Introduction

For many generations, violent conflicts, oppression, persecution and war have characterized people's lives in Iraq and other countries in the Middle East or elsewhere. Flight, expulsion and mass destruction have extensively affected these societies. Basic supplies and services for people as well as psychological support barely meet people's needs. That is why this book is created to help the helpers to provide psychotherapeutic treatment to the people in need. Having the same cultural background or understanding the patient's culture is an important advantage.

This book can be seen as an addition to your existing knowledge about mental disorders and different therapeutic interventions. It contains a selection of exercises, interventions and a theoretical background.

Starting with a definition of psychotherapy, it describes different forms of psychotherapy, the therapeutic relationship and aims and goals of psychotherapy. Furthermore, several mental disorders, specific interventions and exercises are presented. Last but not least, a description of the therapeutic process and instructions on how to write a case formulation are offered.

This book was produced in cooperation with local students of the Institute of Psychotherapy and Psychotraumatology (IPP) at the University of Duhok.

Several useful highlights of the book are:

- Each chapter starts with **introductory questions** that give you an overview of what to expect in the following chapter.
- **Exercises and self-reflection tasks:** Self-reflection is very important for psychotherapists. It is useful to experience yourself in particular situations and reflect different constructs before your work with patients. For this reason, it is useful to have a notebook ready throughout working with the book, in which you can collect all of your answers and thoughts.
- **Information sheets** for you as a therapist and sheets for your patients. These sheets provide additional information on a particular topic. The information sheets for you are tagged with a 'T' as in therapist. The information sheets for your patients are tagged with a 'P' as in patient. References in the text tell you when it would be a good time to have a closer look at these information sheets.

- ***Before we move on* boxes:** These boxes give a short summary of the earlier content.
- **Quizzes:** At the end of each chapter, you will find a quiz that lets you test your knowledge of the content of the chapter. You can find all the answers to the quizzes at the end of this book.
- **Additional supplement:** You will find information sheets and worksheets in this additional book as well as online.

We suggest that you keep a separate notebook to do some of the exercises in this book.

1 Psychotherapy

The following chapter will give you information about several aspects of psychotherapy. It will help you answer the following questions:

- What is the therapeutic relationship?
- What are goals of psychotherapy?
- What is behavioral therapy, what is cognitive therapy?
- What are the principles of cognitive behavioral therapy?

Psychotherapy is a systematic process between a therapist and a client. It aims to solve emotional problems. This includes e.g. personal distress or maladaptive behaviors.

The Therapeutic Relationship

The interaction of the trained professional and the client forms a therapeutic relationship. This bond is both a condition and a tool for any kind of psychological therapy. This relationship or alliance is of voluntary, contractual nature and of limited time. It is confidential. This allows the client to trust the therapist with his or her personal problems.

The therapist must not exploit the trust and the confidence of the client in any way. It is a professional relationship, and must remain so. The therapist helps by being accepting, empathic, genuine and warm to the client. She/he expresses unconditional positive regard to the client. There is no judgment, even if the client is rude or reveals nasty things.

The therapist has empathy for the client. This means she/he feels the way her/his client feels and understands her/him. She/he can put herself/himself in the client's shoes. An important condition for a healing client experience. You will learn more about the therapeutic relationship in the course of this book.

Goals of Psychotherapy

The treatment of psychological disorders has two general goals. One is the reduction of symptoms, the other is to improve the quality of life or functioning.

In case of milder disorders (e.g. phobias), symptom reduction also results in better quality of life. With severe mental disorders (e.g. schizophrenia), this might not be the case.

Often those need rehabilitation to become a productive member of society again. Patients there get

- Occupational therapy, e.g. for better work discipline by making candles.
- Social skills training, e.g. for better interpersonal skills through role play.
- Vocational therapy, to learn skills for productive employment.

Other, more specific examples of therapy goals are:

- Changing thinking patterns,
- modifying habituations,
- increasing self-awareness.

Exercise

Imagine a friend of yours has experienced a negative or traumatic life event. This might be the death of a loved one or something like a break-up.
Practice to be empathic and put yourself in the other person's shoes. Try to feel her/his way and understand her/him. What does it mean to experience such a life event?

In the course of this book, you will learn more about therapeutic goals.

2 Types of Psychotherapy

Generally, all types of psychotherapy aim to remove human distress and foster functional behavior. However, they differ greatly in terms of concepts, methods, and techniques they use.

In this book we will focus on techniques routed in Behavioral Therapy and subsequent developments. They are highly effective for the treatment of traumatized patients.

2.1 Behavioral Therapy

A powerful science of animal learning and behavior was developed, starting in the early twentieth century. First, Ivan Pavlov discovered how animals learn that two things coincide, so called 'classical conditioning' (Rescorla & Solomon, 1967). In his 1906 study, the experimenter would ring a bell and then give a dog food; after a few rounds of pairing bell and food, the dog would start to drool just from hearing the bell. It had learned that the bell signaled that food was going to be served.

A few decades later, scientists like B. F. Skinner were discovering how behavior is shaped. What makes us more likely to do some things and less likely to do others? The results are now well known; punish an action to stop it; reward an action to encourage it. We call this mechanism 'operant conditioning' (Skinner, 1963).

