, character, and personality style.

1. Compliance

Compliance (or adherence) is a medical term that is used to indicate a patient's correct following of medical advice.

Most commonly it is a patient taking medication (drug compliance), but may also apply to use of surgical appliances such as compression stockings, chronic wound care, self-directed physiotherapy exercises, or attending counselling or other courses of therapy. *The most effective way for a physician to improve patient compliance is through a positive physician-patient relationship.*

Other factors that increase compliance:
- Patient feeling ill
- Limitations of patients activities due to disease state
- Written instructions for taking medication
- Acute illness
- Simple treatment schedule
- Short time spent in waiting room
- Physician recommending one change at a time
- Benefits of care outweigh costs

Patients may not accurately report back to health care workers because fear of possible shame, being chastised, or seeming to be ungrateful for a doctor's care.

Causes for poor compliance include:

- Forgetfulness
- Poor rapport with physician
- Few symptoms
- Chronic illness
- Recommendation not collected or not dispensed
- Purpose of treatment not clear
- Supposed lack (отсутствие) of effect
- Real or perceived side-effects
- Instructions for administration not clear
- Physical difficulty in complying (e.g. opening medicine containers, handling small tablets, swallowing difficulties, travel to place of treatment)
- Unattractive formulation, such as unpleasant taste
- Complicated regimen
- Cost of drugs

2. Adherence

An estimated half of those for whom medicines are prescribed do not take them in the recommended way. Until recently this was termed "non-compliance", and was sometimes regarded as a manifestation of irrational behavior or willful failure to observe instructions, although forgetfulness is probably a more common reason. But today health care professionals prefer to talk about "adherence" to a regimen rather than "compliance".

There have been many studies of the effects of different strategies in improving adherence to therapy. These include reducing the frequency of administration during the day and reducing the numbers of medicines a patient has to take. However, there is no evidence that such measures are effective.

Nevertheless, it seems likely that *adherence can be improved by taking care to explain the benefits and adverse effects of a drug*. In a busy clinic it is too easy for the prescriber to give out a prescription with little or no explanation. It also makes sense to reduce the frequency of taking medicine to once or twice a day: though again, there is no evidence that this tactic is effective.

3. Drug compliance

It is estimated that only 50% of patients suffering from chronic diseases in developed countries follow treatment recommendations. This may affect the health of the patient, as well as that of the wider society when resulting in complications from chronic diseases, formation of resistant infections, or untreated psychiatric illness. Compliance rates during closely monitored studies are usually far higher than in later real-world situations: for example, there may be up to 97% compliance in some studies on statins, but only about 50% of patients continue at six months. Again, the word "adherence" is preferred by many health care providers, because "compliance"

suggests that the patient is passively following the doctor's orders. Patients should not be passive: a treatment plan must be based on a therapeutic alliance or contract between the patient and the physician. Yet at least one reference implies that both terms are flawed, giving no meaningful information.

4. Placebos

*A **placebo** is a sham treatment that may be used clinically to placate a patient or experimentally to establish the efficacy of a drug or other medical procedure.*

*The **placebo effect** is the effect produced by administering a placebo.* In addition, active medications may produce placebo effects as well as drug effects and these may be additive. In this case, the placebo effect is that portion of the treatment effect that was produced psychologically, rather than through physical means.

Typically, placebos are physically inert substances which are identical in appearance to an active drug. Occasionally, active substances are used as placebos. Active placebos have side-effects that mimic those of the drug being investigated, but do not possess the physical properties hypothesized to produce the beneficial treatment effect. Active placebos are used to prevent patients from using the sensory cues provided by side effects to deduce the condition to which they have been randomized.

Placebo effects are not limited to drug treatments. *Any medical procedure can have effects due to the physical properties of the treatment and effects due to its psychological properties.* Just as the effects of the physical properties of a medication can be tested by comparing its effects to those of a sham medication, so too the physically produced effects of other medical procedures can be established by comparison with sham procedures (e.g. sham surgery). For example, real and sham surgery have been compared in the treatment of angina and osteoporosis of the knee. In both cases, the effects appear to be due to the psychological properties of the treatment, rather than to the surgical procedures themselves.

Four notable and controversial issues currently occupy the attention of researchers investigating the placebo effect. The *first* is whether placebos are capable of producing psychological or physical effects. The *second* concerns the mechanisms by which these effects are produced. The *third* involves the search for a placebo responder. The *fourth* issue relates to attempts to extend the placebo construct beyond the bounds of physical medicine and into the arena of psychotherapy.

4.1.   Research facts: are placebos effective?

The term placebo is Latin and means 'I shall please'. This reflects the historical use of placebos to placate patients whose complaints could not otherwise be treated. It also indicates a belief that while the placebos might please patients, they are not likely to produce real benefits.

During the 1950s, the possibility that placebo treatment might have real effects became more widely recognized, and the use of placebo controls in medical research became common. In case after case, medicines and treatment procedures that had been 'proven' effective in clinical trials were found to be no more effective than

treatment by placebo. Though the mechanism of placeboinduced change was a mystery, medical researchers began to suspect that many effects previously attributed to specific treatments were in fact placebo effects. It was suggested that placebos could reduce the frequency of asthma attacks, relieve hay fever, suppress coughs, alleviate tension and anxiety, cure headaches, reduce pain, prevent colds and alleviate cold symptoms, cure ulcers, inhibit symptoms of withdrawal from narcotics, alter gastric function, control the blood sugar levels of diabetics, reduce enuresis, lessen the severity of arthritis, reduce the frequency and severity of angina attacks and reverse the growth of malignant tumours. These data led to the concept of 'the powerful placebo' (Beecher, 1955).

The response to a medication is not the same thing as the effect of that medication. This is because there are many reasons by which a person might get better. One is the natural history of the disease. People get better from many conditions (e.g. the common cold) regardless of whether they are treated or not. Sometimes there is spontaneous remission in disorders that aren't always self-healing (e.g. depression or cancer). There is also the statistical problem of regression towards the mean, i.e. when you reassess something, people who scored at the extremes will tend to display scores closer to the mean. Finally, the response to a medication includes the placebo effect. Placebos are intended to control for all these sources of improvement. *Thus, the drug effect is assumed to be the difference between the response to medication and the response to placebo.*

Analogously, a difference can be drawn between the placebo response and the placebo effect. *The placebo response is the change observed following placebo administration. In addition to the placebo effect, it includes the changes due to the natural history of the disorder, spontaneous remission and regression to the mean.* For this reason, the placebo effect is best evaluated via comparisons with a no-treatment control condition. However, this is rarely done in medical research, where the interest is in evaluating treatment effects rather than placebo effects.

In an effort to evaluate placebo effects, Hrorbjartsson and Gotzsche (2001) reported a meta-analysis of treatments in which response to placebo was compared to changes observed in a no-treatment control condition. Finding a small but significant 'placebo effect', along with significant heterogeneity outcomes, the authors concluded that they had 'found little evidence in general that placebo had powerful clinical effects'. This widely cited meta-analysis has sparked an intense debate concerning the supposed power of placebo. Critics of the Hrorbjartsson and Gotzsche (2001) meta-analysis have noted a number of shortcomings. First, they included treatments for a wide variety of conditions, including the common cold, alcohol abuse, smoking, poor oral hygiene, herpes, infertility, mental retardation, marital discord, Alzheimer's disease and other 'undiagnosed ailments'. It is likely that some of these conditions are responsive to placebo treatment and others not, hence the significant heterogeneity of outcomes reported by Hrorbjartsson and Gotzsche. As noted by Wampold et al. (in press), 'aggregating without regard to consideration of heterogeneity of disorders and their amenability to placebo action does not allow for detection of a placebo effect should it exist'.

Wampold et al. (2005) reanalyzed the studies in the Hrorbjartsson and Gotzsche (2001) data set after classifying them by the degree to which the disorder was deemed by independent raters to be amenable to placebo treatment and by the adequacy of the experimental design. Disorders like insomnia, chronic pain and depression were deemed to be amenable to placebo treatment, whereas disorders like anemia and bacterial infection were deemed to be not amenable to placebo treatment. Design adequacy involved on such factors as random assignment and the placebo being indistinguishable from the active treatment. The results of this meta-analysis indicated a significant placebo effect in welldesigned studies of conditions deemed amenable to placebo treatment, but no placebo effect in well-designed studies for conditions that had been deemed to not be amenable to placebo treatment. A particularly interesting finding in this meta-analysis was that there was no significant drug/placebo difference for conditions deemed amenable to placebo treatment.

These are not the only data indicating a powerful placebo effect. Although there are relatively few clinical trials of medications that include no-treatment control conditions, a number of experimental studies have been designed to investigate the effects of placebos. Numerous studies not included in Hrorbjartsson and Gotzsche's (2001) meta-analysis have shown that placebo analgesics, tranquilizers, stimulants and alcohol produce effects beyond those observed in untreated control conditions. In addition, a meta-analysis of published clinical trials of antidepressant medication indicated a change of 1.16 standard deviations on measures of depression following administration of placebo antidepressants, compared with a change of 0.37 standard deviations among untreated controls (Kirsch & Sapirstein, 1998). These data indicate a placebo effect size of 0.79 standard deviations. This is a powerful effect by any standard.

Just as inclusion of a placebo control is only one method of evaluating the effects of medical treatments, the inclusion of a no-treatment control group is only one method of evaluating the placebo effect. Medical treatment effects can be inferred when different doses of the same drug produce different effects or when a particular treatment is found to be significantly more effective than an alternative treatment. Similarly, placebo effects can be inferred when different placebos or apparent doses of the same placebo produce significantly different effects or when the effects of a placebo vary as a function of the information provided to the person to whom it is administered. Effects of this sort have been reported in a number of studies. For example:

• Asthmatic patients have been shown to exhibit bronchoconstriction after inhaling a placebo described as a bronchoconstrictor and brochodilation after inhaling a placebo described as a bronchodilator.

• Placebo morphine is considerably more effective than placebo Darvon, which in turn is more effective than placebo aspirin (Evans, 1974). In each case, the placebo is about half as effective as the pharmacologically active drug. Similarly, placebos produce more pain relief when given after a more potent drug than they do when given after a less potent drug (Kantor et al., 1966). Thus, the effectiveness of a placebo pain reliever varies as a function of its believed effectiveness.

• Placebo and active analgesics are more effective when presented with a well-known brand name (Branthwaite & Cooper, 1981).

• Placebo injections are more effective than placebo pills (de Craen et al., 2000).

• The colour of a placebo can influence its effects (reviewed in de Craen et al., 1996). When administered without information about whether they are stimulants or depressives, blue placebo pills produce depressant effects, whereas red placebos induce stimulant effects. Patients report falling asleep significantly more quickly after taking a blue capsule than after taking an orange capsule. Red placebos seem to be more effective pain relievers than white, blue or green placebos.

• The magnitude of the placebo response has been shown to vary as a function of the dose that the person is asked to consume

• Finally, Benedetti and colleagues (Benedetti et al., 2003) developed a methodology for assessing the placebo effect without the use of placebos. Participants gave permission to receive a medication with or without foreknowledge of the onset of administration. Medication was later administered intravenously, in some cases with the patient's knowledge and in other cases without any signal. Using this methodology, they found that significant proportions of the effects of morphine on pain, stimulation of the subthalamic nucleus in Parkinsonian patients, and beta–blockers (propranolol) and muscarinic antagonists (atropine) on heart rate were due to the placebo effect. In addition, they reported that the effect of diazepam on postoperative anxiety was completely a placebo effect, as hidden infusions of diazepam were totally ineffective in reducing postoperative anxiety.

Taken together, these data provide ample documentation of the presence of a placebo effect.

4.2. Psychological mechanisms underlying the placebo effect
Classical conditioning

How is it that an inert substance can produce psychological and physical changes? Currently, the two most popular explanations of the placebo effect are *classical conditioning* and *response expectancy*. Classical conditioning is a phenomena discovered by the Russian physiologist, Ivan Pavlov, at the beginning of the twentieth century. In classical conditioning, a stimulus (called an *unconditional stimulus*) that automatically elicits a response (called an *unconditional response*) is paired repeatedly with a neutral stimulus (called a *conditional stimulus*). After a number of such pairings, the conditional stimulus acquires the ability to evoke a response (called a *conditioned response*). Generally, the conditional response is the same as the unconditional response, only weaker. In some cases, however, it appears to be the opposite of the unconditional response, in which case it may be referred to as a compensatory response.

As applied to placebo effects, conditioning theory posits the following order of events. Active medications are unconditional stimuli and the therapeutic responses they elicit are unconditional responses. The pills, capsules and injections by means of which the medications are delivered are conditional stimuli. Because these

conditional stimuli are repeated paired with the active medications that produce the therapeutic benefits, they acquire the capacity to elicit these benefits as conditional responses.

Conditioning theory appears able of explaining many placebo effects, but there are also some problems with this explanation. For one thing, the conditional response to morphine is an increase in sensitivity to pain (Siegel, 1983). However, the effect of placebo morphine is a reduction in pain sensitivity. Therefore, it cannot be due to classical conditioning. In fact, it seems to override the conditioning effect. Another problem with the conditioning model of placebo effects is that it does not account well for the existence of placebo effect throughout the history of medicine. Most of the substances that were used as medications before the twentieth century (e.g. turpentine, crushed glass, worms, spiders, crocodile dung, lizard's blood, frog's sperm, pig's teeth, rotten meat, powdered stone, iron filings and human sweat) are now recognized to have been placebos. Because they do not automatically produce therapeutic benefits, they cannot have functioned as unconditional stimuli for placebo effects.

4.3.   Response expectancy

Response expectancies are anticipation of automatic subjective responses (e.g. changes in pain, anxiety, depression). *Response expectancies tend to elicit the expected response.* Thus, the anticipation of anxiety makes people anxious, the belief than one will stay depressed forever is very depressing, and the anticipation of changes in pain alters the perception of pain. More generally, subjective experience appears to be due to a mix of external and internal factors. It is produced partially by external stimuli and partially by the person's beliefs, expectations and interpretations of those stimuli. As applied to the placebo effect, expectancy theory asserts that placebos produce their effects by changing people's expectations. A placebo antidepressant, for example, leads people to expect a change in their depression, and that expectation makes them feel less depressed. A shortcoming of expectancy theory is that it does not easily account for the physical effects of placebos.

4.4.   Individual differences in placebo responding: the search for a placebo responder

There is considerable variation in response to placebo. Some participants may show a strong response, some a weak one and some no response at all. This has led researchers to search for the personality correlates of placebo responding. However, after more than a half century of research, 'the virtually unanimous conclusion among those reviewing the placebo literature is that there is no such thing as the placebo responder' (Brody & Brody, 2000).

The conclusion that there is no such thing as a placebo responder is based on the failure to find reliable personality correlates of the placebo response. However, a failure to find correlates does not necessarily mean that placebo responding is not a personality trait. For example, the search for stable correlates of hypnotic suggestibility has been largely unsuccessful and the few correlates that have been

found account for only a little proportion of the variance. Nevertheless, hypnotic responding itself seems to be exceptionally stable, with test re-test correlations as high as 0.75 even with a 25-year interval between testing (Piccione et al., 1989). Thus, hypnotic suggestibility appears to be a stable trait without many stable personality correlates. *It is conceivable that this is the case for placebo responding as well, which is also, after all, a form of suggestibility.*

Attempts to find correlates of the placebo response could succeed only if there is some reliability in the placebo response. However, it is also possible that there is no such thing as a placebo responder and that placebo response is inherently unreliable. Data in support of this hypothesis were reported in an early but very influential study on the prevention of nausea (Wolf et al., 1957). Participants were successively given placebo treatments for nausea, following which ipecac (emetic) was administered. Response was defined as blocking the emetic effects of ipecac. This procedure was repeated seven times. Wolf et al. reported that response to earlier trials failed to predict response to subsequent trials. On the very last trial, for example, those who had been consistent placebo responders on the previous six trials were no more likely to respond to the placebo than those who had been consistent non-responders. This study supports the widespread conclusion that there is no such thing as a reliable placebo responder.

