Appendix 7. Psychotherapeutic techniques

Psychotherapy can be defined as the psychological treatment of emotional, behavioural, and personality disorders, and it involves communication between a patient and a therapist and uses theoretically-based methods. All psychotherapies are based on the relationship between the therapist and the patient, as well as the use of procedures and specific techniques.

Psychotherapies can be offered in different formats (individual, family, group), and they can differ in specific dimensions such as the frequency of the sessions, the degree of the structuring, the duration, and the proposed objectives.

Moreover, there are different forms of psychotherapy that are derived from particular explanations or theories of psychopathology. Occasionally, this diversity is probably due to interests that are unrelated to scientific rigour or conceptual precision. In this regard, in 1993 Guattari pointed out that “psychotherapeutic practices and their theoretical formulations are currently in a state of almost total dispersion. This situation cannot be considered a sign of freedom, a stimulus to invention and to creativity, but rather it is the consequence of the sectarianism that reigns in this area and is the consequence of unawareness, which at times reaches irritating extremes, about everything that is happening inside each one of these restricted preserves.”

Despite the dispersion in this field, the various psychotherapeutic practices could be framed within five main groups: the behavioural approach, the cognitive approach, the psychodynamic approach, the humanistic approach, and the family approach. There are also other therapies that traditionally have not been included in these five groups but that have acquired great importance, such as interpersonal therapy.

As a starting point, before describing each one of the modes of psychotherapy, it should be pointed out that all of them, regardless of the theoretical model on which they are based, start with an assessment and a clinical formulation or conceptualisation of the problem or problems presented by the patient as a guide to the psychotherapeutic strategy. It must also be pointed out that all psychotherapeutic approaches share general principles, such as the need to establish a therapeutic alliance with the patient or a cooperative relationship that heads towards the proposed objectives of change.

The psychotherapeutic approaches on which controlled studies have been performed to assess their efficacy in childhood and adolescent depression and which have been reviewed in this guideline will be described.

BEHAVIOURAL PSYCHOTHERAPY

Behavioural psychotherapy or behaviour therapy is an approach of clinical psychology that is based on the psychology of learning to explain psychological disorders and the development of strategies directed at therapeutic change. Another, central characteristic of this approach is that it is based on the experimental study of the principles and laws of learning, whose main processes are the following:

- **Classical conditioning.** It is based on the work of Pavlov and other Russian physiologists who performed experimental studies with dogs. They observed that when an initially neutral stimulus (for example, the sound of a bell) was paired with a stimulus, such as food, that was capable of causing unconditioned, automatic physiological responses, and after repeating the pairing a number of times, it began to cause a response (salivation) that was similar to what was caused by the unconditioned stimulus, even without the presence of the unconditioned stimulus. The principle of classical conditioning, in addition to its
involvement in the acquisition of simple conditioned responses, can be involved in the acquisition of complex responses, such as those of anxiety and other emotional states in certain environmental conditions, which is highly relevant to explaining and psychologically treating diverse emotional problems.

- **Operant or instrumental conditioning** refers to the learning of behavioural responses due to the environmental consequences or changes that they cause. When behaviour is associated with environmental changes or favourable consequences, this behaviour is positively reinforced and increases its likelihood of occurrence in the future. Conversely, negative consequences or no consequences would be associated with a decrease of the likelihood of occurrence of the behaviour in the future. In brief, a subject would learn to respond behaviourally under particular environmental conditions (discriminative stimuli) due to the consequences of the subject’s responses throughout their biographical history.

- **Observational or vicarious learning** refers to the learning of behavioural patterns that are derived from the observation of others. In this case, the likelihood of the behaviour increases when it is observed that execution of the behaviour by others under certain stimulus conditions leads to favourable consequences.

Likewise, the likelihood would decrease when it is observed that the behaviour in question is punished or is not followed by any consequence.

The relevance of language in human functioning is reflected in the development (from the behaviourist framework) of concepts such as “derived relations” or “rule-governed behaviour”, which are highly important to understanding a psychopathology and the treatment thereof.

