Clinical Psychology and Cognitive Behavioral Psychotherapy

Recovery in Mental Health

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This book is dedicated to all the people I treated psychotherapeutically, especially Anna, Nikos, Kleopatra, Maria and Theodora; to my parents and my family; to Prof. Dr. Annette Schröder, my supervisor in my Ph.D. studies at the University of Koblenz-Landau, Germany; to my colleagues and friends; and finally, to democracy and human rights.

Preface

This book is about mental health disorders which should be perceived in the same way as organic disorders.

Unfortunately, there is a lot of stigma internationally about being associated with mental health disorders.

This book presents a positive perspective toward mental health, free from stigma and determined through the recovery perspective.

All the people in this world have the right to address their mental health disorders. Furthermore, everyone has the right to access evidence-based treatments for these mental health disorders. This is an important duty of a democratic society toward vulnerable individuals.

This book is the consequence of my psychotherapeutic experience with adults in the context of cognitive behavioral psychotherapy.

This book is for the following readership: Psychiatrists, psychologists, psychotherapists, students of psychology and medicine, researchers, and non-experts interested in mental health disorders and psychotherapy.

Athens, Greece — Stavroula Rakitzi

Acknowledgments

I am grateful to the individuals I treated psychotherapeutically, my colleagues with whom I cooperated all these years, and colleagues who participated in my training seminars about cognitive behavioral psychotherapy and rehabilitation. I am also grateful to Springer Nature.

About This Book

This book presents various mental health disorders with their clinical features and evidence-based treatments. It will present the recovery perspective for each mental health disorder and propose a combination of evidence-based treatments in the context of cognitive behavioral psychotherapy and rehabilitation.

Each chapter begins with an abstract followed by the main text, which is categorized into the following parts: Introduction, clinical features of the disorder, a case formulation, interventions, discussion, conclusions, revision questions, and references. Revision questions are didactic, can ensure the knowledge of each chapter and they are recommended for the entire readership.

The above structure of each chapter and revision questions can contribute to better teaching in seminars and courses.

This book discusses anxiety disorders, obsessive compulsive disorders, trauma, somatic disorders, depressive disorders, bipolar disorders, schizophrenia, psychotic disorders, and personality disorders.

Athens, Greece
December 2022

Dr. Stavroula Rakitzi

Introduction

Clinical Psychology and Cognitive Behavioral Psychotherapy presents a comprehensive book about mental health disorders and their evidence-based treatments in the context of cognitive behavioral psychotherapy and rehabilitation. The recovery perspective is the protagonist in this book and gives an optimistic point of view regarding treating mental health disorders with fewer stigmas and more acceptance and reintegration into society. It will be a useful resource for experts, such as psychologists, psychotherapists, psychiatrists, and researchers, as well as students of psychology and medicine and non-experts interested in cognitive behavioral psychotherapy. Among the topics discussed are anxiety disorders, obsessive compulsive disorders, trauma, somatic disorders, depressive disorders, bipolar disorders, schizophrenia, psychotic disorders, and personality disorders.

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About the Author

Stavroula Rakitzi, Dr. Phil. Diplomsychologist and Cognitive Behavioral Psychotherapist was born and raised in Greece. She studied psychology at the Georg-August-University of Göttingen in Germany and holds the European Diploma of Psychology. She was trained in cognitive behavioral psychotherapy in Athens according to the EABCT Criteria. She completed her doctoral studies in clinical psychology and adult psychotherapy at the University of Koblenz-Landau in Germany. She has been working as a Diplompsychologist and Cognitive Behavioral Psychotherapist in private practice since 2001. She has promoted Integrated Psychological Therapy (IPT) for patients with schizophrenia since 2006 in Greece, and she is a trainer in Cognitive Behavioral Therapy and IPT in her private practice in Athens, Greece. She developed the IPT postgraduate program for CBT-trained psychologists and psychiatrists in Greece. She implements evidence-based recovery-oriented interventions in mental health disorders in private practice. She has participated in many national and international conferences as a speaker and author of papers in Greek and international journals and books. Currently, she is also a member of the Hellenic Society for Behavioral Research and Therapy (www.eees.gr) of BDP (www.bdp.org) and of the American Psychological Association (APA) .

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Abbreviations

ACT	Acceptance and Commitment Therapy
CBT	Cognitive Behavioral Therapy
CBTp	Cognitive Behavioral Therapy for psychosis
CFT	Compassion-Focused Therapy
CT-R	Recovery-Oriented Cognitive Therapy
DBT	Dialectical Behavior Therapy
EABCT	European Association of Behavioural and Cognitive Therapies
EMDR	Eye Movement Desensitization and Reprocessing Therapy
GAD	Generalized Anxiety Disorder
IMR	Illness Management and Recovery Program
MC	Metacognitive Therapy
MCT	Metacognitive Training
MERIT	Metacognitive Insight and Reflection Therapy
MBCT	Mindfulness Based Cognitive Therapy
PTSD	Posttraumatic Stress Disorder

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Part I

Evidence-Based Psychotherapy, Stigma and Recovery

Introduction

1

Health is a basic condition for the individual to live, to have a good quality of life, to achieve goals, and to be an active member of society. Health—physical and mental—is equally important. Our thinking, feelings, and brain functions (mental health) have an effect on organic health.