4.5. Placebo psychotherapy

Given the importance of placebo effects in medical interventions, it was only natural that researchers began to question the degree to which the effects of psychological interventions might be placebo effects. To answer that question, studies were designed to include placebo psychotherapies, the effects of which can be compared to the genuine treatment. At first glance, this strategy seems reasonable, but, in fact, it is very problematic. There are both practical and conceptual problems with attempts to extend the placebo concept from the medical setting to the psychotherapeutic setting. Practically, it cannot be done; conceptually, it makes no sense to try.

Lecture 3
Coping and defense mechanisms. Coping with chronic illness.

1. Coping with chronic illness
1.1. The increase in chronic illness

Chronic illness is now the main disease pattern in most developed countries. Advances in medicine have transformed many previously deadly infectious diseases, such as tuberculosis, pneumonia and influenza into treatable conditions and some have disappeared almost completely. The resulting improved longevity of populations has meant a growth in the trouble caused by chronic conditions such as cancer, heart disease, stroke and diabetes. Chronic illnesses often strike in middle- and older-agegroups and bring with them considerable difficulties in adjustment and coping which can severely compromise patients' quality of life. While chronic

diseases do kill, most people diagnosed with a chronic illness will live for many years with their condition. Understanding and improving the process of coping with a chronic illness has become an important area of health care.

1.2. Adaptation required

The initial psychological adjustments following the diagnosis of a chronic disease generally involve issues related to a loss of function. Individuals at the stage of diagnosis confront the reality that their state of health and function of their body have changed, and are likely to remain impaired. The speed with which individuals confront this loss can be strongly influenced by the nature of the illness. With some chronic illnesses, such as heart disease which is diagnosed following a myocardial infarction, consciousness of the presence of the disease is usually sudden. In other chronic illnesses, such as arthritis, the patient may be attentive to their disease long before a formal diagnosis is made. Dealing with the constant difficulty of a chronic illness often requires the learning of new skills and adjustments to daily lifestyle. Patients need to cope with the *symptoms of their condition* and the *requirements of medical treatment,* which may mean learning new techniques for managing symptoms or administering therapy and coping with daily life disturbance from both symptoms and treatment. Many illnesses, such as insulin-dependent diabetes and end-stage renal disease, need patients to learn specific techniques for controlling symptoms, such as dialysis in the case of renal disease. In addition, an active monitoring of bodily function may be necessary in diseases like diabetes, where patients are often required to provide 95% or more of their daily care to avoid medical crises.

Maintaining near and social relationships and developing effective working relationships with medical staff are other important adaptive tasks of living with a chronic illness. Chronic illness can put a strain on these social support networks. Relationships with healthcare staff can be a major cause of difficulty in the management of chronic illness. The problem of patient independence from healthcare professionals is often an ongoing problem in long-term treatment programmes. Spouses, in particular, accept a large proportion of the stresses engendered by the illness. Tasks that the patient normally completed around the home before developing the illness but can no longer manage, need to be assumed by a spouse or other family member. Sometimes this creates feelings of guilt and inadequacy on the part of the patient and feelings of extra pressure and anger on the part of members of the patient's family.

The limit in social and other previously pleasurable activities is often an outcome of living with a chronic illness. This change, along with the emotional demands of integrating a new view of the self that includes the chronic illness, result in difficulties in affect regulation and an increased risk of adjustment and emotional disturbances. Individuals with chronic illness are more likely to be depressed than those who do not have a chronic condition, and this relationship has been found to be strongest amongst those who develop chronic illnesses early in life.

However only a minority of patients develop clinical levels of emotional disturbance and this is more common among patients who experience greater levels of pain and disability. Emotional problems, such as depression, often interfere with the adoption and maintenance of rehabilitation programmes and seem to worsen prognosis in many conditions. It is important to note, however, that the emotional response to chronic illness is highly variable and not all the emotional consequences of chronic illness are negative. The few studies that have investigated positive outcomes, also known as 'benefit finding', report that individuals have found an increased value in close relationships, greater meaning in day-to-day activities and a greater sympathy towards others with difficulties.

1.3. The coping process

How well patients adjust to chronic illness can be explained in part by their individual coping responses. ***'Coping' is the cognitive, behavioral and emotional ways that people manage stressful situations.*** Coping has been previously conceptualized by researchers as an attribute which is stable across situations, or alternatively, as a process that is strongly influenced by situational factors. However, Lazarus and Folkman's (1984) transactional model has had the largest impact on the existing conceptualization of coping with chronic illness. This model sees the patients' coping responses being determined by both their *assessment of the degree of danger* posed by an illness, and the *resources seen as being available to help them cope in the situation.* Coping responses in this model are divided into:
  1) **emotion-focused strategies**
  2) **problem-focused strategies.**

The function of problem-focused coping is to actively modify the stressful situation in some way, while emotion-focused coping is directed at regulating the patient's emotional response to a stressor. *Each response can be potentially adaptive or maladaptive depending on the situation.* Some emotion-focused strategies show positive benefits across illnesses. ***Reframing the illness in a positive light, acceptance of the disease, and utilizing social support*** appear to be adaptive coping strategies across many chronic illnesses. Other emotion-focused strategies such as ***disengaging*** from the situation by giving up or avoiding thinking about the illness have generally been related to increased distress and disability.

Problem-focused strategies, which in theory should have a greater adaptive potential, have often unsuccessful to demonstrate a strong relationship to outcome in chronic illness. However, ***seeking information*** about the illness and ***planning*** seem to be two strategies that do have the most consistent relationship with positive outcomes. These strategies seem to have the greatest effect when the stressor is appraised by the patient as controllable. The lack of a strong relationship between problem-focused strategies and positive outcomes in chronic illness may be due to a mismatch between situations which are not able to change or control and the use of problem-focused strategies by the individual. In such situations emotion-focused strategies may be more useful, and recently interventions have been developed for patients with chronic illness to more accurately selection the coping strategy to the

characteristics of the situation. Such interventions seem to result in reducing the psychological distress associated with managing a chronic illness.

1.4. Influences on coping

The severity and nature of the disease does not seem to have a consistent relationship to patient coping and adjustment to chronic illness, while the coping process is strongly affected by both psychological and social influences. ***An important influence is the patient's own subjective understanding of their illness.*** Leventhal et al. (1980) have proposed that cognitive illness representations direct both coping strategies and emotional responses to an illness in a parallel process that feeds back to influence the patient's own illness model. For example, a patient who attributes her hypertension to stress caused by work and who later gives up her job only to find that this has made no difference to her level of blood pressure, may change her view of the cause of the hypertension. Evidence suggests that particular illness models may be associated with more functional coping strategies and that illness representations may have a critical role in influencing adjustment to a range of common chronic illnesses such as heart disease, cancer and diabetes. In people who have recently had a myocardial infarction, beliefs about cause, timeline, controllability and consequences have been shown to be related to time taken returning to work and attendance at cardiac rehabilitation and patients' drawings of perceived damage on their hearts predict recovery better than do medical indicators of damage.

Social and partner support also plays an important role in adjustment to chronic illness. A number of studies have shown social support to be related to better disease outcomes and psychological adjustment in a variety of illnesses. A large follow-up study of chronically ill patients found social support was beneficial for health over time and this effect was strongest in older patients. Social support has been associated with better metabolic control in diabetes patients, as well as improved outcomes in breast cancer, kidney failure and heart disease. There may also be a gender difference in the way social support operates. In people with heart disease, the protective effects of social support have been less consistent for women. In addition, support can sometimes be too disturbing and people can be distressed with help or conflicting advice causing negative effects on the outcome of chronic illness. In HIV patients, social conflict has been found to have a stronger association with coping than has perceived support.

The nature of the benefits which increase from social support in the context of chronic illness is not clear. Improved adherence to treatment and better health habits associated with higher levels of social support are likely to be important factors. The role of family and friends noticing changes in the patient's health that need attention may also reduce treatment delay if the illness worsens and the patient needs medical assistance. It seems that patients' perceptions of what actions are helpful are influenced by the social role of the provider. Esteem and emotional support are seen as most helpful when they come from spouses or family. Some researchers have suggested that the benefits of social support may not, in fact, derive from its positive

aspects but rather from the absence of distressing or conflictual relationships that interfere with successful function.

As well as the critical role of illness perceptions and social support, there is evidence that *a number of individual difference variables also influence the coping process.* The age of the person, their educational background and personality traits such as optimism can act to influence coping with chronic illness. *Factors related to the disease itself* in terms of its stage, physical characteristics and symptomotology are also important. It is clear that each chronic illness is made up of a large number of stressors, and patients may apply different coping responses to each of these illness-related problems.

1.5. Coping interventions

A number of successful intervention strategies have recently been developed for patients suffering from chronic illness. These programmes vary in their focus from being strictly information-based to teaching specific skills which help to address problems faced by the patient. Kate Lorig has developed an intervention based around improving patients' self-efficacy and selfmanagement techniques. It has been adopted in a number of countries as a way of improving the management of chronic illness. The Chronic Disease Self-Management Programme, also known as the Expert Patient Programme, uses trained patients as leaders of patient groups and draws on the findings of patients' own experience. The groups, which are also being trialled over the internet, focus on improving patients' ability to interpret changes in the disease and its consequences. Group sessions also aim to improve patients' use of medication and utilization of medical and community support as well as pain control and managing the emotional consequences of the illness. The programme encourages patients to set goals and identify effective feedback. Research shows participants experience improved physical activity, reduced symptoms and have significantly less need for medical treatment in comparison with control groups.

Mike Antoni and his colleagues at the University of Miami have developed a group cognitive behavioural intervention for a number of chronic illness groups including HIV-infected individuals, men with prostate cancer and women diagnosed with early-stage breast cancer. This programme, which is adapted for each specific illness group, provides information on the stress response and various coping strategies best matched to deal with specific stressors. Imagery and progressive muscle relaxation techniques are taught to help patients deal with personal stress. Cognitive behavioural techniques are employed to modify maladaptive appraisals and interpersonal social skills are taught to improve the utilization of social support networks. Results from clinical trials show that the intervention increased the incidence of reporting by patients that breast cancer had impacted positively on their lives, improved quality of life in men recovering from treatment of prostate carcinoma and improved the use of effective coping and reduced mood disturbance in HIV-infected individuals (Antoni et al., 2001). While the results from intervention studies provide impressive support for developing coping skills as a treatment, it is difficult to separate the non-specific factors that occur in these group interventions

from the specific effects of enhancing coping skills. These group treatment programmes incorporate other aspects such as psychological support and education with the teaching of coping strategies, and further research needs to be done to ascertain the specific benefits of coping training. Intervention studies are a valuable method of testing the coping skills model and they provide a useful way of investigating coping processes over time.

Coping with chronic illness has become an important area for research and intervention in medical psychology. Research in this area is likely to become even more important in the future as the large numbers of individuals suffering from such diseases continue to grow. The diagnosis of a chronic illness typically brings with it a number of complex problems, emotional difficulties and changes in lifestyle. The patient's own understanding of the illness and the levels of appropriate social support available to them are key factors in promoting successful long-term coping. Interventions that develop coping strategies and improve the matching of problemfocused or emotion-focused strategies with the situational context seem to provide a promising avenue to improve the quality of life for patients living with a chronic illness.

2. Chronic pain

Chronic pain is a problem that affects millions of individuals every year. Much of chronic pain is associated with significant progressive degenerative disease. Such diseases include arthritis and cancer, and involve prolonged severe pain which may be only partially improved through the use of analgesic medication. This part of the lecture examines the ways in which individuals cope with chronic pain. We describe how pain coping is conceptualized and measured and discuss what has been learned about adaptive and maladaptive methods for coping with chronic pain. We conclude with an exploration of new directions for research in this area.

2.1. Coping with chronic pain

Coping has been defined as the process of managing stressful situations, either external or internal, that are viewed as taxing an individual's adaptive resources. The ways in which individuals view or appraise potentially stressful situations is an important component of this process definition of coping. In chronic pain, *the ways in which a patient views pain are particularly important in their reactions to pain.* Individuals may view pain as unpredictable and feel very little control over pain flares. Conversely, they may view pain as a constant irritation but one that can often be dealt with successfully.

Coping with pain can be thought of as cognitions and behaviours that serve to manage or decrease the sensation of pain and distress caused by pain. Within this basic framework, researchers have formulated several models of pain-coping. We will discuss five such models:

- Problem/emotion-focused coping model
- Active/passive coping model
- Cognitive/behavioural coping model

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- Fear avoidance model
- Acceptance model.

2.1.1 The problem- and emotion-focused coping model

The problem- and emotion-focused coping model using the <u>Ways of Coping Checklist</u> (WCCL; Folkman & Lazarus, 1980), Folkman and Lazarus have created a coping model that categorizes coping strategies as either problem-focused or emotionfocused. *Table 1* lists sample items from the WCCL. ***Problemfocused efforts seek to alter the individual's relationship to a stressor. Emotion-focused coping serves to alter one's internal reactions to a stressor.*** For example, the chronic pain patient faced with the choice of engaging in an activity known to cause pain (say sitting in a cinema for a back pain patient) may use a problem-focused coping strategy such as having a friend pick up a video instead and/or an emotion-focused strategy such as controlling their disappointment by thinking about some other pleasant activity. The WCCL is a 42-item pencil and paper questionnaire. Individuals are asked to indicate a recent stressful experience and then answer each question. When this questionnaire is used in studies of chronic pain, respondents are usually asked to indicate a stressor associated with their pain condition. Some forms of the WCCL use a 'Yes/No' response format while others employ a scale on which respondents indicate the extent to which they use each coping strategy. There are several scoring methods for the WCCL. One which is frequently used adds questionnaire responses to form one problemfocused and four emotion-focused sub-scales. The emotion-focused sub-scales measure *seeking social support*, *wishful thinking, self-blame and avoidance.* The problem-focused scale contains items such as 'just took things one step at a time'. The emotionfocused scales are composed of such items as 'asked someone I respected for advice and took it', 'hoped a miracle would happen', 'blamed myself' and 'kept others from knowing how bad things were'. Research examining the relationships between problem- and emotion-focused coping, and adjustment to chronic pain has been carried out in several groups of arthritis patients. This research suggests that arthritis patients who rely on wishful thinking, and to a lesser extent, on blame and avoidance-coping strategies may experience more depression and greater physical disability than those who use fewer of these emotion-focused types of coping. In low back pain patients, Turner et al. (1987) found that individuals who relied on seeking social support reported lower pain levels than those who did not use this strategy. In the Turner et al. study, problem-focused coping did not relate to pain.

Table 1. Items from the Ways of Coping Checklist

Problem-focused coping:
Concentrated on something good that could come out of the whole thing
Made a plan of action and followed it

Seeking social support:
Talked to someone to find out about the situation
Asked someone for advice and followed it

Wishful-thinking:
Hoped a miracle would happen
Wished I could change what happened

Self-blame:
Realized that I brought the problem on myself
Blamed myself

Avoidance:
Went on as if nothing had happened
Tried to forget the whole thing

2.1.2. The active and passive coping model

Another category system, using the Vanderbilt Pain Management Inventory (VPMI; Brown & Nicassio, 1987), creates a model which classifies pain-coping strategies as either active or passive. Table 2 Lists sample items from the VPMI. In this classification system, ***active coping methods are those that require the individual to take some behavioural action to manage pain.*** An example of an active strategy would be doing muscle strengthening exercises in response to pain. ***Passive pain-coping strategies focus more on withdrawing or giving up instrumental control over pain.*** An example of a passive strategy would be the use of medications in response to pain. The VPMI is an 18-item pencil and paper questionnaire Respondents are asked to indicate the frequency with which they use each of the coping strategies when coping with pain of a moderate or higher level of intensity. The active coping scale of the VPMI is composed of items such as 'participating in leisure activities' and 'distracting your attention away from pain'. The passive coping scale contains items such as 'talking to others about how much your pain hurts' and 'taking medication for purposes of immediate pain relief'.