Psychological disorders are understood as the result of problematic learning experiences throughout one’s biographical history. Psychological symptoms would therefore be responses that have been learned through processes such as the aforementioned.

Therapy is based on a behavioural assessment in which a functional analysis of the specific episodes of the problem is central to identifying both the antecedent conditions and the consequences of the problem behaviour. It is thus possible to establish a hypothesis about the main influences that maintain the behaviour and, based on this, apply the pertinent therapeutic procedures based on the psychology of learning. However, contrary to a simplistic vision of behavioural therapy, it should be pointed out that, according to Marino Pérez262, “problems are presented and help is offered in the natural social context, which must be recognised as being complex with respect to the multitude of nuances that are continuously present. This therefore means that the development of the behaviour can result in a list of scarce and inflexible forms with respect to the infinite nuances of the context. The issue according to behaviourist criteria is to stick to classes of behaviours that are defined precisely for generic purposes (not in the sense of being vague, but rather generalist)”.

In this same sense, it should be added that the context within which there is interaction must be understood in the broad sense, given that a person not only relates with external stimuli but also with private stimuli, such as verbal thoughts or images, emotions, and bodily sensations. At the same time, more than a linear relationship in which the subject reacts to various stimuli, the subject-environment relationship is understood dialectically. In other words, not only does the context induce various behaviours or is an occasion for various behaviours, but these behaviours are also involved, at the same time, in moulding the context.

Some therapeutic techniques of behavioural treatment are the following:

- **Exposure techniques**. This therapeutic strategy involves getting the patient to come into repeated and prolonged contact with those situations that trigger states of anxiety and that the patient systematically avoids. Through repeated and prolonged exposure to these situations, the anxiety responses are progressively extinguished. The specific therapeutic proce-
dures in which the principle of exposure is present are diverse. For example, exposure can be done in the imagination or live (confrontation with life situations that trigger states of anxiety). On the other hand, exposure to avoided situations can be done gradually. In other words, exposure to progressively more anxiety-inducing situations would be planned in advance so that the attenuation of anxiety in the initial situations of the hierarchy facilitates exposure to situations that are associated with more elevated levels of anxiety within the hierarchy. Another variant of exposure is the technique known as systematic desensitisation. In this case, exposure to situations associated with anxiety responses is done in the imagination. Exposure takes place gradually (a hierarchy of situations that cause progressively more intense anxiety responses), while at the same time inducing a response that is incompatible with the anxiety (for example, a state of relaxation). The experience of contact with situations that initially cause anxiety under these conditions would give rise to debilitating their association with the anxiety.

- **Relaxation training.** Although various relaxation procedures exist, the one most frequently used in behaviour therapy is the one developed by Jacobson, which is known as “progressive muscular relaxation.” This method consists of learning exercises for tensing and relaxing different muscle groups. Repeatedly practising the procedure helps the patient to discriminate the stressful experience and to use relaxation responses against it. Characteristically, the number of muscle groups on which exercises are practised is decreased in successive sessions until the muscular tension exercises are dispensed with and relaxation is induced by evocation. The ultimate objective is to be able to apply relaxation to daily life situations that are associated with anxiety.

- **Aversive techniques.** The procedure involves pairing the stimuli, thoughts, or behaviours associated with a response to be eliminated with a stimulus that causes unpleasant or aversive responses so that the likelihood of the undesired response would decrease. One variant of this procedure is covert sensitisation. In this case, the undesired responses are elicited in the imagination and are also associated in the imagination with an aversive stimulus.

- **Reinforcement programmes.** They are directed at increasing certain behaviours. Therefore, after specifying the behaviours to be increased, some form of positive reinforcement that is contingent upon the expression of these behaviours is used. Positive reinforcement is an especially important strategy, for example, in training parents for the purpose of modifying problematic behaviours of children and promoting adaptive behaviours.