Prejudice and stigma against mental disorders present a reality which has no place in our civilized world and in the modern digital cosmos. Organic and mental health disorders are equally significant and need immediate intervention. Every person, regardless of origin, has the right to suffer from mental health disorders and to claim effective treatment.

Our democracy today must protect the rights of people with problems, especially those with mental health problems, and strengthen health systems with effective treatments.

There are many examples of social problems that have highlighted the importance of health interventions, such as the COVID-19 pandemic and the various outbreaks of war around the world, such as the Ukraine-Russia war.

The profession of clinical psychologist and psychotherapist is a fabulous and optimistic profession, which enables people with mental health disorders to overcome their difficulties, ensuring a better quality of life and a new reintegration into society. This profession is associated with high stress and great responsibility and, at the same time, with great spiritual satisfaction from the positive course of the evolution of psychotherapies.

Clinical psychologists and cognitive behavioral psychotherapists must work closely with other medical specialties and especially with psychiatrists to achieve more effective psychotherapy. Thus, all together, we give the gift of health to our fellow human beings!

Nowadays, there are many evidence-based interventions available in the context of cognitive behavioral psychotherapy and rehabilitation. What's important for the next years is the combination of the above evidence-based interventions in the

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context of cognitive behavioral psychotherapy and its evolution over a long term in an ambulant context. The reduction of stigma and rehabilitation and reintegration into society are the main pillars and ultimate goals of psychotherapy.

The protagonists of psychotherapy are people that suffer from mental health disorders and seek help from psychotherapy. These people must have access to evidence-based psychotherapy and learn what they are suffering from, how their problem is expressed, and how it can be treated through evidence-based psychotherapy or a combination of pharmacotherapy and psychotherapy.

Health systems must finance evidence-based treatments and their combination and ensure for individual's access to them. We will have active citizens, who, through the treatment of mental health disorders, will continue to be living cells of our society claiming all their rights.

A democratic society is obliged to protect vulnerable people and to give them equal chances to reintegrate into society. Evidence-based psychotherapy is an important step towards this procedure and an important element to enhance democracy and transparency towards people with mental health disorders. A functional democracy presents an exodus from disability and stigma for individuals with health and mental health issues.

This book is the result of my clinical experience in cognitive behavioral psychotherapy and its evolution of adults; it is for experts and non-experts and focuses on anxiety disorders, obsessive-compulsive disorders, trauma, somatic disorders, depressive disorders, bipolar disorders, schizophrenia, psychotic disorders, and finally personality disorders. Special emphasis is placed on chronic mental health disorders. Finally, the fact emerges that psychotherapy is a beautiful path, through which a new life can begin. Psychotherapy always gives optimism and hope. In life, there are no dead ends.

2 Cognitive Behavioral Therapy, Metacognitive Therapies, and Rehabilitation and Further Developments in Mental Health

2.1 Introduction

Mental health problems are present in people from all over the world regardless of age, socioeconomic status, religion, and sex. They should be treated properly so that people can reintegrate into society and lead a better quality of life in the long term. Mental health problems are divided into two categories: short-term disorders such as panic attacks and long-term or chronic disorders such as schizophrenia.

Given the scale of mental health issues, evidence-based treatments should be available to people who have such issues. In this regard, cognitive behavioral therapy (CBT), metacognitive therapies, and rehabilitation programs present modern and effective treatments for people with mental health problems. Today, we cannot use the excuse that effective therapies are not available. However, we do need more motivated and educated mental health experts and practitioners who can provide these therapies efficiently.

The main characteristics of CBT are presented in this chapter. CBT-based treatments, metacognitive therapies, and rehabilitation and recovery programs are also elaborated on. In addition to this, their clinical and research implications are discussed. Mental health problems can be cured effectively in the long term.

2.2 Clinical Psychology and Cognitive Behavioral Psychotherapy in Different Settings and Their Further Developments

Clinical psychology is a subdiscipline of psychology that deals with the psychological features of mental health disorders. Etiology, classification, diagnostic procedure, epidemiology, and intervention (prevention, psychotherapy, and rehabilitation) constitute the main areas of clinical psychology.

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CBT is a modern treatment based on research and science, which focuses on the relationship between thoughts-beliefs-schemata, feelings, and behaviors and how our thoughts and beliefs influence our behavior. A therapeutic relationship and alliance provides the most effective context, as therapists and clients can work synergistically to find a case formulation [1] of the problems. By working together, they can identify the underlying context of these problems, including their root causes and maintenance. This will help therapists to use psychotherapy accordingly and effectively to treat their clients. A cognitive schema presents a cognitive context, where information about self, others, and the future is organized and interpreted. Automatic thoughts and beliefs can be listed as the elements of various schemata. They should be restructured on a realistic basis to enhance one's emotional levels (Fig. 2.1).