Building on this knowledge, Behavioral Therapy assumes that psychological distress results from faulty or dysfunctional patterns of behavior and thought.

The therapies that then result from this assumption originate from the principles of learning theory – the interaction of stimulus and response. The specific selection of treatments depends on the individual diagnoses or symptoms, however. A depressive client therefore requires a different procedure than a client with an anxiety disorder.

2.1.1 Methods of Treatment

Behavioral therapy focuses on the description and change of dysfunctional behavior and its sustaining factors in the present.

Behavioral analysis is conducted to find malfunctioning behaviors, the antecedents of faulty learning, and the factors that maintain or enforce faulty learning.

- Malfunctioning behaviors are those behaviors which cause long-term distress to the client.
- Antecedent factors are those causes which predispose the person to indulge in that behavior.
- Maintaining factors are those factors which lead to the persistence of the faulty behavior.

Example 1

A young person who has acquired the malfunctioning behavior of smoking and seeks help to get rid of smoking. Behavioral analysis in whose context clients and the family members were interviewed reveals that the person started smoking when he was preparing for the annual examination. He had reported that he experienced relief from anxiety by smoking. Thus, situations prompting anxiety become the causative or antecedent factor. The feeling of relief becomes the maintaining factor for him to continue smoking. The client has acquired the operant response of smoking, which is maintained by the reinforcing value of relief from anxiety.

Once the faulty behaviors and its parts, which cause distress, have been identified, a treatment package is chosen. The aim of the treatment is to extinguish or eliminate the faulty behaviors and substitute them with adaptive behavior patterns.

The therapist does so by establishing antecedent operations and consequent operations.

Antecedent operations control behavior by changing something that precedes such a behavior. The change can be achieved by increasing or decreasing the reinforcing value of a particular consequence. This is called establishing operation.

Example 2

A child refuses to eat enough food when having dinner, an establishing operation would be the decrease of the food quantity served at tea time. This would increase the hunger at dinner and thereby increase the reinforcing value of food at dinner. Praising the child when s/he eats properly tends to encourage this behavior. The antecedent operation is the reduction of food at tea time and the consequent operation is praising the child for eating dinner. It establishes the response of eating dinner.

2.1.2 Various Behavioral Therapy Techniques

A wide range of techniques is available for changing behavior. There are techniques:

- to reduce the level of arousal,
- to alter behavior through classical or operant conditioning,
- for vicarious learning, if necessary.

One specific technique is called ‘Negative Reinforcement’. It refers to following an undesired response with an outcome that is painful or not liked.

For example, the teacher reprimands a child who shouts in class. This is negative reinforcement.

Another technique is called 'Aversive Conditioning'. It refers to repeated association of undesired response with an aversive consequence. For example, an alcoholic is given a mild electric shock and asked to smell the alcohol. With repeated pairings the smell of alcohol is aversive as the pain of the shock is associated with it and the person will give up alcohol.

Adaptive behavior can be reinforced on the basis of operant conditioning. For example, if a child does not do his/her homework regularly, positive reinforcement may be used by the child's mother by preparing the child's favorite dish whenever s/he does homework at the appointed time. The positive reinforcement of food will increase the behavior of doing one's homework at the appointed time.

One can also use so called 'tokens' for this. Persons with behavioral problems can be given a token as a reward every time a wanted behavior occurs. The tokens are collected and exchanged for a reward such as an outing for the patient or a treat for the child. This is known as token economy.

So-called 'Differential reinforcement' can be used to reduce unwanted behavior and increase wanted behavior, at the same time. For that you positively reinforce the wanted behavior and ignore the unwanted behavior. For example, let us consider the case of a girl who sulks and cries when she is not taken to the cinema after having asked. The parent is instructed to take her to the cinema if she does not cry and sulk but not to take her if she does. Furthermore, the parent is instructed to ignore the girl when she cries and sulks.

2.2 **Cognitive Therapy** (Beck, 2016)

As a counter movement to Behavioral Therapy, a so-called 'Cognitive Therapy' has developed in the 1960s and 1970s, which emphasized the power of thoughts to drive our emotions and actions.

The premise of cognitive therapy is, that maladies, like anxiety and depression, are rooted in our thoughts.

If we suffer from overwhelming anxiety, our thoughts are probably filled with danger. The crucial insight of cognitive therapy is that by changing how we think, we can change our feelings and behaviors.

For example, when Hawar saw a bridge and felt extreme fear, his experience was:

Bridge – Fear

From a cognitive therapy perspective, a crucial step is missing: Hawar's *interpretation* of what a bridge represents:

Bridge – *'I'm going to lose control and jump off the side'* – Fear

In light of Hawar's beliefs, his fear makes perfect sense. That doesn't mean his thoughts are accurate, but if we understand what he's thinking, it's easy to see why he feels afraid.

The cognitive therapy sees the problem underlying mental health issues in the so called cognitive distortions. Cognitive distortions can be defined as inaccurate thoughts that reinforce negative thought patterns or emotions.