- **Modelling.** It consists of presenting a behaviour that has to be imitated in order to facilitate the learning of that behaviour. Modelling is an essential element in learning certain abilities, such as social skills.

- **Behavioural trial.** It consists of practising the responses or competencies that the patient has to learn. Practice can take place in simulated or real-life situations.

Finally, the importance of the therapeutic relationship itself, as the context within which problematic behavioural-emotional patterns are revealed, can become an important focal point of the therapeutic process, such as what happens in the behaviourist therapy called functional analytic psychotherapy.
COGNITIVE PSYCHOTHERAPY

Cognitive Psychotherapy is understood as the application of the cognitive model to specific psychological disorders through the use of a variety of techniques that are designed to modify dysfunctional beliefs and erroneous modes of information processing that are characteristic of a disorder.

Within this framework, particular learning experiences throughout development are considered to be important in the formation of cognitive schemes or beliefs that increase vulnerability to psychological alterations. Dysfunctional schemes or beliefs can be activated in life conditions that are related to them and that therefore have special significance for the person. The activation of dysfunctional schemes or beliefs leads to cognitive biases in the processing of information, of which the following are examples:

- Arbitrary inference: it refers to the process of reaching a certain conclusion without evidence that supports it or when the evidence is contrary to the conclusion.
- Over-generalisation: it involves reaching a general conclusion based on one or several isolated facts and applying the conclusion to both related situations and unrelated situations.
- Selective abstraction: it refers to focusing on a specific detail while ignoring other, more relevant characteristics of the situation.
- Magnification and minimisation: it refers to errors committed when evaluating the significance or magnitude of an event.
- Personalisation: it is the tendency of a patient to attribute external events to himself when there is no basis for establishing that connection.
- Absolutist dichotomous thinking: it refers to the tendency to classify all experiences to an extreme, without considering the graduations thereof.

These cognitive errors or biases translate into assessments or interpretations of special relevance in the emotional and behavioural response to a situation. In other words, emotional and behavioural reactions would be a direct consequence of said assessments. Dysfunctional assessments or interpretations can occur automatically in the sense of arising unconsciously in the stream of consciousness, with no consideration by the patient as to whether they are suitable or valid. The patient would assume that these negative automatic thoughts are a true reflection of reality.

Another important aspect of the cognitive model is the consideration given to the interactions between the different elements of the presentation of a disorder in the perpetuation of that disorder. For example, avoidance behaviours can make it difficult to acquire social skills, which in turn increases anxiety in these types of situations, thereby increasing the tendency towards avoidance, increasing negative thoughts about oneself, and so on.

Therapy is based on a clinical assessment and a formulation of the problem. It includes predisposition factors (for example, trait anxiety, deficits in certain skills, dysfunctional beliefs, or a poor social network), trigger factors (for example, a disturbing life event), and maintenance factors (for example, automatic negative thoughts or avoidance behaviours). The clinical formulation or understanding of the problem or disorder orients the specific therapeutic procedures.

The main therapeutic strategies used in cognitive therapy are the following:

- **Cognitive restructuring.** It consists of a careful analysis of the automatic thoughts that are communicated by the patient and that are relevant to the problem. This analysis attempts to specify the subjective meaning of the thought and the evidence on which it is based. More than trying to refute problematic assessments, the therapist asks questions that are focused
on the thought and the evidence on which it is based, as well as on evidence that could challenge the thinking. The goal is to help the patient consider more realistic or adaptive interpretations or assessments. It is important to point out that the challenge of automatic negative thoughts is to try to generalise the changes of these problematic cognitive patterns, through repeated practice, into daily life contexts so that the changes are strengthened.

- **Training on problem-solving.** This strategy is understood as a resource that facilitates the confrontation of conflictive or stressful situations. It consists of various phases that are learned over the course of the therapy sessions in order to be used in problematic situations that the person has to confront. Specifically, the training phases in problem-solving are the following:
  - Orientation towards the problem.
  - Specific definition of the problem.
  - Generation of possible solutions.
  - Examination of the advantages and disadvantages of each solution that is generated.
  - Selection of the preferred solution.
  - Putting the solution into practice.
  - Assessing the results.