A good therapeutic relationship is a requisite but not a sufficient condition for achieving the therapeutic result. Moreover, it is not the only component that contributes to the therapeutic change [2]. The establishment of a therapeutic relationship means that therapists show empathy, acceptance, the ability to communicate, and willingness to help clients. They cooperate with each other through collaborative empiricism [3]. The therapeutic alliance is a part of the therapeutic relationship and is related to the development of therapeutic limits (respect, trust, and mutual appreciation). It also helps the people involved to agree on the therapeutic goals and comprises four characteristics, consulting skills, collaborative empiricism, case formulation, and guided discovery through Socratic questions, which they interact dynamically with each other [4].

The therapeutic relationship in the context of cognitive behavioral psychotherapy is based on transparency, respect, and freedom. Therapists and clients cooperate with each other for the benefit of the latter in a democratic context. A therapeutic relationship and alliance is an opportunity to bring about a change in the future. But, as previously stated, the therapeutic relationship is a requisite but not an ample condition for changes in therapy. It must be combined with the implementation of cognitive and behavioral interventions (Fig. 2.2).

A gut therapeutic relationship has a positive impact on the implementation of the interventions and can lead to positive therapeutic change. This, in turn, can lead to a positive therapeutic relationship. The aforementioned dynamic acts as an impetus for active participation in therapy and further improvements in the therapy procedure.

A great number of specialized interventions and strategies, both cognitive and behavioral, are available [5–8] to help modify beliefs and behaviors. For example, behavioral interventions include relaxation and stress reduction techniques, problem-solving, exposure therapy, assertiveness training, behavior activation, behavioral experiments, and cognitive interventions. These interventions can help

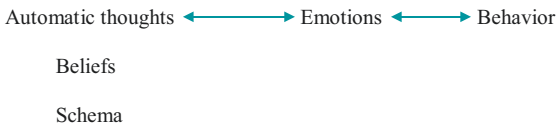

Fig. 2.1 The relationship between thoughts-beliefs, emotions, and behavior in CBT

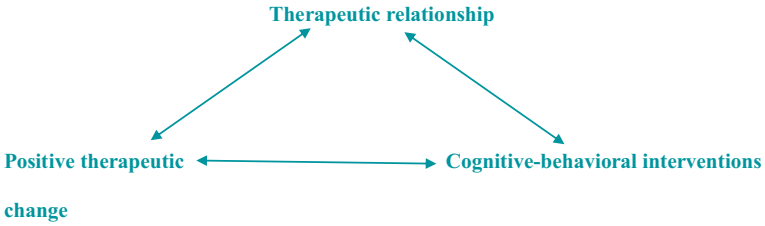

Fig. 2.2 The dynamic relationship between therapeutic relationship, cognitive behavioral interventions, and therapeutic change

identify cognitive distortions and aid in the cognitive restructuring of automatic thoughts and beliefs. Finally, relapse prevention enhances the entire process of psychotherapy.

Creating an effective psychotherapeutic relationship in relation to the combination of cognitive and behavioral interventions enhances the possibilities of successful psychotherapy. Appropriate training in CBT guarantees the success of implementing all the aforementioned characteristics in the psychotherapeutic process.

CBT presents a structured and transparent psychotherapeutic approach, which can be implemented for short-term disorders such as unipolar depression (one episode) and severe mental health disorders, such as schizophrenia, psychosis, bipolar disorder, chronic depression, personality disorders, and trauma. CBT focuses on the present as well as the past, which helps people better understand their behavior.

CBT can be implemented in individual and group sessions, for couples, and among inpatients and outpatients. Moreover, it is based on democratic principles. To put it more clearly, therapists and clients work together as partners in a democratic context.

CBT presents an efficacious and effective treatment in many disorders and situations, such as depressive disorders, anxiety disorders, obsessive-compulsive disorders, post-traumatic stress disorder, insomnia, alcohol and substance use disorders, schizophrenia and psychotic disorders, bipolar disorders, personality disorders, somatoform disorders, eating disorders, fatigue, anger and aggression, criminal behaviors, chronic pain, general stress, distress due to general medical conditions, and dementia, in couple dysfunction and in families [9–55].

The European Association for Behavioural and Cognitive Therapy (https://eabct.eu/about-eabct) and the Beck Institute (https://beckinstitute.org/) give more details of the appropriate training in cognitive behavioral psychotherapy, which opens the way for mental health experts, such as clinical psychologists and psychiatrists, to work as cognitive behavioral therapists. Dr. Aaron T. Beck, who died on December 2021, is a protagonist and a very crucial mentor for all of us in the field of CBT accompanied by competent colleagues [2, 3, 56–63].

Cognitive Therapy of Personality Disorders [61] and Cognitive Behavioral Therapy for psychosis (CBTp) [62] show further developments of the model for severe disorders and its positive dynamic through the years.