An essential principle of cognitive therapy is that our moods are created by thoughts or 'cognitions'. Therapists also focus on the patient's 'automatic thoughts' – that is, the conscious, spontaneous thoughts that are associated with negative effects.

The model is essentially constituted by the following principle: There are specific (and common) ways people distort their thinking. These irrational thoughts and beliefs (i.e., distortions) can lead to problematic emotional states and behavior, like anxiety, low self-esteem, depression and relationship conflicts. That is why we want to be aware of them, so that we can shift your thinking to more rational and objective thoughts whenever possible.

A cognition simply refers to our perception of reality (how we interpret the world around us) and our self (what we communicate to our self, our beliefs, our values, etc.).

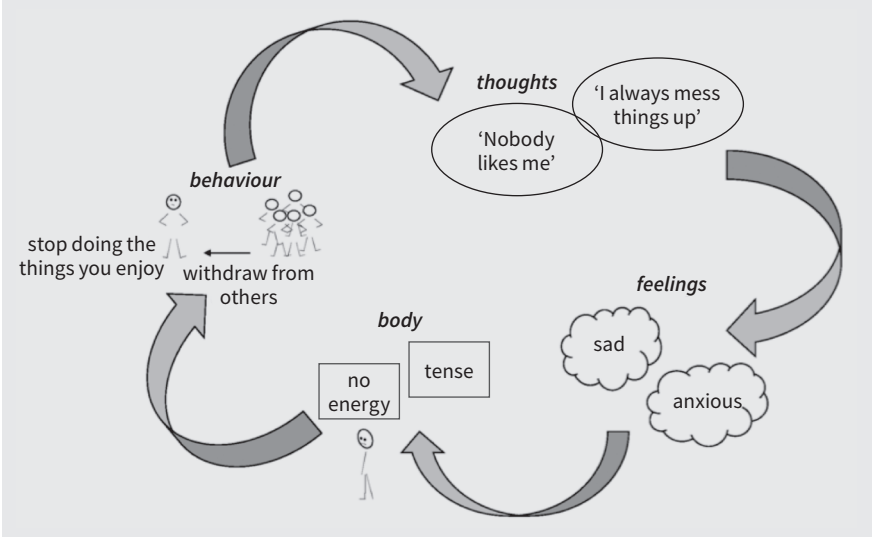

Figure 1: Cognitive distortions

As can be deduced from the graph above, our thoughts (like 'nobody likes me' or 'I always mess things up') determine our feelings ('sad', 'anxious' etc.), which, in turn, affect our body ('tense', no energy' etc.) and, in this way, determine our behavior ('withdraw from others', 'stop doing the things we enjoy'.

A friend, for example, might read your text message and might not reply, and you might interpret that information as 'My friend doesn't care about me' and feel down about it. The problem, though, is that we rationalize 'I'm feeling unhappy therefore I am unhappy', and take that feeling as fact. A cognitive distortion, then, is when we convince ourselves of something that simply is not true. These thoughts are irrational or just plain wrong. In fact, it is not the event itself that causes feelings of negativity; it is your response to the event.

2.3 Cognitive Behavioral Therapy (CBT)

From the two directions of behavioral and cognitive therapy developed what has established itself today as the modern mainstream of psychotherapy. Cognitive behavioral therapy.

2.3.1 What is CBT?

CBT is an umbrella term for many specific types of therapy that don't necessarily have 'CBT' in their name. Examples are

- Exposure and Response Prevention for obsessive-compulsive disorder (OCD).
- Prolonged Exposure for post-traumatic stress disorder (PTSD).
- Dialectical Behavior Therapy for borderline personality disorder.
- Panic Control Therapy for panic disorder.

Each of these therapy programs incorporate the basic principles of CBT to address the condition it is designed for.

On the other hand, one should be aware that not everything which is called CBT actually is genuine CBT. If you look for a CBT therapist, make sure he or she has participated and completed specialized training in this approach. The Resources section at the back of the book includes a link to guidelines for finding a CBT therapist (Spek, Cuijpers, Nyklíček, Riper, et al. (2007).

2.3.2 How Well Does CBT Work?

Meta-analyses consistently find CBT has strong effects in treating anxiety, depression, and other conditions (Hofmann et al., 2012). And these effects are above and beyond any improvement we'd expect simply from the passing of time or from a placebo. Compared to other schools of therapy, there is ample evidence that CBT is effective.

Additionally, the straightforward procedure within CBT programs makes the programs well suited to export from the therapy office into self-directed treatment, like this workbook and Internet-based CBT. Me-

ta-analyses consistently find that self-directed CBT can reduce symptoms of anxiety and depression.

While the self-directed treatments are effective by themselves, studies also find that some people benefit even more from 'guided self-help' (limited involvement from an expert, whether by phone, mail, e-mail, or in person) (Baumeister, Reichler, Munzinger, & Lin, 2014).