- **Behavioural experiments.** The patient could make certain negative predictions that lead to problematic behaviours such as avoidance behaviours or excessive safety-seeking behaviours. Planning during the therapy session and putting changes in these types of behaviour into practice could help the patient to see the appropriateness of the negative predictions and, if they are inappropriate, could lead to changes in the dysfunctional cognitive pattern.

A central characteristic of cognitive therapy is its emphasis on changing problematic cognitive patterns such as automatic negative thoughts and, ultimately, dysfunctional beliefs or schemes that are the basis of those thoughts. The objective is to facilitate coping with situations that are associated with the emotional disturbance and, as a result, improve quality of life and long-term emotional and psychosocial adjustment.

Even though the cognitive model and the behavioural model are based on different assumptions for explaining psychological disorders, cognitive therapy - together with the stated cognitive techniques - systematically uses behavioural techniques (for example, scheduling gratifying activities or training on certain skills). Therefore, the therapy is commonly called cognitive behavioural therapy.

Finally, despite the fact that initially the cognitive model and cognitive therapy were preferably applied to emotional disorders (for example, mood state disorders, generalised anxiety disorder, and panic disorder), over time other disorders have been the objective of research and analysis from within this framework, which has resulted in clinical interventions applied to them also (for example, personality disorders, somatoform disorders, and positive psychotic symptoms with a poor response to psychopharmacological treatment).

1 Basically, behavioural formulations consider symptoms to be a consequence of learning processes. For example, from an absence of control over the environment (or learned helplessness) or from a lack of a positively reinforced repertoire of behaviours. From this approach, characteristic negative thoughts of depression would be another aspect derived from those learning processes, and they would not have a causal role in depressive manifestations. Conversely, cognitive theory – in its explanation for depression – considers learning processes such as the aforementioned to be implicated in the formation of dysfunctional schemes or beliefs, with a causal role in the origin of the disorder.
Thus, dialectical behaviour therapy is a therapy derived from cognitive and behavioural techniques developed by Linehan\textsuperscript{264}. It was specifically designed for treating people with borderline personality disorders, although it has been successfully used in adolescents with depression and suicidal behaviour and in other pathologies. There are two essential parts in the treatment: individual therapy sessions, in which skills are worked on, and group sessions, where patients learn to use specific skills.

Dialectical behaviour therapy, together with other therapies such as acceptance and commitment therapy or functional analytic therapy, have been called third-generation therapies, given that they are the most recent variants of CBT.

PSYCHODYNAMIC PSYCHOTHERAPY

The term psychodynamic psychotherapy refers to a heterogeneous set of psychological interventions that are derived from psychoanalytical theory. Several implementations of this form of treatment emphasise various aspects, which include the following: a) notions of the psychic conflict as a common aspect of the human experience; b) the internal organisation of the mind for avoiding the displeasure that arises from the conflict and maximising the experience of security; c) the use of defensive strategies for the adaptive manipulation of ideas and experience for the purpose of minimising displeasure; d) an evolutionary approach of psychopathology, understood as a product of the long-term consequences of adaptations in the initial phases of development; e) the organisation of experience in terms of internal representations of the relationships between the self and others throughout the life cycle; and f) the expectable re-emergence of these experiences in the relationship with the therapist. Psychodynamic psychotherapies are, above all, verbal and interpretative, and they are directed at restructuring the representations of relationships, predominantly (though not exclusively) through the use of insight\textsuperscript{265}.

According to Coderch\textsuperscript{266}, we could distinguish technical instruments that are characteristic of supportive psychotherapy and technical instruments that belong to psychoanalytical psychotherapy, which present a gradation regarding the patient’s knowledge and awareness of their intrapsychic conflict and of the unconscious processes that are at the basis of their disorders.