The Recovery-Oriented Cognitive Therapy (CT-R) [63–67] presents the newest development of Dr. Beck and his colleagues, which is based on the main principles of CBT, and is a theory-driven, evidence-based therapy promoting recovery and resiliency in persons with serious mental health conditions. It focuses on the positive, on action, on the person and its life, on activating positive beliefs and actions towards specific problems, and on specific interventions for various problems.

The above elements lead to recovery, empowerment, and resiliency. CT-R can be implemented in individuals, in groups, in families, and in in- and outpatients and is an efficacious treatment [63–67].

In sum, CBT and its further developments through the years present evidence-based and recovery-oriented psychotherapy in short term and in chronic disorders.

2.2.1 Group Cognitive Behavioral Therapy

A group cognitive behavioral psychotherapy presents a context in which a number of maximum eight people are treated with a goal- and disorder-oriented therapeutic context, focusing on the restructuring of dysfunctional thoughts, beliefs, and behaviors. The therapeutic change is accomplished through the combination of the therapeutic relationship of the therapists with every member of the group, the implementation of cognitive and behavioral interventions, and the interpersonal dynamic process in the group. That means that the group members learn from each other in a cohesive context of the guidance of the therapists. A group cognitive behavioral psychotherapy can also be offered to families or parents of people with mental health disorders, focusing on psycho-education and on the improvement of coping strategies towards the disorder of the family member.

There are many evidence-based group cognitive behavioral programs available for various disorders, such as depression, bipolar disorder, anxiety, stress management, schizophrenia, assertiveness training, chronic diseases, and personality disorders, but also for families [68–75]. Therapeutic factors, which play a crucial role in group therapy and in the group dynamic, are cohesion, openness, trust, acceptance and giving of feedback, support, altruism, model learning, universality of suffering, catharsis, and hope [71].

It is clear that the cohesion, the feedback, the model learning, and the universality of suffering are expressed better in the therapeutic process in group therapy in comparison to individual therapy. The combination of individual and group therapy has many advantages for people who are willing to participate in psychotherapy. An individual psychotherapy focuses on the person's problems and how beliefs and behaviors can be restructured. It is an introspection process gaining more insight towards the dysfunction of the person and how this dysfunction can be changed. A group presents a miniature of a society. Model learning and the cohesion of the group deepen knowledge about self, others, and the interpersonal process and enhance the coping strategies of the person. It is recommended to combine individual and group therapy, so that vulnerability can be decreased in different therapeutic contexts and through the creative combination of behavioral

and cognitive interventions. A disadvantage of the above combination is that it takes longer as a process.

In conclusion, group cognitive behavioral therapy serves as a miniature of the society and can be combined with individual psychotherapy. People learn from each other in a structured goal-oriented context.

2.2.2 Cognitive Behavioral Couple Therapy

Cognitive behavioral couple therapy presents evidence-based psychotherapy for couples improving relationship functioning [9, 18, 44, 49].

Integrative behavioral couple therapy presents a new development of traditional cognitive behavioral couple therapy including additional acceptance techniques. It improves relationship gratification and communication and also has positive effects on the amelioration of the parenting role and functioning with the children [41].

Cognitive behavioral couple therapy serves as a context for the implementation of cognitive and behavioral interventions; for the improvement of the communication between the two parts; for taking care of each other through positive activities, which improve the atmosphere in the relationship and mood; and for restructuring of negative thoughts and beliefs about each other and the relationship. The above procedure presents a big chance for the people to make a new restart in their lives as a couple and gives them the opportunity to address other mental health disorders, which need individual or group cognitive behavioral therapy after the couple's therapy. In other words, couple's therapy serves as a prophylaxis for mental health.

In conclusion, cognitive behavioral couple therapy improves the quality of life and the cohesion of individuals and helps to address individual mental health problems, which require possibly further psychotherapy after couple therapy.

2.2.3 Cognitive Behavioral Psychotherapy and Its Further Developments

2.2.3.1 Metacognitive Therapies

The cognitive perspective refers to thoughts and beliefs. The metacognitive perspective refers to thoughts about thoughts and beliefs, which enhance the ability to reevaluate the beliefs, gaining an internal distance from them, and to modify them (Fig. 2.3).

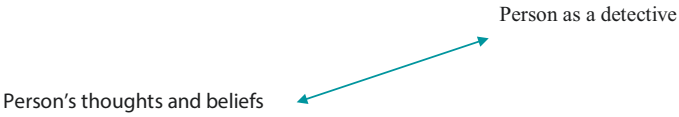

Fig. 2.3 The metacognitive point of view: The person observes and evaluates their own thoughts and beliefs as a detective

The Metacognitive Therapy (MC Therapy) [76] assumes that mental health problems are the consequence of cognitive attentional syndrome (CAS). The main elements of this cognitive style are (1) worry and rumination, (2) threat monitoring, and (3) dysfunctional coping behaviors. The goal of the therapy is the modification of negative metacognitive beliefs and the decrease in CAS.