This is also the approach advocated by this book – a holistic understanding of thoughts, feelings and behavior:

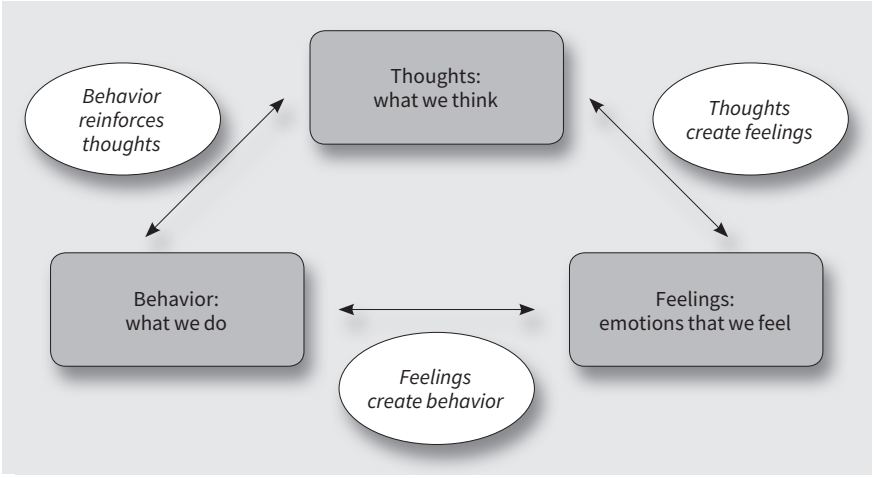

Figure 2: A holistic approach to thoughts, feelings and behavior

Each element affects both of the others. For example, when we feel anxious we tend to have thoughts of danger and want to avoid the object we fear. Additionally, when we consider something dangerous we fear it (feeling) and want to avoid it (behavior).

Example

Imagine you studied a lot for a test but then you got a very bad result. You might think 'I will never succeed and I will always fail, no matter how much I study'. These thoughts will lead to a feeling of sadness and even frustration. These feelings might result in a lack of motivation to study for the next test, so you will not study anymore, and consequently fail the test as well. Failing the test will then again influence how you think and feel.

Exercise

Think of a recent situation where you felt a strong emotion, perhaps anxiety or sadness. Briefly describe the situation in the space below.
Using the diagram below, write down what you remember about the feelings you had, about the thoughts you had, and about what you did.
What I felt:
What I thought:
What I did:

2.3.3 The Principles of CBT

CBT is like other therapies in many ways. It involves a supportive relationship between therapist and client. Effective CBT therapists have positive regard for their clients and strive to understand how they see the world. As with any successful therapy, CBT is a deeply human endeavor.

At the same time, CBT has its own distinctive approach. Here are some of the main principles:

- **CBT is time limited:** CBT is designed to provide the maximum benefit in the shortest possible time – generally around ten to 15 sessions – which minimizes human suffering as well as costs. A shorter course of treatment can also motivate us to focus our efforts on getting the most out of it.
- **CBT is evidence-based:** CBT therapists rely on techniques that have been well tested in research studies. CBT therapists also gather data during treatment to see what is and isn't working so they can adjust their further procedures accordingly.
- **CBT is goal-oriented:** CBT is all about moving toward your goals. You should have a good sense of whether the treatment is addressing your goals, and how much progress you're making toward them.
- **CBT is collaborative:** CBT can't be done to a person. Instead, the therapist is an expert in CBT, and clients have specialized knowledge about themselves. Success in CBT requires bringing together these perspectives to develop a treatment addressing the individual needs of the client. Both, therapist and client, are actively engaged in the process.
- **CBT is focused on the present:** CBT puts the emphasis on how to change current thoughts and behavior to bring about lasting relief as quickly as possible. This is not to say that CBT therapists ignore the past or treat childhood events as irrelevant.
- **CBT is structured:** Formulating clear goals is the first step when applying CBT. Designing a roadmap-like treatment plan is an essential part of this first step. Once we have completed the map, we know whether we are approaching our goal or not. The structure of CBT builds on itself, with earlier sessions providing the foundation for later ones. For example, in week three of this program we'll talk about how to identify unhelpful thoughts, and in week four we'll work on how to change those thoughts.
- **CBT is skills-oriented:** Through CBT we learn techniques to manage the issues we are dealing with, practice them on our own, and take them with us when treatment is over. People in CBT often say things like, 'I'm getting better at learning about my anxiety'.
- **CBT emphasizes practice:** Usually, there is just one therapy session every week. Consequently, the client must practice new skills between the sessions to get the most benefit from them. Many studies have shown

that clients who do more work between sessions have made greater progress in CBT.

2.3.4 Why Does CBT Work?

While CBT has been recognized as a treatment method for only a few decades, the principles it rests on are hardly new. So what does CBT add to the basic tenets that have been around for hundreds or thousands of years?

Targeted exercises

When we feel anxious or depressed, many areas in our lives might feel out of control. CBT provides a structure that helps us develop an idea of where to start. Rather than trying to tackle everything at once, a typical session in CBT will focus on one or two specific issues. Having targeted exercises to practice between sessions further focuses our efforts.

Practice effects

Most of the time, we flourish not by learning new things but by acting on what we already know. Knowing the principles of CBT is essential, and practicing then what drives their effectiveness. CBT serves as a steady reminder of the plan to follow towards our goals.