The VPMI has been used primarily in studies of arthritis patients. In one such study, Covic et al. (2000) investigated the relationship between coping, pain, perceived physical disability and depression in rheumatoid arthritis patients. These researchers found passive coping to uniquely predict higher levels of pain. Passive coping was also found to mediate the effects of pain, perceived physical disability and depression. Consistent results were also found in a study examining the relationships of coping and adjustment to rheumatoid arthritis. Results indicated that patients reporting the usage of passive coping also reported more impaired physical functioning. Though the internal reliability of both the active and passive coping scales of the VMPI has been demonstrated, the passive coping scale has been shown

to be the more valid construct of the two and thus demonstrated more significant relationships.

However, reports of active coping have been shown to be associated with less pain, depression and functional disability.

Table 2. Items from the Vanderbilt Pain Management Inventory

Active coping:
Engaging in physical exercise or physical therapy
Clearing your mind of bothersome thoughts or worries

Passive coping:
Restricting or cancelling your social activities
Taking medication for the purposes of immediate pain relief

2.1.3. The cognitive and behavioural coping model

The cognitive and behavioural coping model using the <u>Coping Strategies Questionnaire</u> (CSQ) to assess cognitive and behavioural coping, Keefe and colleagues have developed a third model of pain-coping. *Table 3* lists sample items from the CSQI. This system parcels coping strategies into a greater number of coping scales. Examples of these scales include coping self-statements, ignoring pain sensations and catastrophizing about pain. The CSQ also assesses individuals' perceived ability to control and decrease their pain. Studies of patients with osteoarthritis, rheumatoid arthritis and low back pain have indicated that most people with chronic pain use combinations of these methods for coping with their pain.

The CSQ is a 48-item questionnaire that asks individuals to indicate the extent to which they use each coping strategy when they experience pain. The items are then totalled to create seven subscales:

1. diverting attention;
2. reinterpreting pain sensations;
3. coping self-statements ignoring pain sensations;
4. praying ;
5. hoping;
6. catastrophizing;
7. increasing behavioural activities.

Two higher order factors, *coping attempts and pain control and rational thinking* may be calculated from the CSQ responses. The CSQ also assesses respondents' perceived ability to control and decrease their pain. Research using the CSQ been carried out in several different ways. Some studies have used the seven sub-scales to assess coping, others have used the two higher order factors, and still others have re-factored the questionnaire to form additional scales. The CSQ has also been used with a wide variety of pain conditions, including osteoarthritis, low back pain, rheumatoid arthritis, fibromyalgia and cancer-related pain. Because of the wide

variety of research with this instrument we will confine our description of findings to a more general level. In general, results have indicated that individuals who cope by trying to exert control over pain report less pain, depression and physical disability than those who make less use of this type of coping. Catastrophizing also appears to be a particularly maladaptive way to cope with chronic pain and individuals using this coping pattern appear to be more depressed and have greater functional disability. For example, Turner et al. (2002) found that greater catastrophizing was found to be significantly associated with greater pain-related disability and psychological distress in patients suffering from chronic pain after a spinal cord injury. Similarly, a longitudinal study focusing on pain and depression in rheumatoid arthritis patients found passive coping strategies, most notably catastrophizing, to be predictive of higher levels of pain and depression.

In examining other sub-scales, Turner et al. (2002) found that coping self-statements and ignoring pain were associated with greater psychological wellbeing. Similarly, Keefe and Williams (1990) found that patients who were referred to a pain management programme that endorsed more items from the coping selfstatements sub-scale and who reported that they felt they could control and decrease pain, had lower depression.

Table 3. **Items from the Coping Strategies Questionnaire**

Diverting attention:
I try to think of something pleasant
I count numbers in my head or run a song through my mind

Reinterpreting pain sensations:
I don't think of it as pain but rather as a dull or warm feeling
I imagine that the pain is outside my body

Coping self statements:
I tell myself to be brave and carry on despite the pain
I tell myself that I can overcome the pain

Ignoring pain sensations:
I don't pay any attention to the pain.
I go on as it nothing happened

Praying or hoping:
I pray to God that it won't last long
I have faith in doctors that someday there will be a cure for my pain

Catastrophizing:
It's awful and I feel that it overwhelms me
I worry all the time about whether it will end

Increasing behavioural activity:
I do something I enjoy, such as watching TV or listening to music
I do something active, like household chores or projects

2.1.4. The fear-avoidance model

Over the past decade, numerous studies have examined the utility of the fear-avoidance model in explaining adjustment to pain. *The fear-avoidance model focuses on two behavioural coping responses to pain-related fear and anxiety: avoidance versus confrontation.* An example of avoidance would be thinking that pain is a signal of damage to oneself and consequently trying to avoid all activities which are pain-related, whereas a more confrontational response would be engaging in activity appropriately considering some pain-related lifestyle changes.

Within this model, avoidant responses are thought to lead to the maintenance or intensification of fear as well as to undesirable pain-related outcomes over time through several pathways, including an increase in negative appraisals of pain and its consequences, a decrease in normal activity leading to the disuse of the musculo-skeletal and cardiovascular system, little opportunity for disconfirmation of maladaptive beliefs about pain and its consequences to occur and more opportunity for mood disturbances to increase. This contrasts with confrontational responses, which are thought to lead to better adaptation to pain over time because individuals are engaged in activity and therefore have more opportunities to confront maladaptive beliefs about their pain, more reinforcers in their environment to regulate mood, and more physical activity to maintain functional ability.

Pain-related anxiety and fear have been assessed most frequently using one of two measures:

1) the Pain Anxiety Symptoms Scale (PASS; McCracken et al., 1992) – a 40-item measure that was designed to assess cognitive anxiety, escape and avoidance, fearful appraisals and physiological anxiety in response to pain and

2) the Tampa Scale for Kinesiophobia (TSK; Kori et al., 1990) – a 17-item measure that assesses fear of (re)injury due to movement.

A growing body of research studies has examined pain-related anxiety and fear in patients with chronic low back pain, neck pain and acute low back pain. One of the most consistent findings emerging from this literature is that patients scoring high on pain-related anxiety and fear measures report higher levels of disability and poorer performance on physical tasks such as lifting and carrying capacity and trunk extension and flexion exercises. These findings are particularly impressive given that they have been obtained even after controlling for important variables which might explain adjustment to pain such as pain intensity and duration.

2.1.5. Acceptance model

Recently, there has been growing interest in acceptance as a pain coping approach. Interest in acceptance comes from the clinical observation that the lives of

many patients having persistent pain are dominated by the struggle to control a problem that is in part uncontrollable. There is growing recognition that maladaptive efforts to control or avoid pain can exacerbate pain and lead to heightened suffering and disability.

Recent studies of acceptance and persistent pain have utilized the Chronic Pain Acceptance Questionnaire (CPAQ; Geiser, 1992), a reliable and standardized measure which assesses two dimensions of acceptance: a) willingness to experience pain – the absence of attempts to reduce or avoid pain; and b) activity engagement - the extent to which a person actively pursues valued life activities. McCracken et al. (1998) found that patients who scored higher on this measure not only had significantly lower levels of pain-related anxiety and depression, but also had lower levels of disability. These findings regarding acceptance were particularly noteworthy in that they were apparent even after controlling for pain intensity. McCracken and Eccleston (2003) compared the predictive utility of the CPAQ and a commonly used pain coping measure (the Coping Strategies Questionnaire) and found that the CPAQ accounted for almost twice as much variance as coping variables in explaining pain, disability, depression, uptime and work status. Finally, a recent study found that acceptance of pain was predictive of fewer health care visits for pain and pain medication intake.

Lecture 4
Coping with death and dying

1. Psychological aspects of dying

Death is, perhaps, the ultimate test which we face as patients, relatives and members of the caring professions. All of us have to cope with it and, no matter how experienced we become, the coping is seldom easy. Death is often a loss but it can also be a time of peaceful transition. It may represent failure or success, ending or beginning, tragedy or triumph. We may try to improve our ways of caring but, whatever the situation, death must never become routine.

When people are coming close to death, the professionals may have little or no control over what is happening. Scientific medicine can help us to lessen some of the pains of dying but, with all our knowledge, 100% of our patients will still die. Despite this, patients and their families continue to turn to us for help. To a large extent, we have replaced priests as the recognized authorities on death, a change of role with which most of us feel uncomfortable.

Death is a social event, it affects the lives of many people. In this circle of people, the patients are the centre of care as long as they are alive; but their troubles will soon be over, those of the family may just be beginning.

Whether or not we think of death as a transition for the patient, it is certainly a transition for the family. Their lives will never be the same again. Death tips the

survivors into new situations, new roles, new dangers and new opportunities. They are often forced to learn new ways of coping at a time when overwhelming grief makes it hard for them to cope with old responsibilities, let alone new ones.

Of course, it is not only the professional staff who find it hard to cope with people who are dying; friends, workmates and family members are equally at a loss and they may deal with their own feelings of inadequacy by putting pressure on us to continue treatment long after it can do good or to collude with them in concealing the true situation from the patient. 'You won't tell him he's dying, will you doctor? It would kill him if he found out'. While such remarks may rarely be reasonable, they are more likely to reflect the informant's own inability to cope with the truth rather than that of the patient.

In all our work with terminally ill patients and their families, we must consider three psychological problems that complicate the psychosocial transitions which they face. ***These are fear, grief and resistance to change.***

1.1. The problem of fear

Fear is the natural response to any threat to our own life or to the lives of those we love. It has important biological functions in preparing our minds and bodies to fight or to flee. Our entire autonomic nervous system exists to support these ends. *Among the many consequences of fear are hyperalertness to further dangers, increased muscular tension, increased cardiac rate and inhibition of digestive and other inessential vegetative functions.* In the types of emergency that arose in the environment of evolution, these reactions ensured our survival, but they are seldom of much use to us today.

It would be highly inappropriate for a cancer patient who has been told the nature of his diagnosis to run away or to hit out at the doctor, yet he may have an impulse to do both things. The hyperalertness produced by fear may cause fearful people to imagine additional dangers where none exist. It may also impair their ability to pay attention to anything but the danger itself. If increased muscle tension goes on for long, the muscles begin to fatigue and to ache; such symptoms may themselves be misinterpreted as signs of cancer or whatever disease it is that the person dreads. Similarly, cardiac hyperactivity is often misinterpreted as a sign of heart disease, in that way increasing fear and setting up a vicious circle of increasing fear and symptoms.

All of us have our own ways of coping when we are afraid. Some of us become aggressive, seeking someone or something to blame in the hope that we can correct the situation. Thus some patients, faced with worsening symptoms, respond by blaming them on the treatment.

It is easier to fight a doctor than a cancer. Others use alcohol or other drugs in an attempt to find courage, a habit which can give short-term relief but may cause fresh problems in the long run.

The logical response to danger is to seek help and, if doctors have failed to cure an illness, we should not be surprised or angry if the patient seeks for a cure from unorthodox practitioners. But cure is not the only thing that people need. Comfort of

the non-verbal kind, that a mother can give to a frightened child, is just as welcome to the frightened adult and just as effective in reducing fear. Nurses, who are touching patients all the time, know how powerful a touch of the hand can be. Doctors are often bad at touching, avoiding physical contact with their patients as if the patient's fear might be infectious, which, of course, it is.

When somebody is dying, it is not only the patient who is likely to be afraid, it is everybody around them. This can produce another kind of vicious circle when frightened patients see their fear reflected in the eyes of the people around them. Although most healthy people, asked where they would want die, will say 'at home', the level of anxiety which sometimes surrounds a person who is dying at home often gives good reason to admit them to a hospital or hospice. As one person who had been admitted to a hospice said, 'It's safe to die here!'

Since most people are afraid of dying, we tend to assume that we know why a dying person is afraid. It is attractive to say, 'I understand'. The truth is that none of us can know another's fear and many of the fears of terminally ill patients have nothing to do with death. Time and again patients have said to us, 'It's not being dead that frightens me, doctor, it's dying'. Most people in our society have not seen anybody die. Their image of death comes from the horror comics and other dramatic and often horrific portrayals of death, which sell newspapers and the like. When people learn about real deaths, it is often the deaths that have been badly handled that get talked about. To many people 'death' means 'agony' and it may come as a surprise to them to learn that, with proper care, pain need not be a problem.

1.2.   The problem of grief

Grief is the normal reaction to any major loss and is not limited by bereavement. Illnesses such as cancers and AIDS tend to progress in steps. At each setback the patient is faced with another cluster of losses. Initially, the loss of security and body parts affected by the disease constitute the major losses but, in later stages of the illness, increasing disability may cause loss of mobility, occupation and an increasing range of physical functions. In the last phase, the patient faces the prospect of losing life itself and all the attachments that go with it.

Each new loss will tend to evoke intense feelings of yearning for the object that is lost. The person experiences a strong need to cry aloud and to search for ways of retaining some or all of the lost object. A woman may intensely miss the breast that she has lost and find some solace in a good prosthesis or in reconstructive surgery. A man may long to return to work and surprise his workmates by arriving at his place of work despite severe weakness. Patients in a hospital regularly pine to go home, and many will do so even with the problems that this may cause to their families.

It is important not to confuse normal grief with clinical depression. Grief is intermittent and, even within an hour or so, people who allow themselves to express grief will feel better, although the pangs will return. Depression, by contrast, is lasting and undermines sufferers, preventing them from doing the very things that

would get them out of the depression. *The slowing down of thought and movement, and the feelings of worthlessness, which characterize clinical depression, contrast with the restlessness of the grieving person.* Other symptoms of depression – **anorexia, loss of weight and early morning waking** – also take place as part of grieving (particularly if the grief is caused by a debilitating illness).

Diagnosis is important because clinical depression requires, and will usually respond to, treatment with antidepressant medication. Given this help, people who are grieving and depressed often find that, as the depression gets better, they can grieve more easily.

1.3. Resistance to change

More problematic is the tendency to deny the reality of the diagnosis, or prognosis, or to avoid facing the implications of this. Many patients make it clear that they do not want to be told about their illness. This is most likely to happen if the doctors are themselves uncertain or are giving conflicting messages. Family members too may find it hard to accept the fact that a loved person's lifespan is very limited and may be more resistant to facing reality than the patient.

Denial is a defence against overwhelming anxiety, and may enable people to adjust more gradually to the massive changes that threaten their internal world. It is a basic assumption in the minds of most people that we know where we stand. This rather trite statement covers a major but under-rated fact that we can only relate to the world around us because we possess an internal model of that world by which we recognize the world that we meet and plan our behaviour accordingly. This applies at the level of everyday habits (getting up in the morning, walking across the room, laying two places for breakfast, etc.) and at the deeper level of finding meaning and direction in life (wanting to get up in the morning, eat breakfast, etc.).

Major losses render obsolete large sections of our internal world and require a process of restructuring at both levels of functioning. For a while, people who are faced with a discrepancy between the world that is, and the world that should be (on the basis of our experience up to now), continue to operate the old obsolete mode which is, after all, the only model they have. The amputee leaps out of bed and finds himself sprawling on the floor, the widow lays the table for two. Even more common are the habits of thought which lead into blind alleys ('When I get better, I shall go back to work' or 'I must ask my husband about that').

Each time we are brought up short by a discrepancy of this kind, we suffer another pang of grief, intense, painful pining for what we have lost. This forces us to take stock and to begin the long and difficult process of revising our assumptive world. This takes time and it takes even longer for us to revise the basic assumptions that give meaning to life, e.g. that we can find new sources of self-esteem without having to go to work each day, that life in a wheelchair can be quite tolerable or that a widow is not condemned to perpetual mourning.

Because we rely on the possession of an accurate internal model of the world to cope with the world and to keep us safe, we feel, and are, extremely vulnerable whenever we are faced with major discrepancies of this kind. More than at any other

time, we need the understanding and protection of people close to us; small wonder that patients and family members grow closer to each other at times of threat and that many people would rather be at home than in a strange or impersonal hospital ward. For those without families, the support of doctors and nurses may be invaluable, but such patients may cling to the security of their home as if this were the only safe place in the world.