The above therapy is efficacious in anxiety and depression, in GAD, in obsessive-compulsive disorder, in alcohol use disorder, and in work-related stress [77–87]. MC Therapy showed superiority in comparison to CBT regarding the long-term recovery of patients with generalized anxiety disorder [86]. The metacognitive model of bipolar disorder presents another treatment option for those patients. Randomized controlled trials with larger samples of individuals with bipolar patients must be conducted in the future [88].

Taken together, MC Therapy presents a very promising and an evidence-based treatment, in which the modification of negative metacognitive beliefs and the reduction of CAS are in the foreground. It is an efficacious treatment which enhances functional improvement.

The Metacognitive Training (MCT) was first developed for psychosis by Prof. S. Moritz and colleagues at the University Psychiatric Clinic at the clinical neuropsychological unit in Hamburg in Germany. It is a group program and aims to modify the cognitive distortions which are related to delusional disorders, increasing the insight towards the cognitive distortions and metacognitive reflection [74]. The above program can also be implemented as individual therapy. For more information, please refer to www.uke.de/mct.

It is an efficacious treatment for individuals with psychotic symptoms and psychotic episodes and for individuals with schizophrenia [39, 85, 89–92]. In the meantime, MCT is also implemented in other disorders, such as depression [93], geriatric depression [94], bipolar disorders [95], and obsessive-compulsive disorders [96], in gambling [97], and in borderline personality disorders [98]. For further information and training, refer to www.uke.de/mct.

In sum, MCT presents a European, modern, very promising, short-term, and evidence-based treatment for individuals with psychotic symptoms and psychotic episodes (psychosis-schizophrenia), with depression, with geriatric depression, with bipolar disorder, with obsessive-compulsive disorder, with gambling, and with borderline personality disorders. People gain greater awareness of their cognitive distortions.

This procedure gives a possibility to the person to be the detective of their own thoughts and beliefs and to gain a distance from them. MCT is a combination of CBT and rehabilitation, serves as a prophylactic context for new psychotic episodes, and is a recovery-oriented psychotherapy enhancing the reintegration into society.

The Metacognitive Insight and Reflection Therapy (MERIT) has been developed by Prof. P. Lysaker and his colleagues. It is efficacious long-term individual psychotherapy for patients with schizophrenia and other psychotic disorders [39, 73, 99–106]. For more information and training, refer to https://www.meritinstitute.org/.

MERIT helps people understand self, others, and the meaning of what happens in their life. This increases metacognitive flexibility. MERIT includes eight core elements: agenda, therapist transparency, narrative analysis, problem definition, dyadic reflection, client assessment, specific reflection, and stimulating mastery. It is a recovery-oriented psychotherapy [102, 104].

Taken together, MERIT is an evidence-based individual, long-term, and very promising psychotherapy, which helps people to understand self, others, and how the two principles are related. Life can be more meaningful through this process, decreasing vulnerability through psychosis, increasing the structure of life, and enhancing recovery and reintegration into society.

2.2.3.2 Third-Wave Cognitive Behavioral Psychotherapy

The first wave of behavioral psychotherapy focuses on observing and modifying behavior and is being represented by behaviorism [107, 108]. The second-wave therapy focuses on the relation between dysfunctional thoughts-beliefs and dysfunctional behaviors, which is being represented by cognitive therapy of Beck and from rational emotive behavior therapy by Ellis [109]. The third wave of cognitive behavioral psychotherapy contains some very promising therapies, such as dialectical behavior therapy (DBT) [110], mindfulness-based cognitive therapy (MBCT) [111], acceptance and commitment therapy (ACT) [112], and compassion-focused therapy (CFT) (117). Third-wave psychotherapies prefer mindfulness-acceptance and exposure techniques. Second-wave psychotherapies prefer cognitive restructuring and relaxation interventions [113].

DBT understands psychological acts contextually and functionally [114]. It helps individuals to tolerate negative emotions without evaluating them and to develop skills which lead them to more functional behaviors and less suicidal and self-destructive behaviors. DBT can be implemented as individual or group therapy.

ACT targets dysfunction and distress as a consequence of avoidance. In other words, difficult moments in the daily routine lead to avoidance, and ACT helps individuals to decrease the avoidance and to cope with the situation by implementing various strategies: acceptance of difficult moments, defusion, self as perspective, contact with the present moment, value identification, and committed action for a change in the future [112].

In other words, people learn to accept their vulnerability in difficult moments, such an illness, a grief process after a loss, and a chronic organic or mental health disorder, and to cope with it with new perspectives and actions.

MBCT is a brief 8-week group therapy, which combines mindfulness mediation and CBT for people with depression, and it contributes to relapse prevention of depression [115]. MBCT is based on the cognitive model of depression [58]. The basic philosophy of MCBT consists of the doing mind, which focuses on a particular goal trying to solve the problem, and the being mind, which focuses on the present moment without evaluating it and trying to gain a better insight towards the present moment. It is necessary for people that relapse into depression to learn to focus on the being mind [115]. In other words, individuals with depression learn to

focus on being minded and to relax, without struggling with it. After this procedure, the depression can be improved, which activates problem-solving easier.