Breaking loops

When we are highly anxious or depressed, our thoughts, feelings, and behavior tend to work against us in a vicious spiral. CBT helps us break out of this spiral. As we practice better thinking and more helpful behavior, our thoughts and actions reinforce each other in a positive direction.

Skills acquisition

Finally, the focus on learning and practicing new skills in CBT ensures we take the treatment with us once it is over. When we face new challenges, we are equipped with a set of tools for dealing with the new challenges. So the benefits of CBT outlast the treatment by far.

Exercise

In this chapter, we covered a brief history of CBT as well as its basic principles and why it works. Now, take a few moments to check and recapitulate in order to see to what extent you can apply what you've learned in your own life. Write down your thoughts and feelings, paying attention to be as open as possible. Spend some time here.

3 The Initial Interview

The following section informs you about the initial interview. It will give you answers to the following questions:

- How does the therapist structure and prepare the initial interview?
- What does the patient's perspective look like before the initial interview?
- How does the therapist approach this perspective at the beginning of the interview?
- What are the therapist's goals for the initial interview?
- Which questions does the therapist ask?
- How does a therapist approach different types of patients and their respective perspective while pursuing his/her goals?
- Why are biographical information about the patient and the patient's history important within the initial interview?
- How does the initial interview form the foundation for therapeutic process and how does it set the stage for therapy?
- Which documentary obligations and organizational aspects are important for the therapist?

The initial interview marks the start of a very important phase in the therapeutic process: It is the introductory stage. During this stage, the therapist and the patient lay the foundations for the therapy process. Everything is still open. The therapist and the patient have not yet established what their respective roles are in this process. This means the following: As far as the relationship level is concerned, the therapist has a lot to gain as well as a great deal to lose.

The Patient's Perspective and First Contact

Patients often have mixed feelings and conflicting emotions about consulting a psychotherapist. The initial interview may be the first time the patient has ever had any contact with psychotherapy or with a psychotherapist. Patients might be unsure about whether they have come to the right place. They might feel anxious, uncertain or concerned ('The therapist can see into my soul'). They might be afraid they will not be taken seriously.

Psychotherapy is, at least in urban regions, no longer a taboo subject. But many people may still feel a sense of shame when they decide to see a psychotherapist. From their perspective, seeing a therapist may be linked to

stigma and weakness. They feel ashamed about having to seek help. Sometimes, they are afraid others will think they have 'gone mad'.

In therapy sessions many people report that they would rather have a somatic illness than a mental health issue. They say that they can clearly see the somatic illness.

Therapists must be aware of these feelings and assumptions in order to be able to establish a viable working alliance with the patient.

Patient's and Therapist's Objectives

The initial interview helps the patient and the therapist find their attitude and get to know each other. For both sides the following is important: They must find out everything they need to know to assess the situation and its prospects of success. The following paragraphs will describe what this means in concrete terms.

Patient's Goals

The patient wants to get information about which treatments are available for dealing with his/her issues or problems. Additionally, the initial interview gives the patient a chance to talk openly about personal matters. Patients hope to finally be able to get the help and support they need.

Patient	
Goals ↓	
Clarify what therapies are on offer	Do I feel comfortable? Do I think I can work well with the therapist?
Clarify what relationships are on offer	Does the treatment on offer sound promising?

Figure 3: Patient's objectives during the initial interview

Therapist's Goals

The initial interview also gives the therapist the opportunity to ask some important initial questions before embarking on the therapeutic process. The therapist should cover the patient's personal details, his/her social environment, current symptoms, and how the problem evolved and is being maintained (Figure 4).

Information sheet 01 provides a checklist for structuring and preparing the initial interview. In this way, the therapist and the patient can collect all the information they need to make an informed decision.

Therapist	
Goals ↓	
Clarify referral	Has the patient himself/herself decided to seek treatment, or was he/she referred for treatment (terms of probation, at family's insistence)?
Clarify indication	Are the conditions for psychotherapeutic treatment in the respective setting met?
Clarify symptoms	What are the patient's symptoms?
Clarify diagnostic tools	What other information do I need and how should it be weighted?
Clarify quality assurance	What basic data do I need?

Figure 4: Therapist's objectives during the initial interview

Three Types of Relationships

Steve de Shazer (1988) defined three types of relationship between a therapist and a person seeking therapeutic support (see table 1). His distinction helps therapists approach the initial interview in the following way: They know what to expect in terms of the therapeutic relationship. It is a heuristic description, not a diagnostic or classificatory determination. If the patient expects too much of the therapist or of the therapy, the therapist will quickly be assigned the role of 'medicine man' or 'miracle healer'. If the patient expects too little, this may be revealed in overt or covert hostile behavior.