The psychosocial transition faced by the dying patient may be more frightening but is usually less complex than the transition faced by the patient's spouse. Having faced the facts of the illness, the patient has not got to learn new ways of coping, acceptance brings its own rewards and the patient will often find that family and other carers are happy to take over responsibility for managing the affairs which previously caused anxiety and stress in the patient's life. 'Don't you worry, we'll look after things now', can be very reassuring to someone who has never previously had the opportunity to 'let go'. Perhaps, because of this, patients who face their illness, and accept that there is nothing more to be done, often enter a peaceful state and achieve a relatively happy conclusion to their lives. They seem to come through the process of grieving more quickly and completely than their spouses who have to discover a new identity and who will often continue to grieve for years to come.

2. Coping strategies

Many of the differences between the ways people cope with threats reflect the assumptions and coping strategies that have been found to minimize stress early in life. At times of threat, those who lack the confidence in their own resources may seek help of others, express clear signals of distress and cling inappropriately. Those who lack trust in others, on the other hand, may keep their problems to themselves, bottle up their feelings and blame health care providers or therapies for their symptoms. Their lack of trust makes it necessary for them to control us rather than be controlled by us. A few, who lack trust in themselves and others, may keep a low profile, turn in on themselves and become anxious and depressed.

Some people may have learned that the one sure way of getting love and attention is to become sick. In later life they respond to threat by developing hypochondriacal symptoms or exaggerating the symptoms of organic illness. If the threat has been caused by an illness, the interaction of psychological and physical influences may be difficult to disentangle. These interactions have been explored, with sensitivity, by Wilkinson who stresses that we need to learn 'the music that the patient is dancing to, the form of their complaining'.

3. Influencing the transition

All of these strategies reflect insecurity and will respond to reassurance and the creation of a 'secure base', a safe place and a secure relationship in which, little by little, the insecure person can begin to pay attention to and discuss the problems that make them insecure.

To those who lack self-esteem the most important thing we have to offer is our esteem for their true worth and potential. To those who lack trust in others we can

show that we understand their suspicion and their need to be in control of us. We act as advisors rather than instructors and show that we accept that trust must be earned: it is not our right to be trusted.

Life-threatening illness can undermine the confidence and trust of us all and the process of revising one's internal model of the world is made easier if the issues are clear and if there is someone nearby who will keep us safe during the period of vulnerability. It follows that members of the caring professions can do a great deal to help people through these psychosocial transitions. Accurate information is essential to planning; hence the reaction of relief that is expressed by many patients when they are told they have cancer. It is easier to cope with the worst than to live in a state of planlessness.

Much has been written about the patient's right to know the truth about an illness, but we must respect his or her right to monitor the amount of new and painful information that he/she can cope with at any given time. It is just as wrong to tell people too much, too soon, as it is to tell them too little, too late. Patients who refuse to give consent to major surgery may just need a little time to call on the support of other family members before changing their mind. If we respond by threatening them with the dire consequences of their refusal, this may increase their anxiety and delay the final decision.

Similarly, we need to recognize that it takes time to break bad news. To impart the information to a person that they have cancer or AIDS is to inflict a major psychological trauma. No surgeon would think of operating without booking an operating theatre and setting aside sufficient time to do the job properly. The same should apply to all important communication between professional carers and the families we serve.

We need to know whose lives are going to be affected by the information we possess, to decide who should be invited to meet us and where the meeting should take place. This means that someone must draw a genogram, a family tree which identifies each relevant person in the patient's family. Having identified the key people, we must decide who is the best person to talk with them and whether they should be seen together or separately.

People will remember, for the rest of their lives, the details of the occasions when important news was broken. Even the pictures on the wall are important, and there is a world of difference between the doctor who adopts a relaxed and supportive attitude in a pleasant home-like atmosphere and the busy, impersonal consultant who breaks bad news in a public ward, or in the sterile environment of a treatment room. The placing of chairs at the same level, and at an angle to each other so that human contact is possible and there are no desks or other barriers between us, helps to create the conditions in which communication is possible.

Before telling people what we think they need to know, we should find out what they already know, or think they know, about the situation and what their priorities are. If they use words like 'cancer' or 'death', we should check out that these words mean the same to them as they do to us. 'There are many kinds of cancer, what does the word mean to you?', 'Have you seen anyone die? How do you view

death?' will often reveal considerable ignorance and open the door to positive reassurance and explanation. Too often, doctors fail to invite questions and miss the opportunity to help people with the issues that are concerning them most.

Members of the primary care team are in a position to provide continuity of care throughout the illness and bereavement, and are particularly important sources of support. They are likely to be familiar with the social context in which the illness has arisen, to know the family members who are most at risk of adjustment problems and to have a relationship of trust with them that will enable the team to see them through this turning point in their lives. The fact that the primary care team are providing long-term care means that they will often have more time and opportunities to help the family to work things out than other caregivers have.

Finally we must recognize that the care of the dying can be stressful for the professionals as well as those for whom they care. A good staff support system is essential and should include the recognition that, if it is all right for patients and their families to cry when they grieve, it should be all right for us too. The 'stiff upper lip' which makes it so hard to help some patients and family members is even more of a problem in doctors.

Lecture 5
Coping with Stressful Medical Procedures

Stressful medical procedures range from highly stressful ones, such as major surgery and chemotherapy, to simple procedures such as immunizations and blood tests. Though such procedures vary greatly in the degree of *physical intrusiveness, pain and discomfort* they cause, the stress experienced by patients results not only from these physical factors but also from the *subjective meaning of the procedure* for the patient and his/her resources for coping. The physical aspects are interpreted within the subjective framework, which determines the extent of psychological reactions. Therefore, in order to understand how patients cope with these procedures and how to assist them in their effort, health care providers must understand both the objective and the subjective aspects of this experience.

Undergoing a medical procedure entails coping with the procedure itself and coping with the accompanying negative feelings (mainly anxiety). Such feelings are related to the context in which the procedure is carried out, for example, cancer as highly anxiety provoking, infertility as a low-control situation, coronary artery bypass surgery or transplant surgery, which elicit fears due to the uncertainty involved. Negative feelings also arise from discrepancies between prior expectancies or pre-existing imaginings and the actual procedure (e.g. the difference between the expectation and the reality of giving birth). Prior experiences also influence reactions to a stressful medical procedure, whether these are prior medical experiences as a child or as an adult (for example, undergoing mammography among women who have had a lumpectomy), recent life stress or even early traumatic experiences (such as the Holocaust).

Procedures such as surgery require a recovery period. Anxiety related to the procedure can delay recovery from it. Studying the direct predictors or outcomes of such anxious reactions is not enough since anxiety operates through a variety of behavioural and physiological mechanisms, within a personal and social context. Therefore, this chapter will first briefly review individual differences in coping with stressful procedures as well as the effects of the social and cultural context and then discuss ways to assist patients undergoing these procedures.

1. Individual differences in coping with medical procedures

Many studies have examined differences in coping styles. One of the most common distinctions is between an _avoidant and an active or instrumental coping style._ Typically, studies found avoidant coping with medical procedures and the physical and psychological distress they cause to be related with worse outcomes and active coping with better outcomes among adults, and young people. Moreover, a maladaptive spiral of distress and avoidant coping can progress over time.

Another distinction is between _attention focusing and distracting_ as ways of coping. Distraction by focusing on a specific stimulus could be helpful whereas simply attempting to ignore the situation could result in a rebound effect that leads to more intrusion later on. Attention focusing has been found to be helpful in some studies and negative in others. The inconsistencies may be due to the nature of the stressor with which patients coped: attention to an injury-related procedure could increase post-traumatic responses whereas attention to concrete aspects of a procedure aimed at curing an illness or removing a health threat could decrease such responses.

The attention/distraction distinction has also been studied as a personality disposition, typically labelled as _monitoring versus blunting information-seeking style_. In relation to medical procedures, research has shown that relaxation training led low monitors and high blunters to suffer from less surgical pain and less anxiety due to cancer chemotherapy, possibly because relaxation is a distraction technique. High monitors benefited from the provision of detailed information, such as viewing the contraction monitor during labour, and fared most poorly with no preparation at all.

Other personality dispositions have also been associated with coping and outcomes of medical procedures: _dispositional optimism_ was related to better recovery and lower rates of re-hospitalization following coronary artery bypass surgery; _internal locus of control_ moderated the relationship between coping strategies and long-term recovery from surgery for scoliosis among young people.

2. Age differences in coping with medical procedures

Though many findings replicate across ages, there are indications that we need to consider children and adolescents separately (from each other and from adults) when attempting to understand and facilitate their coping with medical procedures. _Children's conceptualization of pain, their appraisal of the situation and their ways of coping differ from those of adults._ Children's approach-avoidance coping may be

qualitatively different from adult's approach-avoidance and they may need more preparation and training for coping with medical procedures. Their ability to cope at different ages is also a major factor in decisions regarding the best age for elective surgical procedures. Even within childhood, coping varies by age: older children, compared with younger ones, exhibited more attentive coping that was related to quicker return to activities following surgery and older adolescents' coping, compared with younger ones', was more strongly related to recovery from surgery. In addition, it is important to remember that *children are greatly influenced by their parents' reactions to the situation and ways of coping with it*. In light of the differences between adults and children in their reactions to procedures, there are also separate instruments that measure individual differences in coping with stressful medical procedures among adults and among children and their parents.

3. Gender differences in coping with medical procedures

Women report higher levels of fear than men in reaction to injections and blood sample collection, examinations and symptoms and report more pre-operation anxiety than men. Women and men often perceive stressful medical procedures differently, sometimes because they are experienced at a different age (for example, cardiac procedures, Hawthorne, 1994). Some procedures have different effects on women's and men's self and body image, and coping with them could be differentially affected by social support in the two gender groups. Yet, there has been surprisingly little attention paid to these differences and their implications for planning interventions.

4. The social and cultural context

Coping with stressful medical procedures entails intensive contact with health care providers in a situation that often involves a lot of uncertainty. Different 'languages' are used in the culture of patients and the culture of providers when talking about health, illness and uncertainty. Patients often interpret statistics and other information in ways that are biased so as to preserve their hopes, whereas doctors judge treatment success across the general patient population.

This **cultural conflict** can result in much frustration and feelings of being misled on the part of the patients and in similar feelings of frustration among providers in reaction to their patients' responses. The physician–patient cultural differences can be intensified if they occur within wider cultural gaps, such as a different ethnic or religious background. Sculptures of childbirth from traditional societies typically show several figures surrounding the woman at labour. Drawings of folk healers typically portray an encounter that takes place amidst a small crowd. These depictions of traditional medicine vastly differ from modern clinics and hospitals. The differences they portray can lead to misunderstandings and feelings of alienation and anxiety among immigrants and patients from more traditional families. In culturally sensitive issues, such as third-party assisted conception procedures, it is especially important to be aware of ethical considerations that differ around the globe.

The family environment is also of utmost importance to the person coping with a stressful procedure. Family members typically offer a lot of encouragement and support while the patient undergoes the procedure and during initial recovery but may underestimate the length of time required for full recovery and the patient's needs during that time. In addition, family care givers have their own fears and therefore their own needs for information and reassurance. This is especially prominent for female spouses.

Finally, the *immediate social context* also plays a role. The opportunity for social comparison with someone who has already undergone the procedure can provide reassurance and useful information: pre-operative patients assigned to a room at the hospital with a post-operative patient showed less anxiety and a quicker recovery; patients with any roommate recovered faster than no-roommate patients, and cardiac patients assigned to a room with another cardiac patient were discharged sooner after bypass surgery compared with those assigned to a non-cardiac roommate.

5. Assisting patients coping with stressful procedures: what troubles them?

In order to plan interventions to assist patients, we need to understand the issues that bother them as they face a stressful medical procedure. The common-sense model of illness (Leventhal et al., 1980, 1984) provides a useful framework to illustrate these issues. This model attempts to delineate the principles underlying lay people's perceptions of health threats. Research has shown that these perceptions are mostly structured around five dimensions: *the identity and symptoms of the health threat; its causes; the timeline; the degree of controllability; and the consequences.* In relation to stressful medical procedures, these dimensions suggest that patients are troubled by the following concerns:

1) *Identity and symptoms* – patients focus on questions such as: What is happening to me? What am I supposed to feel? What will I feel?
2) *Causes* – What caused my situation? Why do I need to undergo this procedure?
3) *Timeline* – Is this an elective procedure or an emergency one? What happens before, during and after the procedure? How long will I have to wait for the procedure? How long will it take? How much time will it take me to return to my normal routine?
4) *Controllability* – Is it mandatory that I undergo this procedure? What are the potential benefits and risks? Who is responsible for the decision to undergo this procedure? What are the alternatives? What information do I need in order to choose among them? How can I regain control and decrease helplessness? Is there anything I can do to increase the chances of success of the procedure and of quick recovery?
5) *Consequences* – How serious is my condition? How serious and intrusive is this procedure? What are the expected side-effects in the short and the long term?

6. Assisting patient coping with stress procedures: planning interventions

Successful interventions must be planned so that they address patients' concerns, as suggested above. A single intervention cannot cover all possible concerns and problems that could arise. Therefore, when planning (and evaluating) such interventions *it is important first to characterize the population, the health problem and the context in which it is experienced.* In the light of these characteristics, it is important to clearly define criteria for success: *Is the goal to decrease anxiety? To lessen the side effects? To minimize patient problem behaviours? To facilitate recovery? To shorten the period of hospitalization?* Many studies have evaluated interventions aimed at preparing patients so that they will cope more adaptively with stressful procedures. Their findings suggest several principles and essential components that should be included when planning and administering such interventions.

The provision of information is a necessary component of any intervention in this area. In order to determine which information will be provided and at what level of detail, one needs to consider this from the patient's viewpoint. Patients will need various types of information:

• **factual/procedural** (what will happen to you)

• **behavioural** (what do you need to do in preparation for the procedure and for the recovery period; how can you cope most effectively with the procedure itself and its side effects)

• **sensory** (what will you feel)

• **emotional** (which emotions will you feel)

• **administrative** (what do you need to do in order to set this up, receive reimbursement, etc.).

While all of these aspects should be addressed, it is also *important to consider the level of detail that is beneficial to the patient*: detailed information could 'overwhelm' the patient beyond his or her ability to process it and benefit from it and/or result in increased instead of decreased levels of anxiety. Therefore, for many procedures preparation should be a multi-stage effort. For example, patients undergoing surgery may have different concerns and need different types of information and support pre-operatively, post-operatively and pre-discharge.

Preparation for procedures typically includes mostly verbal information. Providing this information in written form also allows patients to retain it for future reference. The information need not be merely verbal: many hospitals and clinics have used videotapes or tours. It is not clear whether tours are effective for adults and for children they are even more questionable. In touring a ward there may be less control over the stimuli to which patients are exposed whereas videotapes allow for preplanned and well controlled exposure.

In providing information to patients, it is important to attend to the full timeline from the initial consideration regarding whether to undergo the procedure until full recovery. Naturally, when preparing the patient and his/her family, providers tend to

concentrate on alleviating the immediate distress from the procedure they are about to administer by focusing on the procedure itself and the time around it. This focus can lead to disregarding both the difficulties of decision-making and preparation for the procedure, and, even more importantly, the long-term effects. Inadequate preparation for the long-term recovery can result in later patient distress and misunderstanding within the family. Even procedures that end positively and are not considered by the health care system to have any long-term effects, such as biopsies that provide reassuring results, require thought about the after-effects: some patients, especially the less educated and the more anxious to begin with, are not easily free from anxiety.

Ideally, the information provided should be adapted to the patient's characteristics and preferences. Patients vary greatly in the types of pre-operative information and support they preferred. Many studies have shown better outcomes when the information matched the patients' coping styles. When children are the patients, it is especially important to provide developmentally appropriate information. For example, an explanation that 'you will be put to sleep before the procedure' leads them to think that they will feel the same as they do every night in bed. It does not prepare them for the very unnatural way of falling asleep through the use of anaesthetics, which could include a few quite terrifying moments in which everything swirls around them.