CFT is a new and very promising therapy. Compassion goes in three directions: compassion we can feel for others, compassion we can feel from others, and self-compassion. People are trained in the above issues, which lead to improvement in their quality of life [116]. In other words, people learn to understand others better, to assert more understanding from others, and to show respect to themselves in difficult moments, in which rejection plays an important role.

Third-wave therapies, such as DBT, ACT, MBCT, and CFT, were not superior to CBT in eating disorders [117, 118]. DBT is implemented in borderline personality disorder [110, 119], but in the meantime, it is also implemented in other disorders. DBT is acceptable for autistic adults without intellectual disability and reduces emotion dysregulation [120], reduces emotional dysregulation in couples [121], enhances the trauma acceptance and decreases the trauma-related emotions [122], and is efficacious in post-traumatic stress disorder for women survivors of childhood abuse [123]. It decreases suicidal ideation [124, 125] and is effective against adolescents with bipolar disorder; in reducing suicidality, emotional dysregulation, and depression; and in adults with bipolar disorder [126, 127]. DBT is efficacious in reducing self-destructive behaviors and in enhancing compliance [128] and in reducing self-harm and suicidal ideation in adolescents [129].

ACT is effective in reducing stress and enhancing academic skills [130], in reducing insomnia [131, 132], in improving depression [133], in depression in a web-based format of ACT [134], in GAD in a web-based format of ACT [135], in chronic pain [136], in improving well-being in parents with individuals with autism spectrum disorders [137], and in coping with diabetes type 2 [138]. ACT is an evidence-based therapy for depression, mixed anxiety disorders, psychosis, chronic pain, and obsessive-compulsive disorder [139]. More evidence for the effectiveness of ACT for psychosis is appropriate [140, 141].

MBCT is effective in decreasing symptoms of post-traumatic stress disorder [142], has short-term positive effects on anxiety [143], an e health MBT program and mobile health improved stress, anxiety, depression, sleep problems and pain in cancer patients and increased levels of mindfulness and post-traumatic growth [144]. MBCT is effective against decreasing stress at work [145], in reducing anxiety and residual depression, and in improving mood regulation in persons with bipolar disorder. Mania didn't improve. Further, studies must be conducted [146]. Mindfulness-based therapy improves stress, anxiety, and depression [147].

CFT improved depression and social functioning [148], anxiety, depression, stress, and clinical outcomes of diabetes [149] and was effective in obsessive-compulsive disorder [150].

2.2.4 Rehabilitation

Rehabilitation in mental health presents a procedure in which persons with mental health problems are trained, structured, and goal-oriented through various

programs, in order to reduce disability and to achieve a better functioning and reintegration into society. Those programs focus generally on cognitive functions, symptoms, behavior, and functioning. There are recovery programs available, which aim to improve the way of coping with the disorder and the insight towards the disorder and to reintegrate into society with new realistic personal goals.

Today, we have many available evidence-based, recovery-oriented rehabilitation programs for individuals with schizophrenia and their families [39, 70, 151–156], for persons with bipolar disorder [157, 158], for depression [159], for dementia [160, 161], for persons with autism and intellectual disability [162–165], for persons with alcohol and substance abuse [166], and for organic disorders [167, 168].

There are also evidence-based recovery-oriented programs, such as the Illness Management and Recovery Program (IMR) [169] and the Wellness Recovery and Action Planning Program [170].

Cognitive variables—a major goal in the rehabilitation—are divided according to MATRICS initiative in neurocognition (speed of processing, attention/vigilance, verbal and visual memory and learning, working memory, and problem-solving) and social cognition (emotion processing, social perception, theory of mind (TOM), social schema, attribution) [171].

Rehabilitation programs are divided into the following categories: programs, which focus only on cognitive variables, such as neurocognition and social cognition, and integrative programs, which focus on the improvement of cognitive variables, symptoms, social skills, problem-solving, and social functioning. Integrative programs are preferable due to better achievement of long-term and generalization effects in the recovery process on the interventions on different levels.

2.3 The Importance of the Above Interventions

The above journey to the psychotherapeutic treatment of mental health disorders gives an optimistic point of view on the interventions in all the mental health disorders. The variety and the feast of the evidence-based interventions as well as the ongoing process of the evaluation of their effectiveness and efficacy through all these years present the best proof that psychotherapy as a science respects individuals with mental health issues.

Persons with mental health problems need a safe, transparent, scientific, and democratic context to understand the roots of the mental health problems and to be engaged in interventions which releases their disorders and opens the way for quality of life in daily routine. It is clear that evidence-based cognitive behavioral psychotherapy with its further developments and rehabilitation presents a treatment of choice for all the mental health issues leading to improvement of symptoms and quality of life and to recovery. Additionally, the insurance of health systems can be based on the efficacy and effectiveness of CBT and rehabilitation, so that the cost of psychotherapy can be covered by them.