Table 1: Three types of patient-therapist relationship according to Steve de Shazer

Type of patient	Typical characteristics of this type
Visitors	• Have no complaints • Have no goals • Were sent by someone else • Were taken along by someone else
Claimants	• Have complaints • May have goals • See themselves as part of the problem but not as part of the solution • Expect others to change
Customers	• Have complaints • Have goals • See themselves as part of the solution • Are prepared to do something to solve their problem

Documentation

'Finally, I have found someone who listens to me.' Most likely, patients are more willing to talk about themselves and their concerns during the initial interview than in subsequent sessions. The initial interview can prove to be an important source of information. This information is relevant for the rest

of the therapeutic process. That is why it is worth recording the initial interview, using audio-visual means. The therapist needs to get the patient to sign a consent form (Worksheet 02 – Consent form for recording of therapy sessions). The more transparently and matter-of-factly this is explained, the more willing a patient will be to give his/her consent. Should the patient refuse, however, the therapist should write down what was discussed in as much detail as possible.

In order to explain the purpose of the consent form, you could say something like that: 'The consent form is a document you need to sign, if you agree with the audio or visual documentation of the therapy sessions. Your signature allows me the documentation of the sessions which can be very helpful in the course of treatment. If you do not wish the documentation, you do not need to sign it.'

3.1 Talking to Patients

Therapists need to tread a fine line during the initial interview. On the one hand, the goal is to make the experience a pleasant one for the patient. On the other hand, the therapist wants to get as much accurate information as possible. But first, the therapist must establish an atmosphere of trust. Therapists elicit relevant diagnostic information during the initial interview from the way the patient speaks and by observing the therapeutic relationship. They should not ask complicated questions. The therapist must signal to the patient that he/she understands the situation the patient is in as well as the difficulties he/she is describing. At the same time, the therapist should get permission from the patient to delve further into the difficulties he/she has described. Then, the therapist should ask more detailed questions about some of the relevant aspects of the difficulties. Here is a list of what the therapist should do:

The therapist should …
… be the one to initiate the contact and open the conversation;
… give the patient the opportunity to speak freely;
… support the patient by asking targeted questions;
… summarize what has been said and check back by asking questions;
… give the patient the opportunity to ask questions.

Table 2 shows what the therapist should not use very often during the initial interview. If the therapist uses the following, he/she should use it very carefully.

Table 2: What therapists should not do

What a therapist should not do	Example
Ask fixed-alternative questions about symptoms	'Is the pain sharp, stabbing, pulling or throbbing?'
Ask dichotomous questions that can be answered by yes or no	'Have you already had this symptom today?'
Ask leading questions	'And then you must have felt very frightened, correct?'

Before you move on to the next part: Short summary course and the role of the initial interview in the overall therapeutic process:
The initial interview is important in shaping the patient–therapist relationship. At the start of the initial interview the focus is on establishing the patient–therapist relationship. In the course of the interview the focus shifts to the patient's substantive problems. Patients have often been suffering for a long time, are frustrated and believe that no-one understands them. That is why it is important to put patients at their ease. Ideally, psychotherapeutic treatment should be clearly structured, rule-based and transparent. Patients can expect a 'warm welcome' at the start, though. They should get the feeling that someone understands both, them and their concerns. The key here is creating a pleasant, anxiety-free atmosphere in which the required diagnostic information can be gathered step by step.

Worksheet 03 – Acute checklist
Worksheet 04 – Release from confidentiality
Worksheet 05 – Life contract
Worksheet 06 – Abstinence contract

3.2 Understanding the Patient's Current Situation in Life and the Patient's Biography

3.2.1 Current Situation in Life

The therapist should consider the patient's current situation in life. This is useful in many ways. First, this helps the therapist decide whether the patient needs outpatient or inpatient psychotherapeutic treatment. Secondly, it helps the therapist better understand the patient, because precarious social situations can be the decisive factor in perpetuating problems.

How does the therapist get an overview of the patient's current situation in life? The therapist asks the patient about the following aspects:

- general life and job satisfaction,
- general ability to function in various areas of life,
- level of social integration and participation (family and friends),
- family and social environment.

Collecting information on these aspects is important for making a prognosis. Have a look at the following example: The therapist is well-informed about a patient's interpersonal potential (problem-solving skills, coping capacity, attitude to life, cognitive style) and social resources. Based on this knowledge, the therapist can focus on resilience factors in his/her prognosis. Examples for resilience factors are a stable relationship, intact family, small circle of reliable friends and a larger informal network of friends and acquaintances. On the other hand, the therapist will make a different prognosis if risk factors are at the fore. Examples for risk factors are social isolation or conflict-laden interpersonal relationships. These risk factors significantly increase vulnerability to a mental disorder.

When it comes to work, a therapist can come across the following resilience factors: job satisfaction, a collegial working atmosphere and planning certainty. The following are examples for risk factors: unemployment, precarious work situations, workplace bullying and conflicts at work, overwork and other stress factors (e.g. shiftwork).

Furthermore, the therapist must consider socio-ecological and socio-economic factors. The following list shows examples for these factors: unfavorable living conditions (noise pollution, cramped accommodation), poverty, debt.

Information about all these factors can help the therapist find out about what is helping to maintain the patients current disorder and problems. Then the therapist refers to risk factors. On the other hand, the therapist can refer to resilience factors. The therapist and the patient look at the resilience factors in a targeted manner to improve the probability that treatment will be successful and the prognosis.