Of the psychotherapy techniques that are described below, the first three belong to supportive psychotherapy and the last three belong to psychoanalytical psychotherapy\textsuperscript{266}:

- **Suggestion**: it is a technical procedure that tries to generate certain ideas, impulses, and forms of behaviour in the patient; or conversely, make other ideas, etc. disappear, regardless of their logical or rational opinion, supported only on the prestige and authority that the therapist holds before the patient.

- **Abreaction**: it consists of providing the patient with an emotional purge of the effects through verbalisation of the events or circumstances that are linked to the effects, either consciously or unconsciously.

- **Counselling**: it is mixed with suggestion. The therapist offers indications about new guidelines of behaviour, alternatives, ways of resolving difficult situations, paths to follow, etc.

- **Confrontation**: in confrontations, the therapist tries to direct the patient’s attention towards situations, conflicts, and alternatives that, even when they are not unconscious, the patient may not consider at a given time or may overlook too quickly. It is also used to focus the patient’s awareness towards certain circumstances that merit more in-depth and careful thought than what the patient gives them, or to promote in the patient a more accurate study of his own attitudes towards others, towards himself, and towards various environ-
mental situations, or to more precisely weigh the quality and content of his experiences and his responses to them.

- **Clarification**: in clarification, the therapist tries to help the patient to be more aware of his feelings, of how he relates to himself and to others, and of the meaning of his behaviour in order to obtain a more precise understanding of the organisation of his personality and of the structure of his response systems to the world in which he lives. Technically, the therapist, in the attempt at clarification, more precisely and intelligibly summarises what he considers to be essential from the material offered by the patient.

- **Interpretation**: based on communication with the patient, the therapist tries to explain to the patient those unconscious mental processes that are expressed through such communication and that are the true driving force of his behaviour and, especially, of the clinical symptoms and personal difficulties.

Over time, the psychodynamic approach and psychoanalytical theory have been developed, and they have given rise to disagreements with respect to some of the assumptions and principles initially proposed by Freud. As a result, models that differ to a greater or lesser extent have been developed, and they have given rise to particular forms of psychodynamic psychotherapy (for example, Adlerian individual psychotherapy, interpersonal psychodynamic psychotherapy based on Sullivan’s contribution, Lacanian psychoanalysis, and psychodynamic psychotherapy based on object relations theory). On the other hand, some forms of psychotherapy, although based on traditional psychodynamic (psychoanalytical) assumptions, place the emphasis on specific technical procedures, such as the case of brief psychodynamic psychotherapies or supportive psychodynamic psychotherapy. These psychodynamic psychotherapies can be considered to be an extension of psychoanalysis in which greater direction and focus is given to more specific goals of a more limited scope. Unlike traditional psychoanalysis, the approach of psychotherapy is short term.

**FAMILY THERAPY**

Even though the different psychotherapeutic approaches can be used in a family format when applicable, the family therapy approach places the emphasis of its explanation of psychopathology on patterns of dysfunctional family communication and on the notion of system, based on the theory of human communication and on general systems theory.

The theory of human communication identifies behaviour with communication: every behaviour has message value and every message is a behaviour that can be modified.

General systems theory sustains the impossibility of understanding a system through a separate examination of the elements of which it is composed. To understand systems, it is necessary to consider the relationships between the individual elements and the underlying rules that govern them.

Applied to psychopathology, systems theory alludes to concepts such as mutual causality in the development and perpetuation of a problem; the inflexibility of the rules that govern a system, which makes it difficult to adapt to changes and stressful events and which leads to imbalances that are manifested as a form of psychopathology; and the function that the symptomatic behaviour can fulfil in regulating the family system.

The way that psychopathology is conceived means that this psychotherapy is preferably applied in a family format.
Gotlib and Colby\textsuperscript{269} indicate the general principles of this approach to therapy:

1. The central goal of therapy is to promote changes in the patterns of family communications and in the behaviours that interrupt the sequences involved in the problems that led the family to therapy.