2.4 Discussion

This book presents the consequences of scientific knowledge and clinical experience in the field of cognitive behavioral psychotherapy for adults. It aims to send a very positive message to all the people in this world who are confronted with mental health problems. The adults, who were/are treated by me, present an inspiration for me for this book, and I am very grateful to them. Mental health disorders are possible as organic problems. Evidence-based treatments are available and very effective in a scientific-psychotherapeutic context. Psychotherapy must be based on research and science.

CBT presents a manual, structured, goal-oriented, and transparent psychotherapy following democratic principles. Clients and therapists are working together in an understandable and mutual context searching for a case formulation of the disorder. Clients understand from the first moment until the end what is going on in the psychotherapeutic process. The therapeutic relationship in combination with the cognitive behavioral interventions enhances the therapeutic process.

CBT is efficacious in many and different organic and mental health disorders and under different conditions [20].

CBT is effective and efficacious, which proves the scientific character of it. The evaluation of the efficacy and effectiveness is an ongoing process. Compliance and relapse prevention present two elements, which must be taken into account in every therapy.

It is very crucial that further evidence-based CBT programs for chronic disorders, such as schizophrenia, personality disorders, and CR-T, are available and give us a way to implement them for chronic disorders. That proves that CBT is not only short-term psychotherapy.

Group cognitive behavioral therapy and cognitive behavioral couple therapy present a different context for different reasons for implementing CBT and can be combined with individual CBT. Further research regarding their efficacy is necessary.

Metacognitive therapies display a new perspective and point of view in the context of CBT. Further studies regarding their efficacy are necessary.

The third wave of CBT, like ACT, DBT, MBCT, and CFT, educates people to accept their disorders better, to learn to cope with them, and to understand self and others better. Further, meta-analysis and efficacy studies for the third wave of CBT must be conducted following the paradigm of the second wave of CBT.

Efficacious rehabilitation programs enhance the reintegration into society, improving cognition, symptoms, and functioning, and are available to the scientific community for different disorders. The evaluation of their efficacy is going on nowadays. Recovery-oriented programs enhance the insight towards the disorder and the recovery process which leads to a new beginning of life taking into consideration the vulnerability as well as the potential resources of the individuals.

CBT focuses on the content of thoughts and beliefs and how they can change. Metacognitive therapies focus on the thoughts about thoughts and beliefs and enhance metacognitive flexibility. Rehabilitation focuses on the improvement of

cognitive functions, social skills, and problem-solving. Recovery programs improve the insight towards the disorder, the coping mechanisms, and the communication within families with persons with mental health issues. ACT, DBT, MBCT, and CFT contribute to a better understanding, acceptance, and coping of the disorders.

Schema therapy [172] has been well known during the last years, and it is implemented by many psychotherapists and cognitive behavioral therapists, but it is based on psychodynamic techniques, and it is a totally different psychotherapy from CBT and its further developments and rehabilitation programs. It is very crucial for experts, who seek psychotherapeutic training in CBT, to focus only on CBT.

There is limited evidence for schema therapy [173]. Health systems need, on the other hand, evidence-based treatments for individuals who need psychotherapy.

The above pluralism of evidence-based interventions in the context of CBT sends a very optimistic message towards mental health. There is always an alternative way, such as scientific psychotherapy, which opens the way for a recomposition of life.

Evidence-based psychotherapy should be combined with the activation of resources [174]. A person, a group, or a couple is confronted with dysfunctions. Additionally, there are also some functional characteristics of them, who have to be enhanced, and who coexist with the dysfunctions. This is a very common method of the context of CBT, which proves that people can be vulnerable as well as strong in their lives. Both perspectives can coexist and can be a psychotherapeutic goal, meaning that resources enhance people to reduce their vulnerability.

It is very crucial that a variety of interventions in the context of CBT and rehabilitation is available. The question is how we can combine those interventions with each other in favor of people with mental health disorders. CBT, metacognitive therapies, rehabilitation, and the third wave of CBT can be implemented in combination, enhancing the recovery process. Individual psychotherapy can also be combined with group and couple therapy. People learn in this way to evaluate their concerns through different perspectives and on different levels. A long-term recovery and better relapse prevention can be a consequence of the above combination.

In other words, there must be no antagonism between the various interventions, which is the best. A synthesis of the combination of evidence-based interventions should be the most important goal. Further research protocols regarding the efficacy of the combination of the therapies in the context of CBT are necessary.

A psychotherapeutic training according to EABCT or the Beck Institute is nowadays an appropriate condition, in order to offer CBT under the best potential conditions. This training displays a responsible behavior of therapists towards individuals with mental health problems. Additionally, every country needs a legal framework of a law for psychotherapists defining the criteria and the license of psychotherapists and for psychotherapy.