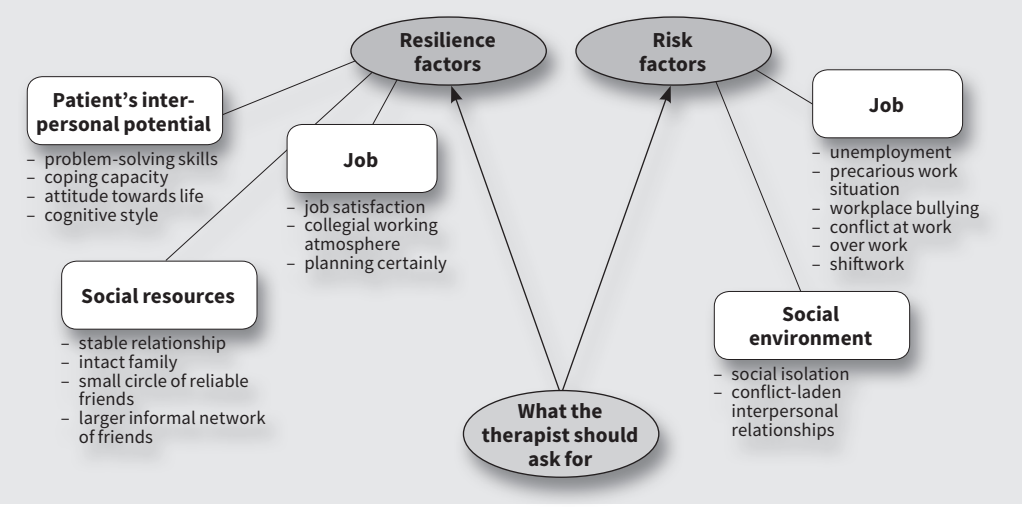

Figure 5: What the therapist should ask questions about

When looking at the patient's current situation in life, the therapist should look beyond the therapy setting. The therapist must consider the patient's life system. Figure 5 shows what this includes.

3.2.2 Links between Patient's Biography and Patient's Issues or Problems

Instead of doing an extensive 'system analysis', the therapist should collect specific information about the following:

- Primary and secondary reinforcers in the patient's environment and biography;
  → examples of primary reinforcers are things that satisfy basic survival needs like water, food, sex, sleep and air. A secondary reinforcer is money. Primary and secondary reinforcers are linked because with a secondary reinforcer like money, you can buy food which is a primary reinforcer.
- Possible resources in the patient's environment and biography;
  → for example: support from family and friends, healthy relationships, hobbies like sports and other activities, stable living conditions

In order to do this, the therapist must find answers to the following questions (see also the example on Information sheet 8):

- How does the patient's biography and his/her situation relate to his/her issues or problems?
- What prompted the patient to seek treatment?

The initial interview helps the therapist to find out more about the patient's biography and current psychosocial context. Possibly, the therapist can also get information about his/her financial situation. When we use the term 'biography', we talk about 'facts' about the patient's life. Date of birth, dates of moving housees are typical examples of biographical information. The therapist and the patient elaborate on biographical information at a later stage. During that stage, the patient tells his/her biographical story. When we use the phrase 'biographical story', we talk about how the patient talks about his life and what person's aspect he/she includes to describe his/her life. Some patients talk about their grandparents and the time before the patient was born. The therapist and the patient would not consider this time when collecting biographical information.

Some factors which contributed to the development of a disorder might not be important in maintaining the disorder. The patient may not even be experiencing these triggers internally or externally.

Nevertheless, the therapist must find out about the two following things:

1) When did the disorder begin?
2) What has the course looked like and how is it related to the patient's personal history?

The therapist should not use this information to draw any conclusions with regards to the etiology (causes) of the patient's current difficulties. But the therapist can use this information to do relapse prevention towards the end of treatment and to build the patient's resources in that regard. Analyzing the triggers can provide insights into useful coping mechanisms for when the disorder recurs. Subsequently, the therapist can teach the patient how to use these adaptive and new strategies in the course of the treatment and in everyday life.

3.2.3 Taking the Patient's History

In behavioral therapy, taking the patient's history aims at collecting information on the following:

- How has the disorder evolved up to the point of time when the patient seeks help?
- What are individual risk factors (vulnerabilities, predispositions and stressors)?
- What are protective factors (resilience, protective environmental influences and resources)?

This information can (help) explain how the patient's individual disorder/difficulties arose, namely in the form of a stress-vulnerability model. This model is a retrospective reconstruction of past conditions. According to the model, the biological vulnerability, stress and protective factors play a role in the development of a psychiatric disease. The biological vulnerability is linked to genetics or physical and psychiatric diseases. Examples for stressors are life events or tensions and arguments in relationships. Finally, the protective factors can reduce the person's biological vulnerability and stress (for example good coping skills or social support). Admittedly, this reconstruction is often mere speculation. However, an individualized etiological model can give a plausible (and thus more acceptable) explanation (for the patient) of how his/her difficulties arose. Additionally, it can give indications for possible therapeutic interventions in the patient's current situation (e.g. triggers or resources).