The main reason for providing information has always been to reduce anxiety. Information can reduce anxiety by decreasing uncertainty and helplessness and by enhancing feelings of control. Control can also be increased by other means:

- Patients can be more involved in decision-making regarding the preferred procedure.
- Patints can be given control over aspects of the procedure and recovery, whenever possible (as in patient-controlled analgesia following surgery).
- Patients who are more involved could improve the quality of preparation for procedures if they are assertive, ask questions, gather information, do their 'homework', and attend structured preparation sessions.

However, it is important to remember that many patients expect to be obedient to medical and nursing staff when they undergo a procedure and they do not always understand that they can exercise active control, even when clearly instructed to do so. Patients may also initially accept a more paternalistic approach but over time desire more active involvement in the choice of treatment.

In addition to preparing the patients, it is important that they receive effective support from their family members and care givers. Negative support can hinder recovery more than positive support and other resources can improve it. Therefore, it is important to attend to the perceptions and misperceptions of the situation by the care givers and to provide information and training specifically to the care givers. With children, it is essential to train the parents so that they will boost their children's ability to cope effectively instead of increasing the children's distress as well as their own.

Lecture 6
Psychosomatics

1. Introduction and historical overview

The term 'psychosomatic' was first used in the early nineteenth century by **Heinroth** to mean 'belonging to the body and the mind'. Psychosomatic conceptions were much older than this however. **Plato** observed that the ability of the 'physicians of Hellas' to cure disease was limited because they disregarded 'the Whole, which ought to be studied also, for the part can never be well unless the whole is well'. The term 'psychosomatic' is a modern designation for that holistic view of man and medicine which has its roots in ancient Greece. Throughout the nineteenth century it was widely accepted that psychological factors could play a part in the aetiology of physical illness.

The term has been used in a number of different ways in the last hundred years however. In the first half of the twentieth century three psychosomatic schools emerged and competed for prominence: ***the psychoanalytic, the psychophysiological and the psychobiological (holistic, biopsychosocial)***. The development of these three schools, which proved difficult to integrate, will be briefly described.

<u>Psychoanalytical school</u>, led by **Alexander**, focused on the postulated psychogenesis of a handful of somatic disorders of unknown cause such as <u>*bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neuro-dermatitis, thyrotoxicosis and peptic ulceration.*</u> Alexander (1950) proposed that emotional changes in human beings were accompanied by physiological changes which led in turn to pathological physical changes: once physical pathology was established, psychological factors could help to maintain or aggravate it or to trigger relapse. For Alexander, a specific <u>'emotional constellation'</u>, one consisting of an unconscious conflict, defences against it, and emotions engendered by it, would elicit specific vegetative responses, which could lead to a specific bodily disorder. This led to the belief that a physical condition produced in this way would improve if the psychological disturbance improved, either spontaneously or as a result of psychological treatment.

Alexander's theories came to connote for many people nothing but the psychological causation of bodily disorders, and this psychological reductionism fell into disfavour after the 1950s. The other psychosomatic schools, **<u>the psychophysiological and the psychobiological</u>**, have gained prominence over the last 50 years, as the psychoanalytical school's influence has faded away. The psychophysiological school, derived from the work of **Pavlov** on the conditioned reflex and of Canon on the physiological concomitants of emotions, such as fear and rage, was prominently represented by **Wolff**, who postulated the contributory role of psychological stress on in the occurrence, course and outcome of a wide range of diseases. Wolff and his colleagues examined the mediating physiological mechanisms that occur following one's exposure to personally meaningful

information. That whole area of research has flourished subsequently under the label of psychophysiology.

The **psychobiological school** was derived from the work of **Adolf Meyer**. Led by **Flanders Dunbar**, this school was most explicitly holistic in its orientation. Dunbar, who founded the American Psychosomatic Society, published a substantial survey of her own and other clinicians' observations in the book *'Emotions and Bodily Changes'* (Dunbar, 1954). She emphasized the need for a comprehensive, biopsychosocial approach to the study and management of all patients and not just those called 'psychosomatic'. She was one of the pioneers of liaison psychiatry, and also emphasized the need for preventive medicine and stressed the important role played by psychosocial factors in disease development and prevention.

In its modern usage the term 'psychosomatic' has come to connote holistic. This refers to a set of assumptions about mind and body, the role of psychosocial factors in health and disease and the place of these factors in medical management. Recent definitions of the term psychosomatic emphasize the mind-body relationship as follows:

1. Involving or concerned with the interdependence of mind and body

2. (Medicine) designating, pertaining or relating to illnesses having
 both physical and mental components, usually involving a physical condition caused or aggravated by mental or emotional disorder (Shorter Oxford English Dictionary, 2001).

Psychosocial factors are believed to be involved, to a greater or lesser extent, in every disease and episode of illness. All disease is assumed to be multicausal, which is to say it is the result of a complex interplay of biological, psychological and social variables.

2. Recent developments

Since the 1970s theories have been less dogmatic. A key publication by **Engel** in 1977 proposed the ***biopsychosocial approach to illness***. Subsequent research has focused on a number of broad areas that are not mutually exclusive. They include:

- ✓ psychophysiological mechanisms;
- ✓ the impact of life events and difficulties on illness;
- ✓ the physical manifestations of psychological illness;
- ✓ the psychological consequences of physical illnesses;
- ✓ the effect of psychological treatments.

These five areas will be discussed below. The word 'psychosomatic' now appears in five leading journals, and both general hospital (liaison) psychiatry and health psychology have developed as major areas of clinical practice and research over the last two decades. A recent updated database of key references in this field has been published by Strain et al. (2003).

2.1 Psychophysiological research

A major purpose psychological physiological research has been to detect the physiological mechanisms and pathways between the perception of personally meaningful stimuli or information by the individual and the consequent changes in the functions of his or her various organs or tissues. Every sick person is exposed to personally meaningful information, such as remarks from doctors, which have the potential to affect mood or behaviour and in turn elicit changes in physiological functions. These may be therapeutic or deleterious. The most commonly researched psychosocial variable has been emotional stress.

The two main biological systems involved in the stress response are the sympathetic nervous system and hypothalamic–pituitary–adrenal system (HPA axis). The normal role of the sympathetic nervous system is to mediate the unconscious regulation of basic bodily functions. In a stressful situation it is also the chief mediator of the bodies' immediate alarm reaction – the so-called fight-or flight response.

Disturbed regulation of the HPA axis can also occur in response to long lasting arousal. Regulatory disturbances in the HPA axis have been suggested to play a role in certain illnesses. For example, the lack of response to stimulation of the HPA axis results in low plasma cortisol levels: as a consequence normal activation does not take place when the HPA axis activated artificially. A subgroup of patients with chronic fatigue syndrome and fibromyalgia show these characteristic patterns.

Other studies have shown that a person's psychological state may induce, presumably through neuroendocrine mechanisms, changes in the immune system that would facilitate the development of neoplasia. The field of psychoneuroimmunology has recently been the subject of a major review.

Arising from the work of Dunbar in the 1950s a number of investigators examined the links between certain personality and behavioural characteristics and the development of coronary heart disease (CHD). Despite two decades of research effort the 'Type A' behaviour pattern turned out not to be aetiologically relevant, and a meta-analysis of the body of research on the physical health consequences of hostility concluded that the psychological trait of hostility – cynical mistrust, anger and aggression – is a risk factor for not only CHD but also for virtually physical illness.

One of the most potent (and most frequently investigated) stressors in contemporary life is work. Occupational stress has become very topical, and is also a legitimate field of research. It has been demonstrated that certain occupational characteristics are more likely to lead to adverse outcomes than others. For example, many jobs involving high degrees of effort but providing lower levels of reward – in terms of remuneration, job security and prospects for promotion – are at higher risk of developing several of the biological precursors of heart attack, such as raised cholesterol level and blood pressure. Job strain and effort – reward imbalance have also been found to be associated with high health risk behaviours and psychological illness.

This research in occupational stress has emphasized that being unsure of your ability to control a stressor appears to make matters worse. Uncontrollable stressors

carry a higher risk of provoking psychological depression than equally severe but controllable stressors. For example, when animals are subjected to severe and uncontrollable stressors they can develop a mental state called **learned helplessness**, which bears many of the hallmarks of clinical depression in humans (Seligman, 1986). Marmot has extended this work and recently argued that low social standing is seen not only as a condition of material deprivation but also an indicator of people's capability to control life and fully participate in society (psychosocial disadvantage). As a person's position in the social hierarchy decreases, the less likely he or she is to have full control over life and opportunities for full participation in society. Marmot (2004) has made a forceful case showing that low control over life and social disengagement are the most powerful explanatory factors for the social gradient of health: *people who are lower in the hierarchy tend to have worse health and shorter life expectancy.*

Control has multiple ramifications for mental and physical wellbeing. For instance, it helps people to deal with chronic pain. A person who feels he/she is in control of pain and of their life will be consistently better able to cope with prolonged high levels of pain than one who feels helpless. Research has confirmed that boosting patients' sense of control helps in the management of pain. This is an important practical issue for cancer patients and others suffering from chronic pain.

2.2 Life events and difficulties

The notion that we are at increased risk of falling ill when exposed to a lot of disruptive change or emotional turmoil is not a new one. Early studies of absenteeism indicated that employees with unsettled personal lives tended to suffer frequent bouts of illness and take more sick leave from work.

The formulation of the concept of stressful 'life events' has led to thousands of research projects which have investigated the relationships between life events and health. Methodological problems bedeviled this work, which is essentially retrospective in nature and influenced by the perception and interpretation of the significance and meaning of events by individuals.

George Brown and his colleagues in London have been pioneers in this research endeavor and have developed a methodology that attempts to circumvent these difficulties. In a key early study they demonstrated that the *link between severe life events and the onset of organic illness* was likely to be mediated by the occurrence of a psychiatric (affective) disturbance. Subsequent research, using the Life Events and Difficulties Schedule (LEDs) has shown that life events can have a very important role not only as precipitants but also as formative causes of a wide range of illnesses. For example, important links have been established between life events and the onset of a number of physical disorders such as multiple sclerosis and stroke. In the recent INTERHEART study, in which patients were recruited from 52 countries, the presence of a range of psychosocial stressors was associated with increased risk of myocardial infarction. A range of functional somatic syndromes such as functional dysphonia, chronic fatigue syndrome and functional gastrointestinal disorders have also been shown to be related to stressful life events.

In addition to major life events, such as *bereavement and unemployment*, more routine 'hassles of everyday life' and 'chronic ongoing difficulties' have also been shown to have an impact on health. Indeed, because these everyday problems are such a frequent occurrence, their cumulative influence on health may be more pervasive than the effects of rarer, but more traumatic life events.

2.3 Physical manifestations of psychological disorder

Patients who report physical symptoms with no identifiable cause have attracted considerable interest and controversy; not least because there is no consensus on how these disorders should be described. For many years patients with unexplained symptoms were said to have a 'psychosomatic' illness. However, this term is now considered to be potentially misleading when used to describe these patients, as it implies that the symptoms necessarily have a purely psychogenic origin, which is not always the case. An alternative term, **'somatisation'**, has been coined to describe a supposed process by which some people experience and communicate psychological distress as physical symptoms, but this description presumes that psychological problems are being avoided and that the physical symptoms are 'all in the mind'. To avoid the artificial separation of the mind and body, terms such as **'medically unexplained symptom'** and **'functional somatic symptoms'** have been used. None of these terms is satisfactory, but it has been shown recently that patients with these disorders prefer the term **'functional'** to other descriptions.

Clusters of chronic medically unexplained symptoms can appear to form symptom syndromes, and so are sometimes given diagnostic labels such as irritable bowel syndrome, chronic fatigue syndrome or fibromyalgia, depending on the symptoms and the medical specialty to which the patient is referred. The results of a recent observational study suggest that substantial overlap exists across diverse symptom syndromes. Indeed, the overlap between such syndromes is so great that they are better seen as a single underlying disorder.

In adults, medically unexplained symptoms prompt almost half of all primary care consultations, but are shown to have an organic origin in only about 10–15% of patients who were followed for one year. In general hospitals these patients are responsible for 30–50% of presentations in outpatient departments: these patients are difficult to manage, costly and often the victims of iatrogenic illness if they are not identified and treated promptly. These disorders have attracted considerable attention and have been the subject of numerous treatment studies in the general hospital. Cognitive behaviour therapy (CBT) is widely advocated for these patients, and in a systematic review of 31 controlled studies (29 randomized) physical symptoms improved in 71% of studies, psychological distress decreased in 38% and functional status improved in 47%. Group CBT also helps patients with medically unexplained symptoms, and hypnosis has also shown benefits. Regrettably, there are insufficient clinical psychologists in general hospitals available to provide appropriate treatment for these patients, who are an enormous burden on healthcare resources.

2.4 Psychological consequences of physical illness

Organic mental disorder may occur in the course of many serious physical illnesses or surgical procedures, especially among the elderly. Delirium, dementia and other organic disorders associated with specific medical conditions have been described by Lishman (1998). This section is concerned with emotional disorders consequent upon physical illness.

Certain factors increase the risk of serious psychiatric disorders developing in the physically ill. Patients are more vulnerable if they have had a previous psychiatric disorder or a life-long inability to deal with adversity, or if they have a disturbed home life or an otherwise unsatisfactory social background. Furthermore, certain kinds of physical illness are more likely to provoke serious psychiatric consequences. These include life-threatening illnesses, and illnesses requiring lengthy and unpleasant treatment such as radiotherapy or renal dialysis or mutilating treatment such as mastectomy.

In the physically ill, the commonest psychiatric disorders are emotional disorders, which occur in 10–30% of patients with severe physical illnesses. Most of these emotional disorders can be diagnosed as adjustment disorders, whilst specific anxiety and affective disorders are also common. Other conditions that are less frequent are somatoform disorders and paranoid disorders. The many psychological symptoms that can be caused directly by physical illness are shown in Table 1.

Table 1. **Determinants of the occurrence of psychiatric disorder among physically ill patients**

The physical disease as a cause of:
Symptomatic psychiatric disorder
Threat to normal life
Disability
Pain

Nature of the treatment
Side-effects
Mutilation
Demands for self-care

Factors in the patient
Psychological vulnerability
Social circumstances
Other life stresses

Reactions of others
Family
Employers
Doctors

Depressive and anxiety disorders precipitated by physical illness or injury may be regarded as being mediated by the meaning of the illness for the patient, rather than as a direct manifestation of cerebral dysfunction. Significant depression has been found in approximately 20–25% of unselected medical inpatients, but its prevalence has been reported as much higher immediately following myocardial infarction, and in patients suffering from rheumatoid arthritis, Parkinsonism or carcinoma of the pancreas. It is important to diagnose mood disorder in patients with physical illnesses because the psychiatric complications may adversely effect patients' prognosis and interfere with rehabilitation and timely return to work.

Furthermore, depression is associated with an approximately 50% increase in medical costs of chronic medical illness, even after controlling for severity for physical illness. Increasing evidence suggest that both the depressive symptoms and a major depression may be associated with increased morbidity and mortality from such illnesses as diabetes and heart disease. The adverse effect of major depression on health habits, such as smoking, diet, overeating and sedentary lifestyle, its maladaptive effect on adherence to medical regimens, as well as direct adverse physiological effects (i.e. decreased heart rate variability, increase adhesiveness of platelets) may explain this association within morbidity and mortality.

In the last two decades there has been considerable interest in the psychosocial and psychopathological effects on modern medical and surgical technology, for example, transplantation surgery, chronic dialysis, intensive care units and long-term parenteral nutrition. More recent surgery for obesity has become a safer and more 'evidence based' procedure with improved outcomes. The recent clamor for cosmetic and plastic surgical procedures in patients with body image disorders has resulted in psychiatric casualties. As a consequence a need for pre-operative psychological assessment has increased, placing extra demands on psychological resources that often cannot be met.