2. The therapeutic approach is the here and now rather than the family history.

3. The therapist is an active participant in the therapeutic process.

4. The therapist adopts a problem-solving approach.

5. The therapist explores the patterns of family interaction involved in maintaining the problem.

6. Therapy is generally short term.

7. The therapist expands the focus to the family, without limiting it to the symptomatic behaviour.

8. The emphasis of the therapy sessions is the process more than the content.

In the family approach of psychotherapy, four main modes can be distinguished, which – even based on shared principles (derived from communication and systems theories) – place special emphasis on certain conceptual aspects, and they have distinctive characteristics or variants in the specific therapeutic procedures:

1. Strategic communication therapy.

2. Strategic family therapy.

3. Structural family therapy.

4. Systemic family therapy.

**INTERPERSONAL THERAPY**

Interpersonal therapy is a form of treatment that is of particular interest to this guideline, given that its efficacy has been proved in several controlled studies with depressed patients, and it arose specifically as maintenance therapy for major depression. Its founders are Klerman and Weissman\textsuperscript{143}, and it has been adapted for use with adolescents.

Interpersonal therapy focuses on four, clinically relevant aspects in depressive disorders:

1. Grief. Therapeutic intervention in this area involves helping the patient to reconstruct the relationship with a lost person by facilitating emotional expression and the formation of sorrow, as well as emphasising the establishment of new relationships.

2. Interpersonal conflicts in different scopes (marital, family, social, and work). They occur when a patient and other people have different expectations of a situation and the resulting conflict is of a sufficient magnitude to cause significant distress. Intervention involves identifying the sources of misunderstanding the other’s point of view, which occurs due to communication problems, as well as unreasonable or invalid expectations that can exist. As from this point, procedures are applied to provide training on communication, problem-solving, or other techniques that help to facilitate a change in a conflictive situation.

3. Role transitions. This refers to situations in which a patient has to adapt to a change in his life or circumstances. These changes can be derived from a development crisis, adjustments to changes at work or socially, as well as the occurrence of disturbing life events.
such as situations of attachment and loss. In interpersonal therapy, the sources of difficulty in adapting to a new role are identified, and new ways to confront them are sought.

4. Deficits in personal relations. It refers to aspects of interpersonal behaviour such as excessive dependency or hostility, which contribute to poor social adjustment. Within the framework of the therapeutic relationship, adaptive changes in these behavioural patterns would be attempted.

Obviously, in this psychological treatment, the interpersonal aspect of the behaviour is prioritised, but it is not family therapy. At the same time, the focus is on the problems that can explain the depression, but it also isn’t problem-solving therapy. It is an approach that takes ideas and techniques from other schools and organises them in an original way. Thus, concepts and techniques of cognitive behavioural therapy, experiential therapy, and supportive therapy are characteristically used.

Therefore, interpersonal therapy does not ascribe to a specific theoretical school, although the interpersonal psychiatry of Sullivan and Meyer and Bowlby’s attachment theory would have to be pointed out as the main influences in its development.

Over time, since interpersonal therapy arrived on the scene as a form of treatment for depressive disorders, it has adapted to the peculiarities of other psychopathologies such as bulimia nervosa, somatisation, substance abuse, or post-traumatic stress disorder.

Therapy lasts approximately 12 to 16 weeks in one-hour sessions on a weekly basis, which are structured by an initial evaluation phase (normally the first interviews are the evaluation phase). The evaluation phase is followed by the therapeutic intervention phase, which focuses on the indicated interpersonal areas throughout the following sessions. The last two sessions are centred on ending the therapy.

**BIBLIOThERAPY**

It is a form of therapy in which the patient is given carefully selected material to read in order to treat their emotional and behavioural problems. It is characterised by using an especially applied format and mode and not by belonging to a specific school.

Bibliotherapy can be oriented from any psychotherapeutic approach. Intervention by the professional is considered to be minimal, and reading the texts gives rise to a process of self-help through the patient’s own reflection. These reflections are only occasionally discussed with the professional.