History of Disorder

When taking the patient's history, the therapist pursues the following goal: He/She wants to reconstruct as exactly as possible how the disorder has evolved over time. This may range from initial inconsistencies and abnormalities in the patient's experiencing and behavior, to unspecific precursors and prodromal symptoms. Additionally, it can range to the onset of the patient's specific symptoms. Moreover, it can range to how the disorder has developed up until the current point in time. This includes the following:

- aspects of the individual course of the current disorder
  - static, episodic,
  - recurring, remitting, progressive,
  - exacerbations, symptom-free periods, long periods of euthymia;
- the prevalence of other mental comorbidities over the course of the patient's life,
- somatic illnesses and past treatments.

The therapist must not neglect the latter. In connection to the latter, the therapist must find out how many medications the patient took for organic illnesses. Medications can have serious psychopathological side effects (e.g. cortisone, bronchodilators used to treat asthma, cytostatics).

Treatment and self-treatment history

The patient's previous attempts at treating his/her issues, symptoms and problems are closely related to the etiology of the disorder. In particular, the therapist must collect sufficient information on the following:

- previous psychotherapeutic or psychiatric/pharmacological treatments in an outpatient or inpatient setting,
- previous therapeutic experiences relating to current or earlier disorders, including their success or failure.

Additionally, the therapist should ask the patient for other relevant documents (diagnoses, test results, diagnostic findings, epicrises, discharge reports). The patient must give his/her consent to this. If consent is given, the therapist looks at the documents and checks on the following:

- ongoing ancillary treatments (e.g. medication prescribed by the patient's general practitioner (GP) or consultant psychiatrist or neurologist),
- alternative therapies (e.g. homeopathy),
- patient's attempt of self-treatment.

The latter point is very important. First, patients usually try to help themselves and treat their symptoms before looking for professional help. The therapist must ask the patient sufficient questions about the patient's attempts of self-treatment. The therapist must ask about what the patient has tried to do. Additionally, the therapist asks about the effects of self-treatment. The patient's answers can give useful hints to suitable or unsuitable entry points during intervention planning. Patients often take inappropriate or counterproductive steps in their search for some (short-term) alleviation of their symptoms. But these steps can have serious (long-term) consequences. For example, the use of psychoactive substances to reduce symptoms and overcome problems can quickly lead to substance abuse or drug dependency. The use of psychoactive substances may prove a serious impediment to treating the patient's primary disorder. For this reason, they may become the subject of the therapy. From the previous example, a therapist should also learn the following: The drug anamnesis should cover both legal drugs

such as alcohol, medications and tobacco and illegal drugs such as cannabis, amphetamines and opioids.

The therapist can incorporate all the documents into his/her own treatment planning.

Family history

The initial interview is important because it helps collect information on possible genetic predispositions or (unfavorable) family models. The therapist should find answers to the following questions:

- Were there any familial incidences which included a mental health issue (possibly subclinical ones)?
- Have any family members previously undergone psychiatric treatment?
- Have there been any suicides in the family?

The family history should include information with regards to the following:

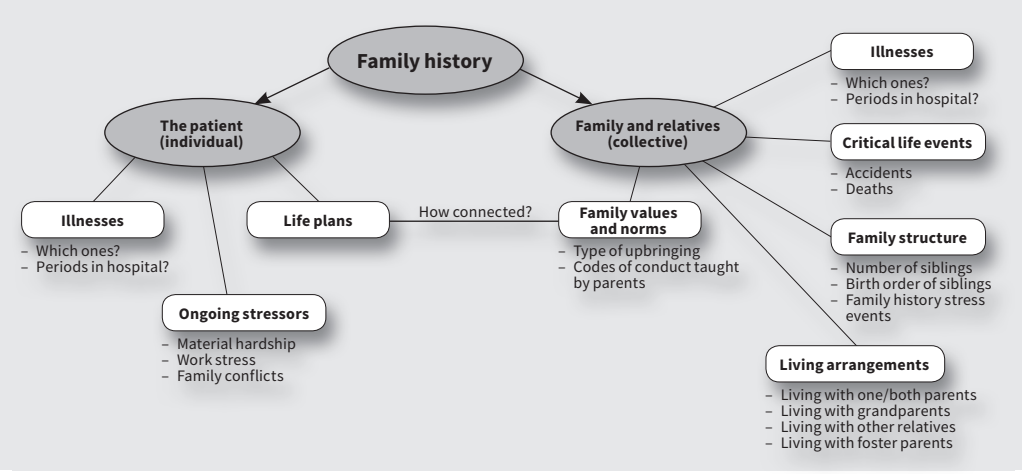

Figure 6: What the therapist must incorporate in the family history

There might be a connection between these aspects and the patient's current disorder. These aspects can point to risk and protective factors. Living arrangements can be stressors or resources at the same time. Have a look at the following example: There are serious conflicts within a patient's family. The patient lives together with eight other family members in a tiny apartment. In this way, the patient is always reminded of the conflict. He/She might not be able to solve the conflict. In this way, the living arrangement becomes a stressor. On the other hand, living arrangement can be a protective factor, too. The patient might experience a lot of emotional support when living together with several family members.