2.5 Therapeutic research

Interventions in this field are usually directed towards modifying selected **psychological variables: behavioral, cognitive or emotional**. Therapeutic studies can be divided into two groups, which are not mutually exclusive: *(a) those that employ psychotropic medication and (b) those that employ psychological methods.*

a. Drug therapy. Hypnotic and anxiolytic drugs are valuable for short periods when distress is severe, for example, during treatment in hospital. The indications for antidepressants are probably the same as those for patients who are not physically ill, although the older tricyclic antidepressants have drawbacks because of their side-effects. In a recent randomized, doubleblind, placebo-controlled trial, Sertraline was found to be a safe and effective treatment in patients with recent myocardial infarction or unstable angina and without other threatening medical conditions.

b. Psychological treatments. Behaviour medication and biofeedback have been used for many years for the relief of a wide range of symptoms such a urinary incontinence, tension headache, various other painful disorders and, more recently, chronic constipation. This field of behavioural medicine demonstrates that physiological and pathophysiological functions can be modified by manipulation of psychological variables, a demonstration predictable from psychosomatic assumptions discussed earlier.

Psychological interventions have also been used in the rehabilitation of a wide variety of physical disorders such as stroke and myocardial infarction. Although there is no evidence to support the routine use of pharmaco- or psychotherapeutic treatment for depression after stroke, the evidence for behavioural treatment after myocardial infarction is more positive.

Weinman and his colleagues showed that patients' initial perceptions of illness are important determinants of different aspects of recovery after myocardial infarction. Furthermore, they predict overall functioning and number of visits to the outpatient clinic in patients with chronic obstructive pulmonary disease. More recently Petrie et al. (2002) showed that an in-hospital intervention designed to alter patients' illness beliefs and perceptions about their heart attack resulted in improved functional outcome. This is clearly a key area for future research in cardiac rehabilitation.

The usefulness of Cognitive behaviour therapy in medically unexplained symptoms – the so-called 'functional' disorders – has already been mentioned. Similar approaches have been used to treat patients with chronic pain, especially in the setting of multidisciplinary pain clinics.

3. Conclusion

Like hysteria, the word 'psychosomatics' continues to be widely used and has outlived its obituaries. The concept of psychosomatic medicine has become more widely accepted and is recognized as not only a reaction against mind-body dualism, but also as an organized field of scientific enquiry. In a clinical sense it represents an approach to the patient that recognizes the important relationship between psychological factors and bodily function, both in health and disease.

Lecture 7
Anxiety Disorders

1. Introduction

While normal fear is adaptive and prevents people from entering threatening situations, with anxiety disorders people develop irrational fears of situations which do not threaten their survival. They also develop non-adaptive behavioral patterns associated with avoidance of feared situations or experiences. For people with anxiety disorders, their fears are accompanied by intense physiological arousal which is shown by the presence of some of the following features:

- *accelerated heart rate;*
- *sweating;*
- *trembling;*
- *sensations of shortness of breath or smothering;*
- *feelings of choking;*
- *chest pain;*
- *nausea;*
- *numbness or tingling;*
- *chills or hot flushes.*
- *dizziness;*
- *derealization (feelings of unreality);*
- *or depersonalization (being detached from the self).*

Within DSM IV and ICD 10 distinctions are made between a variety of different anxiety disorders based on the developmental timing of their emergence, the classes of stimuli that elicit the anxiety, the pervasiveness and the topography of the anxiety response, and the role of clearly identifiable factors in the etiology of the anxiety. The following are the principal anxiety disorders described in DSM IV and ICD 10:
- **Separation anxiety**
- **Phobias**
- **Generalized anxiety disorder**
- **Panic disorder**
- **Post-traumatic stress disorder**
- **Obsessive-compulsive disorder**

Descriptions of these conditions and case examples are given below.

1.1. Separation anxiety

With separation anxiety, ***inappropriate fear is aroused by separation from an attachment figure. Although not the only cause of school refusal, it is one of the most common causes of this complaint.*** Separation anxiety with chronic school refusal is a serious condition since it has such a poor prognosis if left untreated. As many as a third of youngsters with this condition go on to develop panic disorder with secondary agoraphobia.

Case example. Barry, aged 11, was referred because he had not attended school for two months, following the Easter holidays in the year prior to his entry to secondary school. The family doctor could find no organic basis for the abdominal pain or headaches of which he periodically complained, particularly on the mornings when his mother asked him how his health was. Barry's friends visited him at weekends and he went off cycling with them regularly. But on Monday mornings he was unable to get to school both because of the abdominal pains and also because of

a sense of foreboding that something dangerous might happen to his mother. If forced to go to school he would become tearful or aggressive.

Family history. While there was no serious threat to Barry's mother's health, she had a variety of complaints including rheumatism and epilepsy which compromised her sense of wellbeing. Her epilepsy was usually well controlled, but she had experienced a number of grand mal fits in the six months prior to the referral. Barry was one of four children and all had histories of school refusal. Barry's three brothers, aged 20, 25 and 30, all lived at home and had few friends. His eldest brother ran a computer software business from his bedroom. All of the boys had very close relationships with their mother and distant relationships with their father. The father, Martin, who was a healthy man, ran a corner shop and worked long hours. He left early in the morning and returned late at night. He was very concerned for the welfare of his son, Barry, and believed that his wife mollycoddled the boy. But he was reluctant to challenge her because he did not want to upset her. The parents had a history of marital discord and over the year prior to the referral had strongly disagreed about how to handle the boy's separation anxiety.

Two of Barry's uncles had psychological adjustment difficulties and both had been on medication, although details of their problems were unavailable. These uncles had lived at home with their mother until her death and both of them and Barry's mother and her sister Gina had very close relationships with their mother, Mary, but distant relationships with their father. Barry's mother's parents had also quarrelled about how best to manage the children, with Mary being lenient and her husband being strict. Thus, the pattern of relationships in both Barry's mother's family of origin and Barry's family was very similar.

At school, Barry was very popular, particularly because he generously shared candy and sweets from his father's shop with his peers. He had complained of bullying once or twice and on one occasion said the gym teacher victimized him. Psychometric assessment showed that Barry was of high average intelligence and his attainments in reading, spelling and arithmetic were consistent with his overall level of ability. His school reports were good and he was in the top third of his class with respect to ability.

Formulation. Predisposing factors in this case include a possible genetic vulnerability to psychological adjustment problems and the modelling experience of seeing his three brothers develop separation anxiety and subsequent school refusal. Barry's anticipation of the transition to secondary school in the autumn and his awareness of his mother's worsening health may have precipitated the onset of the separation anxiety. The anxiety and the school refusal were maintained by his mother's overconcern and the father's limited involvement in the management of the child's difficulties. They may also have been maintained by the availability of an active social life within the house (involving contact with his mother and three brothers) during school hours and outside school hours at the weekend. Protective factors included the good relationships that Barry had with both his teachers and peers at school and the willingness of the father to become involved in treatment.

1.2. Phobias

Phobic anxiety is the intense fear which occurs when faced with an object, event or situation from a clearly definable class of stimuli which is out of proportion to the danger posed by the stimulus, and leads to persistent avoidance. In DSM IV specific phobias are distinguished from social phobias and agoraphobia. Specific phobias are subdivided in DSM IV into those associated with animals, injury (including injections), features of the natural environment (such as heights or thunder), and particular situations (such as elevators or flying). With social phobias the principal fear is of being evaluated by other unfamiliar people and behaving in an embarrassing way while under their scrutiny. Social phobia leads to a constriction of social life. In earlier versions of the DSM the term avoidant disorder has been used to designate this condition.

Case example. Nora, aged 9, was referred because of her fear of the dark. She wanted to go on a camping trip with the Brownies but was frightened because she would have to sleep in complete darkness. This was something she had never done. She always slept with the light on in her bedroom and with the door open and the landing light on. Her developmental history was unremarkable and she had never experienced a traumatic incident in the darkness. Her parents had tried to persuade her to sleep with the light off, but she became so distressed on these occasions that they had stopped making such attempts and believed that she would eventually grow out of the darkness phobia. Nora was an only child and there was no family history of anxiety disorders or adjustment problems, nor was there a developmental history of a particularly traumatic incident.

1.3. Generalized anxiety disorder

When individuals experience generalized anxiety, they have an ongoing apprehension that misfortunes of various sorts will occur. ***Their anxiety is not focused on one particular object or situation.*** In earlier versions of the DSM the term overanxious disorder has been used to designate this condition.

Case example. Margie, aged 10, was referred because of excessive tearfulness in school which had been gradually worsening over a number of months. The tearfulness was unpredictable. She would often cry when spoken to by the teacher or while playing with her friends during break-time. In the referral letter her family doctor described her as a worrier, like her mother.

Presentation. In the intake interview Margie said that she worried about many routine daily activities and responsibilities. She worried about doing poorly at school, that she had made mistakes which would later be discovered, that her friends wouldn't like her, that her parents would be disappointed with the way she did her household jobs, that she would be either too early or too late for the school bus, that there would be no room for her on the bus and that she would forget her schoolbooks. She worried about her health and had frequent stomach-aches. She also had wider-ranging fears about the safety of her family. She worried that the house would be struck by lightning, that the river would break its banks and flood the lowlying fens where she lived and that her house would be washed away. She had concerns about

the future and worried that she would fail her exams; be unable to find a satisfactory job; fail to find a marital partner or marry an unsuitable person. She reported feeling continually restless and unable to relax.

Family history. Margie was the eldest of four children and the only girl in the family. Both of her parents showed symptoms of anxiety in the intake interview and her mother had been treated with benzodiazepines for anxiety over a number of years. The parents regularly discussed their worries about their own health, safety and their own concerns about the uncertainty of the future. The father, Oliver, worked with an insurance company, and frequently discussed accidents and burglaries that had befallen his clients. Margie regularly participated in these conversations, being the eldest child. The parents'chief concern was about Margie's tearfulness which they viewed as unusual. Her worries and fears they saw as quite legitimate.

Margie had a couple of close friends with whom she played at the weekends, but spent a lot of time in her parents' company.

Formulation. Predisposing factors in this case include a possible genetic vulnerability to anxiety and exposure to a family culture marked by a concern with safety and an oversensitivity to danger. No clearcut precipitating factor is apparent. Ongoing involvement in parental conversations about potential threats to the well-being of family members possibly maintained the condition along with the attention and concern shown towards Margie's tearfulness at school.

1.4. Panic disorder

With panic disorder there are recurrent unexpected panic attacks. These attacks are experienced as acute episodes of intense anxiety and are extremely distressing. The person may experience <u>a fear of losing control; a fear of going crazy; or a fear of dying.</u> People with this condition come to perceive normal fluctuations in autonomic arousal as anxiety-provoking, since they may reflect the onset of a panic attack. Commonly secondary agoraphobia develops. The person fears leaving the safety of the home in case a panic attack occurs in a public setting.

Case example. Sandra, a 15-year-old girl, was referred because of anxiety about sitting exams. She lived with her grandparents, Ruth and Josh. She slept and ate well and appeared to be happy. However, she would not venture away from the house. A tutor from the local technical college at which she was enrolled had regularly brought schoolwork to her for about nine months. The imminence of her GCSE exams, which were due to be held at the college, precipitated the referral. She wanted to overcome her anxiety so that she could travel to college and sit her exams, which she had felt unable to complete the previous year due to anxiety.

History of the presenting problem. In a preliminary interview, conducted at her grandparents' house, she described a fear of leaving the safety of her own home and how this fear increased with distance from her house. The fear began during her mock GCSE school exams a year previously. She had a panic attack and left the exam hall. She ran to her grandparents' house after this incident and subsequent attempts to return to school led to further panic attacks. Her family and the college staff, after some preliminary ineffective attempts to help her get out and about, gave

up trying. On many occasions, when she found herself any distance from the house, she would begin to panic and run back quickly. This led to the symptoms of panic abating. One staff member at the college visited her and taught her some relaxation exercises. He suggested she use these to help her cope with attempts to leave the house, but she found them of little benefit. Eventually she settled for a house-bound life.

During the attacks she was afraid she would die. She couldn't catch her breath and felt dizzy. She also felt as if she were out of her body and as if the world was dreamlike. The attack lasted no more than a few minutes. Subsequent attacks were similar to the first. On a couple of occasions when she had sufficient courage to visit her friends she had panic attacks. She described the fear o taking hot tea which she might not be able to finish without scalding herself, should she experience a panic attack and need to run home quickly. She said she would not like to offend her friends by not finishing her tea. Sandra's principal fears were that she would have an attack and would not get home safely. She was therefore frightened of going on buses or in cars on the motorway. She was frightened also of queuing at the bank.

Family history. Sandra's parents were divorced. Her father, Des, was a police officer in London and had left her mother, Lynn, when Sandra was 7 years old. Lynn lived near the grandparents, in a rural village about a three-hour drive from London. Lynn cohabited with Jeff whom she had met while hospitalized for depression. The mother had an extensive history of psychiatric treatment for anxiety disorders and depression. The grandparents and the mother were preoccupied with physical illness and psychological problems and regularly discussed threats to each other's well-being. There was also a view, based on Lynn's experiences, that psychological problems ran a chronic course and were unresponsive to psychological treatments. The grandparents and the mother had very close relationships with Sandra. Lynn was involved in regular conflicts with her mother over the suitability of Jeff as a partner for her. Sandra's brother, Paul, who attended university, visited her occasionally with his friends and she envied his lifestyle. He rarely joined in the conversations about illness at the grandparents' house. He was a drama enthusiast and Sandra would help him rehearse his lines when he visited. For Sandra, this was a welcome break from the regular conversation at her grandparents' house. Sandra had four or five friends who lived locally and two of these visited regularly.

Formulation. In this case the principal predisposing factors were a genetic vulnerability to anxiety from the mother's side of the family and a family culture that focused on illness, fear, danger and anxiety. The exam situation was the principal precipitating factor. Multiple unsuccessful treatments and the experience of negative reinforcement afforded by escaping from threatening situations maintained the condition. Other maintaining factors included the father's lack of involvement in attempts to help Sandra recover, the grandparents' and mother's danger-saturated family culture and their beliefs that psychological problems had a chronic course and were unresponsive to treatment. However, two positive peer relationships and a desire for vocational progression were also present in this case and were important protective factors.

1.5. Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) occurs in many people following a catastrophic trauma which the individual perceived to be potentially life-threatening for themselves or others. In PTSD there are recurrent intrusive memories of the trauma which lead to intense anxiety. The person attempts to avoid this by suppressing the memories and avoiding situations that remind them of the trauma.

Case example. Margaret, a 25-year-old woman, was referred because of recurrent nightmares and erratic behaviour at work. She was employed as a cashier in a petrol station in a busy suburban area. On two occasions, while at work, a man armed with a hypodermic syringe filled with blood, which he claimed was HIV-infected, had coerced her into handing over the contents of the cash register. She subsequently suffered from nightmares and daytime flashbacks. She also suffered from a high level of generalized physiological arousal and was anxious and short-tempered at work. She attempted to deal with the nightmares and flashbacks by putting them out of her mind and thinking about other things, but found that this was becoming less and less effective. When she became flooded with feelings of anxiety she would become inappropriately aggressive to customers at work and was frightened that she would lose her job because of this inappropriate behaviour. At home her relationships with her mother and sisters had deteriorated.

1.6. Obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) is a condition typically characterized by distressing ***obsessional thoughts or impulses***, on the one hand, and ***compulsive rituals which reduce the anxiety associated with the obsessions***, on the other.

Case example. April, a 35-year-old woman was referred because she had, gradually over a two-year period, developed some unusual habits, beliefs and feelings. With respect to her behaviour, she scrubbed the floors and walls of the kitchen, bathroom and toilet every day and put a full set of bathroom towels in the dustbin after a student lodger had used them once. She also put crockery and dishes she had used to cook the family's dinner in the dustbin. She prevented the children from playing anywhere where they might fall and cut themselves, including the playground. She took an hour to go to bed each night because she had to repeatedly go downstairs to check that the doors were locked and the fire was extinguished. She had been an affectionate person, but now balked if her friends tried to embrace or kiss her.

With respect to her beliefs, she was frightened that she or her children or husband would catch HIV and develop AIDS. She feared that the student lodger or her friends might infect her with the HIV virus. She was also frightened that a burglar might break in if she did not lock up at night and stab her with a needle and infect her or the children with the HIV virus.

With respect to her mood, she felt anxious much of the time and had difficulty sleeping. She also felt sad and empty. She was embarrassed, because she knew that her fears were unfounded.

Family history. April was brought up by strict parents with whom she continued to have close contact. She had trained as a nurse but now was a homemaker with a caring and successful husband and two healthy children. She devoted herself fully to the welfare of her children and her husband. Before the onset of her problems, in every way she was an exemplary wife and mother.

While on duty as a nurse she pricked her finger with a needle and this led to her first thought of AIDS contamination. Her HIV test was negative, but she could not accept this and developed the obsessional belief that she, her kids and her husband would get AIDS. The belief became stronger when her husband changed job, her younger child went to playschool and she took in a lodger. Her family responded to her condition in the following way. Her husband helped with her cleaning and checking rituals and reinforced them. Her children did not object to overprotection. Her friends were very understanding of her lack of physical affection. Her sisters discussed her fear of AIDS with her regularly in a sympathetic manner.

Formulation. April was predisposed to developing OCD by two main factors. First, she came from a family where control and cleanliness were valued. Second, she was also highly medically aware of the risk of possible infection with the HIV virus. The OCD was precipitated by the event where she pricked her finger with the hypodermic needle. The OCD was maintained in the following way. She found that her compulsions to clean, discard food, overprotect the children, and check the house over every night relieved her anxiety so she repeated these actions compulsively. Her family and friends reinforced her obsessional thoughts and her husband participated in her compulsive behaviour. There were two protective factors in this case deserving mention. April was very intelligent and able to take on board a formulation of her problem and understand its relevance to treatment. Her husband was prepared to be involved and enlist family help in combating the compulsions.

Lecture 8
Depression and Somatoform Disorders

1. Depression
1.1. Introduction

Feelings of happiness and sadness are adaptive. Many behavior patterns that lead to happiness, such as socializing with others and developing longstanding friendships, are important for the survival of the species. Sadness, which commonly follows loss of valued objects, events, personal characteristics and skills or relationships, may also be adaptive, in that it reminds us to take care of valued objects, events, characteristics or relationships in future, lest we lose them again. *Extreme mood states* such as mania and depression are less adaptive. There is no doubt that, during periods of mania or hypomania, some individuals with bipolar disorder—which is characterized by episodes of mania and depression—produce

highly creative work (Jamison, 1995). However, this is done at a high cost. Inevitably people who suffer from bipolar disorder, during a manic phase, run the risk of exhaustion, dehydration and excessive and dangerous risk-taking. <u>Seasonal affective disorder</u> (or winter depression as it is colloquially known) may be linked phylogenetically to hibernation and this may have been adaptive for our cave-dwelling ancestors. However, nowadays depression seems to fulfill no adaptive function. Despite this, it is a highly prevalent condition. Because of its prevalence, the main focus in this chapter will be on major depression, although reference will be made to other mood disorders such as bipolar disorder. ***Depression is not simply 'feeling sad'***. <u>**Major depression is a recurrent episodic condition involving:**</u>

- ✓ *low mood;*
- ✓ *selective attention to negative features of the environment;*
- ✓ *a pessimistic belief-system;*
- ✓ *self-defeating behavior patterns,*
- ✓ *particularly within intimate relationships;*
- ✓ *disturbance of sleep and appetite.*

The **clinical features** of depression are presented in table (see below).

1.2. Case example. May, a single woman in her early thirties, was referred for counseling by her GP. She insisted on being seen by the psychologist at her house, since she had not been out of bed for two years. May had her first episode of depression in her midtwenties after her first and only significant adult relationship with a man (Rob) ended. The episode lasted almost a year and consequently she lost her job as a teacher. During this first episode of depression she spent the time in bed. She lived in a small maritime town about 250 miles from the village where she grew up. Her mother came to stay with her during her first episode of depression. At her family doctor's suggestion she also attended a series of counseling sessions which resulted in her recovery. Shortly after this the counselor left the district. After a few months and a series of disappointing and unsuccessful attempts to rekindle old friendships, May relapsed. She spent two years in bed and refused to see anyone except her mother and the family doctor.

1.3. Family history. May was born and brought up until the age of 8 in a small rural village. She moved house when she was 8 and lost a number of close friends through the change in address. This was particularly stressful because she had difficulty making new friends. She also relied on her old friends a lot to make living with her parents bearable. So when she moved house, she lost this support. Her home life was very stressful because she was regularly beaten brutally by her father and knew that her mother was also physically abused by him. This continued throughout her life until she left home to go to college at 18. During her childhood and teenage years she spent a lot of time at home studying, to distract her from the unhappy home atmosphere.

Perception	• Perceptual bias towards negative events
	• Mood-congruent hallucinations*
Cognition	• Negative view of self, world and future
	• Excessive guilt
	• Suicidal ideation*
	• Mood-congruent delusions*
	• Cognitive distortions
	• Inability to concentrate
Affect	• Depressed mood
	• Inability to experience pleasure
	• Irritable mood
	• Anxiety and apprehension
Behaviour	• Psychomotor retardation or agitation
	• Depressive stupor*
Somatic state	• Fatigue
	• Disturbance of sleep
	• Aches and pains
	• Loss of appetite or overeating
	• Change in weight*
	• Diurnal variation of mood (worse in morning)
	• Loss of interest in sex
Interpersonal adjustment	• Deterioration in family relationships
	• Withdrawal from peer relationships
	• Poor school performance

Note: Features are based on ICD 10 and DSM IV descriptions of major depression.
* These features occurs in severe episodes of depression

On the positive side, she had a good relationship with her cousins and some happy childhood memories about staying at their house. She had a couple of good friends at college with whom she went on holidays to Greece. When she left college, she began work as a teacher and loved her job. She got on well with children and was admired for this by her colleagues.

Within her extended family there was a history of mood and alcohol problems. Her aunt and a cousin had both suffered from depression. She also had an uncle with a drink problem.

1.4. Presentation. May presented with feelings of sadness, emptiness and an inability to experience pleasure. She talked about herself in self-deprecating ways. For example, she reported the following beliefs: 'I'm no good as a teacher. I've lost my job because of this illness; I'm no good as a woman. I'll never be married. I'm no good as a person, I'm dirty and worthless and I'm rotting inside.' She also viewed the world negatively. What follows are some of her beliefs: 'My father is no good. He

beat me as a child and beat my mother. He is the reason why I am ill. I can't change the past so I will be ill forever. My mother is no good. I would recover if she were not here looking after me. She interferes in my life and tries to control me. I have no friends so there is no point in recovery. Whatever pleasant things that I have experienced were few and far between. For example, my holiday in Greece. I had no control over either the good or bad things that happened to me, so I cannot control my recovery.' May's view of the future was also bleak. For example, she said: There is no point in recovery because other people will only take advantage of me. I have been unfortunate in the past so I will always be unfortunate.'

Notable features of May's behaviour were the fact that she lived a constricted housebound lifestyle; experienced early morning waking, diurnal variation of mood, and appetite and weight loss; and refused medication.

1.5. Formulation. May's family history of mood disorders suggests that she may have had a genetic vulnerability which, at a biological level, predisposed her to developing depression. Her negative childhood experiences, particularly physical abuse, moving house, losing supportive friends and using homework as a way to distract herself from her stressful family life, probably led her to develop a set of core beliefs, assumptions and coping styles that rendered her vulnerable to depression at a psychological level. These assumptions included the following: 'I deserve to be hurt. I am only acceptable to myself and others if I am hurt. Other people deserve to be hurt. You can't trust anyone because they will abandon you. If people don't like me, I'm worthless. If I fail at work, I'm worthless.' Each of her episodes of depression was triggered by a precipitating stressful life event. The first episode was triggered by her losing her boyfriend and the second by her failing to rekindle old friendships, the loss of her job and possibly the loss of her counsellor. These stressful events reactivated all of her depressive beliefs and assumptions so she was prone to view the world in negative terms. This negative way of interpreting events maintained her depressed mood. She also had a cognitive style which maintained her depressed mood. She tended to minimize positive events and maximize negative events, and attribute failure experiences to personal characteristics rather than situational factors. In addition to these cognitive maintaining factors, aspects of her behaviour also maintained her depressed mood, particularly her constricted life-style. Her lifestyle reduced her opportunities for forming relationships, finding work or experiencing pleasure. The absence of these opportunities confirmed her negative view of herself, her world and her future. She was locked into a vicious cycle. Eventually this had taken its toll on her appetite, circadian rhythms and activity level. She slept poorly, awoke early, ate little and rarely exercised. These sleeping, eating and activity problems may also have maintained her depressed mood. These difficulties may also have been subserved by dysregulation of neurotransmitters in the midbrain.

2. Somatoform Disorders

<u>Somatoform disorder</u> (also known as Briquet's syndrome) **is a psychological disorder characterized by physical symptoms that mimic disease or injury for which there is no identifiable physical cause or physical symptoms such as pain,**

nausea, depression, and dizziness. Somatoform disorder is a condition in which the physical pain and symptoms a person feels are related to psychological factors. These symptoms can not be traced to a specific physical cause. *In people who have Somatoform disorder, medical test results are either normal or don't explain the person's symptoms.* People who have this disorder may undergo several medical evaluations and tests to be sure that they do not have an illness related to a physical cause or central lesion. Patients with this disorder often become very worried about their health because the doctors are unable to find a cause for their health problems. Their symptoms are similar to the symptoms of other illnesses and may last for several years. People who have Somatoform disorder are not faking their symptoms. The pain that they feel is real, and they feel what they say they are feeling.

2.1. <u>Conversion disorder</u> *is a condition where patients present with neurological symptoms such as numbness, paralysis, or fits, but where no medical explanation can be found.* It is thought that these problems arise in response to difficulties in the patient's life, and conversion is considered a psychiatric disorder in the International Classification of Diseases and Related Health Problems (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV). Formerly known as **"hysteria"**, the disorder has arguably been known for millennia, though it came to greatest prominence at the end of the 19th century, when the neurologist **Jean-Martin Charcot**, and psychiatrists **Pierre Janet** and **Sigmund Freud** made it the focus of their studies. The term **"conversion"** has its origins in Freud's doctrine that anxiety is "converted" into physical symptoms. Though previously thought to have vanished from the west in the 20th century, some research has suggested it is as common as ever.

Conversion disorder can present with any motor or sensory symptom including any of the following:

- Weakness/paralysis of a limb or the entire body (hysterical paralysis or motor conversion disorders)
- Impaired hearing or vision
- Loss/disturbance of sensation
- Impairment or loss of speech (hysterical aphonia)
- Psychogenic non-epileptic seizures
- Fixed dystonia unlike normal dystonia
- Tremor, myoclonus or other movement disorders
- Gait problems (Astasia-abasia)
- Syncope (fainting)

Diagnosis

The diagnosis of conversion disorder involves three elements: the exclusion of neurological disease, the exclusion of feigning, and the determination of a psychological mechanism. Each of these has difficulties.

Exclusion of neurological disease

Conversion disorder presents with symptoms that typically resemble a neurological disorder such as stroke, multiple sclerosis, or epilepsy. The neurologist

must carefully exclude neurological disease, through examination and appropriate investigations. However, it is not uncommon for patients with neurological disease to also have conversion disorder, in which case the task becomes to determine how much of the patient's problem is due to conversion.

In excluding neurological disease, the neurologist has traditionally relied partly on the presence of positive signs of conversion disorder—certain aspects of the presentation that were thought to be rare in neurological disease, but common in conversion. The validity of many of these signs has been questioned, however, by a study showing that they also occurred in neurological disease. One such symptom, for example, is La belle indifférence, described in DSM-IV as "a relative lack of concern about the nature or implications of the symptoms". In a later study no evidence was found that patients with "functional" symptoms are any more likely to exhibit this than patients with a confirmed organic disease. Another feature thought to be important was that symptoms would tend to be more severe on the non-dominant (usually left) side; there were a variety of theories such as the relative involvement of cerebral hemispheres in emotional processing, or more simply just that it was "easier" to live with a functional deficit on the non-dominant side. However, a literature review of 121 studies established that this was not true, with publication bias the most likely explanation for this commonly held view.

The process of exclusion is not perfect, so misdiagnoses will occur. However, in a highly influential study from the 1960s, Eliot Slater demonstrated that misdiagnoses had occurred in one third of his 112 patients with conversion disorder. Later authors have argued that the paper was flawed, however, and a meta-analysis has shown that misdiagnosis rates since that paper are around 4%, the same as for other neurological diseases.

Exclusion of feigning

Conversion disorder is unique in DSM-IV in explicitly requiring the exclusion of deliberate feigning. Unfortunately, this is only likely to be demonstrable where the patient confesses, or is "caught out" in a broader deception, such as a false identity. One neuroimaging study suggested that feigning may be distinguished from conversion by the pattern of frontal lobe activation; however this is a research, rather than a clinical technique. True rates of feigning in medicine remain unknown, though neurological presentations of feigning may be among the more common.

Establishing a psychological mechanism

The psychological mechanism can be the most difficult aspect of the conversion diagnosis. DSM-IV requires that the clinician believe preceding stressors or conflicts to be associated with the development of the disorder, though how this might come about is still the subject of debate. The original Freudian model suggested that the emotional charge of painful experiences would be consciously repressed as a way of managing the pain, but this emotional charge would be somehow "converted" into the neurological symptoms. Freud later argued that the repressed experiences were of a sexual nature. As Peter Halligan comments, conversion has 'the doubtful distinction among psychiatric diagnoses of still invoking Freudian mechanisms' Janet, the other great theoretician of hysteria, argued that

symptoms arose through the power of suggestion, acting on a personality vulnerable to dissociation. In this hypothetical process, the subject's experience of their leg, for example, is split-off from the rest of their consciousness, resulting in paralysis or numbness in that leg. Later authors have attempted to combine elements of these models, but none of them has a firm empirical basis. Some support for the Freudian model comes from findings of high rates of childhood sexual abuse in conversion patients and from a recent neuroimaging study showing abnormal emotion processing of a traumatic event linked to motor processing of the affected limb, in a patient with conversion. Support for the dissociation model comes from studies showing heightened suggestibility in conversion patients, and in abnormalities in motor imagery. There has been much recent interest in functional neuroimaging in conversion. As researchers identify the mechanisms which underlie conversion symptoms it is hoped these will allow the development of a neuropsychological model. A number of such studies have been performed, including some which suggest that blood flow in patients brains may be abnormal while they are unwell. These have all been too small to be confident of the generalisability of their findings, however, so that no neuropsychological model has been clearly established.

2.2. <u>Somatization disorder</u> (also Briquet's disorder or, in antiquity, hysteria) **is a psychiatric diagnosis applied to patients who chronically and persistently complain of varied physical symptoms that have no identifiable physical origin.** One common general etiological explanation is that internal psychological conflicts are unconsciously expressed as physical signs. *Patients with Somatization Disorder will typically visit many doctors trying to get the treatment they think they need.* <u>However, it must be remembered that this behavior would also occur if the patient has a genuine physical condition that previous physicians have failed to diagnose.</u> The first step for a physician must be to take the patient's claims seriously and consider if their symptoms match any other known condition.

Criteria

Somatization disorder is a somatoform disorder. The DSM-IV establishes the following five criteria for the diagnosis of this disorder:

- a history of somatic symptoms prior to the age of 30
- pain in at least four different sites on the body
- two gastrointestinal problems other than pain such as vomiting or diarrhea
- one sexual symptom such as lack of interest or erectile dysfunction
- one pseudoneurological symptom similar to those seen in Conversion disorder such as fainting or blindness.

Such symptoms cannot be related to any medical condition. The symptoms do not all have to be occurring at the same time, but may occur over the course of the disorder. If a medical condition is present, then the symptoms must be excessive enough to warrant a separate diagnosis. Two symptoms cannot be counted for the same thing e.g. if pain during intercourse is counted as a sexual symptom it cannot be

counted as a pain symptom. Finally, the symptoms cannot be being feigned out of an effort to gain attention or anything else by being sick, and they cannot be deliberately induced symptoms.

People suffering from temporal lobe epilepsy are often misdiagnosed as having somatization disorder. This occurs because their seizures are not convulsive, sometimes involve hallucinations, and are often difficult to capture on an EEG.

Somatization disorder is a hard disorder to diagnose but, there are two tests to determine if you have it. A physical examination of the specified areas that the symptom seems to be in is the first test, along with thorough clinical evaluation of the patients expressed symptoms. This is to determine whether or not the pain is due to a physical cause. Once the physical cause is ruled out, then a psychological test is performed to rule out any other related disorders. Since there is no definite way to determine somatization disorder just from a simple test, those other tests are performed to rule out the other possibilities.

2.3. <u>Hypochondriasis</u> (or hypochondria, sometimes referred to as health phobia) **refers to an excessive preoccupation or worry about having a serious illness.** *Often, hypochondria persists even after a physician has evaluated a person and reassured them that their concerns about symptoms do not have an underlying medical basis or, if there is a medical illness, the concerns are far in excess of what is appropriate for the level of disease. Many people suffering from this disorder focus on a particular symptom as the catalyst of their worrying, such as gastro-intestinal problems, palpitations, or muscle fatigue.*

Hypochondria is often characterized by fears that minor bodily symptoms may indicate a serious illness, constant self-examination and self-diagnosis, and a preoccupation with one's body. Many individuals with hypochondriasis express doubt and disbelief in the doctors' diagnosis, and report that doctors' reassurance about an absence of a serious medical condition is unconvincing, or un-lasting. Many hypochondriacs require constant reassurance, either from doctors, family, or friends, and the disorder can become a disabling torment for the individual with hypochondriasis, as well as his or her family and friends. Some hypochondriacal individuals are completely avoidant of any reminder of illness, whereas others are frequent visitors of doctors' offices. Other hypochondriacs will never speak about their terror, convinced that their fear of having a serious illness will not be taken seriously by those in whom they confide.

Hypochondriasis manifests in various ways. Some people have numerous intrusive thoughts and physical sensations that push them to check with family, friends and physicians. Other people are so afraid of any reminder of illness that they will avoid medical professionals for a seemingly minor problem, sometimes to the point of becoming neglectful of their health when a serious condition may exist and go undiagnosed. Again, some people are afraid of getting a disease because they have a disease. Yet, some others live in despair and depression, certain that they have a life-threatening disease and no physician can help them, considering the disease as a punishment for past misdeeds.

Hypochondriasis is often accompanied by other psychological disorders. Clinical depression, obsessive-compulsive disorder (also known as OCD), phobias and somatization disorder are the most common accompanying conditions in people with hypochondriasis, as well as a generalized anxiety disorder diagnosis at some point in their life.

Many people with hypochondriasis experience a cycle of intrusive thoughts followed by compulsive checking, which is very similar to the symptoms of obsessive-compulsive disorder. However, while people with hypochondriasis are afraid of having an illness, patients with OCD worry about getting an illness or of transmitting an illness to others. Although some people might have both, these are distinct conditions.

Patients with hypochondriasis often are not aware that depression and anxiety produce their own physical symptoms that might be mistaken for signs of a serious medical disease. For example, people with depression often experience changes in appetite and weight fluctuation, fatigue, decreased interest in sex and motivation in life overall. Intense anxiety is associated with rapid heart beat, palpitations, sweating, muscle tension, stomach discomfort, and numbness or tingling in certain parts of the body (hands, forehead, etc.)

2.4. Pain disorder *is when a patient experiences chronic pain in one or more areas, and is thought to be caused by psychological stress.* The pain is often so severe that it disables the patient from proper functioning. It can last as short as a few days, to as long as many years. The disorder may begin at any age, and more women than men seem to experience it. This disorder often occurs after an accident or during an illness that has caused genuine pain, which then takes a life of its own.

Lecture 9
Psychotherapy

1. Introduction

Psychotherapy is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. It aims to increase the individual's well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may also be performed by practitioners with a number of different qualifications, including psychologists, marriage and family therapists, occupational therapists, licensed clinical social workers, counselors, psychiatric nurses, psychoanalysts, and psychiatrists.

There are several main broad *systems of psychotherapy*:

Psychoanalytic - it was the first practice to be called a psychotherapy. It encourages the verbalization of all the patient's thoughts, including free associations, fantasies, and dreams, from which the analyst formulates the nature of the

unconscious conflicts which are causing the patient's symptoms and character problems.

__Cognitive behavioral__ - generally seeks by different methods to identify and transcend maladaptive cognition, appraisal, beliefs and reactions with the aim of influencing destructive negative emotions and problematic dysfunctional behaviors.

__Psychodynamic__ - is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Although its roots are in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis.

__Existential__ - is based on the existential belief that human beings are alone in the world. This isolation leads to feelings of meaninglessness, which can be overcome only by creating one's own values and meanings.

__Humanistic__ - emerged in reaction to both behaviorism and psychoanalysis and is therefore known as the Third Force in the development of psychology. It is explicitly concerned with the human context of the development of the individual with an emphasis on subjective meaning, a rejection of determinism, and a concern for positive growth rather than pathology. It posits an inherent human capacity to maximize potential, 'the self-actualizing tendency'. The task of Humanistic therapy is to create a relational environment where this tendency might flourish.

__Brief__ - "Brief therapy" is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes a focus on a specific problem and direct intervention. It is solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change.

__Systemic__ - seeks to address people not at an individual level, as is often the focus of other forms of therapy, but as people in relationship, dealing with the interactions of groups, their patterns and dynamics (includes family therapy & marriage counseling).

__Transpersonal__ - Addresses the client in the context of a spiritual understanding of consciousness.

There are hundreds of psychotherapeutic approaches or schools of thought. By 1980 there were more than 250. By 1996 there were more than 450). The development of new and hybrid approaches continues around the wide variety of theoretical backgrounds. Many practitioners use several approaches in their work and alter their approach based on client need.

2. Psychoanalysis

Psychoanalysis was developed in the late 1800s by **Sigmund Freud**. His therapy explores the dynamic workings of a mind understood to consist of three parts: the hedonistic **id** (German: das Es, "the it"), the rational **ego** (das Ich, "the I"), and the moral **superego** (das Überich, "the above-I"). Because the majority of these dynamics are said to occur outside people's awareness, Freudian psychoanalysis seeks to probe the unconscious by way of various techniques, including dream interpretation and

free association. Freud maintained that the condition of the unconscious mind is profoundly influenced by **childhood experiences**. So, in addition to dealing with the **defense mechanisms** employed by an overburdened ego, his therapy addresses fixations and other issues by probing deeply into clients' youth.

Psychoanalysis is primarily devoted to the study of human psychological functioning and behavior, although it also can be applied to societies.

Psychoanalysis has three applications:
1. Method of investigation of the mind
2. Systematized set of theories about human behavior
3. Method of treatment of psychological or emotional illness.

Under the broad umbrella of psychoanalysis there are at least twenty-two different theoretical orientations regarding the underlying theory of understanding of human mentation and human development. The various approaches in treatment called "psychoanalytic" vary as much as the different theories do. In addition, the term refers to a method of studying child development.

Freudian psychoanalysis refers to a specific type of treatment in which the "analysand" (analytic patient) verbalizes *thoughts, including free associations, fantasies, and dreams,* from which the analyst formulates the unconscious *conflicts* causing the patient's symptoms and character problems, and interprets them for the patient to create *insight for resolution of the problems*.

The specifics of the analyst's interventions typically include *confronting* and *clarifying the patient's pathological defenses, wishes and guilt*. Through the analysis of conflicts, including those contributing to resistance and those involving transference onto the analyst of distorted reactions, psychoanalytic treatment can clarify how patients unconsciously are their own worst enemies: how unconscious, symbolic reactions that have been stimulated by experience are causing symptoms.

3. Cognitive Psychotherapy
Cognitive therapy seeks to help the client overcome difficulties by **identifying and changing dysfunctional thinking, behavior, and emotional responses**. This involves helping clients develop skills for modifying beliefs, identifying distorted thinking, relating to others in different ways, and changing behaviors. Treatment is based on collaboration between client and therapist and on testing beliefs. Therapy may consist of testing the assumptions which one makes and identifying how certain of one's usually-unquestioned thoughts are distorted, unrealistic and unhelpful. Once those thoughts have been challenged, one's feelings about the subject matter of those thoughts are more easily subject to change. **Beck** initially focused on depression and developed a list of "errors" in thinking that he proposed could maintain depression, including:
- ➢ *arbitrary inference*
- ➢ *selective abstraction*
- ➢ *over-generalization*

> *magnification (of negatives) and minimization (of positives).*

A simple example may illustrate the principle of how CT works: Having made a mistake at work, a person may believe, "I'm useless and can't do anything right at work." Strongly believing this then tends to worsen his mood. The problem may be worsened further if the individual reacts by avoiding activities and then behaviorally confirming the negative belief to himself. As a result, any adaptive response and further constructive consequences become unlikely, which reinforces the original belief of being "useless." In therapy, the latter example could be identified as a self-fulfilling prophecy or "problem cycle," and the efforts of the therapist and client would be directed at working together to change it. This is done by addressing the way the client thinks and behaves in response to similar situations and by developing more flexible ways to think and respond, including reducing the avoidance of activities. If, as a result, the client escapes the negative thought patterns and dysfunctional behaviors, the feelings of depression may be relieved over time. The client may then become more active, succeeding and responding adaptively more often; further coping with or reducing his negative feelings.

3.1. Cognitive therapy and depression

According to Beck's theory of the etiology of depression, depressed people acquire a negative schema of the world in childhood and adolescence; children and adolescents who suffer from depression acquire this negative schema earlier. Depressed people acquire such schemas through a loss of a parent, rejection by peers, criticism from teachers or parents, the depressive attitude of a parent and other negative events. When the person with such schemas encounters a situation that resembles the original conditions of the learned schema in some way, even remotely, the negative schemas of the person are activated.

Beck also included a negative triad in his theory. A negative triad is made up of the **negative schemas** and **cognitive biases** of the person. A cognitive bias is a view of the world. Depressed people, according to this theory, have views such as "I never do a good job." A negative schema helps give rise to the cognitive bias, and the cognitive bias helps fuel the negative schema. This is the negative triad. Also, Beck proposed that depressed people often have the following cognitive biases: *arbitrary inference, selective abstraction, overgeneralization, magnification and minimization.* These cognitive biases are quick to make negative, generalized, and personal inferences of the self, thus fueling the negative schema.

3.2. Cognitive behavioral therapy (or cognitive behavior therapy, CBT) *is a psychotherapeutic approach that aims to influence dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure.* CBT can be seen as an umbrella term for a number of psychological techniques that share a theoretical basis in behavioristic learning theory and cognitive psychology.

There is empirical evidence that CBT is effective for the treatment of a variety of problems, including *mood, anxiety, personality, eating, substance abuse, and*

psychotic disorders. Treatment is often brief, and time-limited. CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self-help applications. Some CBT therapies are more orientated towards predominantly cognitive interventions, while others are more behaviorally oriented.

CBT was primarily developed through a merging of behavior therapy with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the "*here and now*", and on alleviating symptoms. Many CBT treatment programs for specific disorders have been evaluated for efficacy and effectiveness; the health-care trend of evidence-based treatment, where specific treatments for symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments. In the United Kingdom, the National Institute for Health and Clinical Excellence recommends CBT as the treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa and clinical depression.

4. Humanistic Psychotherapy

The humanistic approach has its roots in existentialist thought (see Kierkegaard, Nietzsche, Heidegger, and Sartre). It is also sometimes understood within the context of the three different forces of psychology: behaviorism, psychoanalysis and humanism. Behaviorism grew out of Ivan Pavlov's work with the conditioned reflex, and laid the foundations for academic psychology in the United States associated with the names of John B. Watson and B.F. Skinner. This school was later called the science of behavior. Abraham Maslow later gave behaviorism the name "the first force". The "second force" came out of Freud's research of psychoanalysis, and the psychologies of Alfred Adler, Erik Erikson, Carl Jung, Erich Fromm, Karen Horney, Otto Rank, Melanie Klein, Harry Stack Sullivan, and others. These theorists focused on the depth of the human psyche, which, they stressed, must be combined with those of the conscious mind in order to produce a healthy human personality.

In the late 1950s, psychologists concerned with advancing a more holistic vision of psychology convened two meetings in Detroit, Michigan. These psychologists, including **Abraham Maslow, Carl Rogers, and Clark Moustakas**, were interested in founding a professional association dedicated to a psychology that focused on *uniquely human issues, such as the self, self-actualization, health, hope, love, creativity, nature, being, becoming, individuality, and meaning* – in short, the understanding of "the personal nature of the human experience".

These preliminary meetings eventually led to other developments, which culminated in the description of humanistic psychology as a recognizable *"third force" in psychology* (along with behaviorism and psychoanalysis). Significant developments included the formation of the Association for Humanistic Psychology (AHP) in 1961 and the launch of the Journal of Humanistic Psychology (originally "The Phoenix") in 1963. Subsequently, graduate programs in Humanistic Psychology at institutions of higher learning grew in number and enrollment. In 1971, humanistic psychology as a field was recognized by the American Psychological Association

(APA) and granted its own division (Division 32) within the APA. Division 32 publishes its own academic journal called The Humanistic Psychologist.

The major theorists considered to have prepared the ground for Humanistic Psychology are **Abraham Maslow, Carl Rogers and Rollo May**. Maslow was heavily influenced by **Kurt Goldstein** during their years together at Brandeis University. The work of **Wilhelm Reich**, who postulated an essentially 'good', healthy core self, in contrast to Freud, was an early influence, especially his Character Analysis (1933). Other noteworthy inspirers and leaders of the movement include Roberto Assagioli, Gordon Allport, Medard Boss, Martin Buber, James Bugental, Erich Fromm, Hans-Werner Gessmann, Kurt Goldstein, R. D. Laing, Clark Moustakas, Lewis Mumford, Fritz Perls and Anthony Sutich.

Person-centered therapy (PCT) is also known as *person-centered psychotherapy, client-centered therapy and Rogerian psychotherapy.*

PCT is a form of talk-psychotherapy developed by psychologist Carl Rogers in the 1940s and 1950s. It's one of the most widely used models in mental health and psychotherapy. In this technique, therapists create a comfortable, *non-judgemental environment by demonstrating congruence (genuineness), empathy, and unconditional positive regard toward their patients while using a non-directive approach.* This aids patients in finding their own solutions to their problems.

PCT is predominantly used by psychologists and counselors in psychotherapy. The therapist's role is that of a facilitator and to provide a comfortable environment, rather than to drive and direct the patient toward recovery.

While in session, therapists encourage patients to discuss their experiences and express their feelings. Therapists then empathetically *repeat emotionally significant statements back to their patients*. The purpose is to allow patients to arrive at solutions to their problems by examining their own thoughts. Patients can then decide for themselves in what ways they need to change.

Although this technique has been criticized by some for its lack of structure, it has proven to be a vastly effective and popular treatment.

Rogers (1957; 1959) stated that there are six necessary and sufficient *conditions required for therapeutic change*:

1. *Therapist-Client Psychological Contact*: a relationship between client and therapist must exist, and it must be a relationship in which each person's perception of the other is important.
2. *Client incongruence, or Vulnerability*: that incongruence exists between the client's experience and awareness. Furthermore, the client is vulnerable to anxiety which motivates them to stay in the relationship.
3. *Therapist Congruence, or Genuineness*: the therapist is congruent within the therapeutic relationship. The therapist is deeply involved his or herself - they are not "acting" - and they can draw on their own experiences (self-disclosure) to facilitate the relationship.
4. *Therapist Unconditional Positive Regard (UPR)*: the therapist accepts the client unconditionally, without judgment, disapproval or approval.

This facilitates increased self-regard in the client, as they can begin to become aware of experiences in which their view of self-worth was distorted by others.

5. ***Therapist Empathic understanding*:** the therapist experiences an empathic understanding of the client's internal frame of reference. Accurate empathy on the part of the therapist helps the client believe the therapist's unconditional love for them.

6. ***Client Perception*:** that the client perceives, to at least a minimal degree, the therapist's UPR and empathic understanding.