In other words, an appropriate training in CBT and a legal framework of psychotherapy present the best prophylaxis for individuals who are interested in psychotherapy. The USA and most of the European countries, such as Germany and France, offer the above prophylaxis. By other countries, such as Greece, a legal framework for psychotherapy should be immediately redefined and specialized.

Clinical psychologists, psychiatrists, and psychotherapists, who offer CBT, should work under supervision, especially during the first years of their career, and they should take care of themselves. Psychotherapy is a highly demanded work [175], which must be combined with activities enhancing work hygiene and relaxation. Otherwise, it is not possible to work with mental health problems.

The pandemic of COVID-19 [176] presents an excellent example of an emergency, in which people were confronted with the danger of death. This emergency leads to many organic disorders, mental health problems, and restrictions of social life for people who were infected with COVID-19 and to many mental health issues and social restrictions for all the people in this world. The need for psychotherapies is very huge in all over the world. Psychotherapy showed a way of coping with this pandemic and motivated people to be vaccinated.

A war, another good example, displays a social emergency, in which people are confronted with the danger of death. A war leads to an increase in aggression, refugees, and deaths and many mental health problems, which is very traumatizing for all people. Psychotherapy can help people cope with the trauma of a war and begin a new life. Psychotherapy could contribute to better communication between the two parties in war.

The suffering from a mental health disorder, especially a chronic disorder, is many times combined with a grief process. Coping with grief [177, 178] should be a part of psychotherapy in combination with resource-oriented interventions. The question "why do I have to cope with a mental health disorder?" should be discussed and replaced with the question "How can I cope with this disorder?" Life has positive and negative moments. Otherwise, we couldn't be human beings.

Psychotherapy must be combined with psychiatric treatment for various disorders, when it is necessary. The synthesis of those two interventions leads to a more effective recovery process in favor of people, who seek psychotherapy.

Finally, there are many associations in the USA and Europe, which give valuable information about potential competent therapists, who offer CBT. EABCT, the Beck Institute, the national psychological and psychiatric associations, and the insurance systems in various countries display some important information sources.

2.5 Conclusions

In conclusion, CBT and its further developments and rehabilitation and recovery programs present evidence-based treatments for mental health problems and in different contexts, which lead to recovery and reintegration into life. A psychotherapeutic training in CBT displays an inalienable condition to work as a psychotherapist. Resources should be activated in psychotherapy and contribute to the reduction of psychopathology. Psychotherapy leads to a redefinition of many contexts of life. A new beginning is possible.

2.6 Revision Questions

1. How do you define CBT?
2. What is the relationship between therapeutic relationship and cognitive behavioral interventions in CBT?
3. Is CBT an effective and efficacious therapy?
4. Please describe some further developments of CBT.
5. How do you define group cognitive behavioral therapy?
6. How do you designate cognitive behavioral couple therapy?
7. What is the difference between the cognitive and the metacognitive perspective?
8. Please define MC Therapy, MCT, and MERIT. Are they effective and efficacious?
9. Please designate DBT, ACT, MBCT, and CFT. Are they effective and efficacious?
10. Please define the term rehabilitation. Why is rehabilitation important to mental health?
11. Please designate the recovery programs.

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Stigma

3

3.1 Introduction

The word "stigma" comes from the Greek language. "The stigma of health disorders" presents a metaphorical use of the word "stigma" and means that someone or something was marked negatively, which leads to shame, guilt, and accusations. Stigma can be associated with organic as well as with mental health disorders. In other words, health disorders are something that people feel shame and blame themselves. This situation leads to social withdrawal and decreases the possibility for people to seek help for the treatment of health issues. Stigma is the consequence of negative interpretations of health issues and, alongside it, can be a separate disorder, which coexists with health problems (Fig. 3.1).

The models of stigma, the consequences of it on mental health, and the interventions to reduce stigma will be discussed in this chapter.

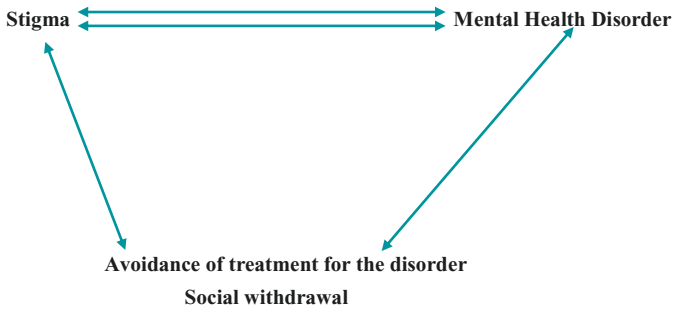

Fig. 3.1 The dynamic relationship between stigma and mental health disorder and its consequences

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3.2 Stigma

There are several models of stigma. Public stigma is related to the stigmatized opinions of people in society about mental illness. It has three aspects: stereotypes, prejudgment, and discrimination. Self-stigma presents the adoption and internalization of the public stigma from individuals with mental health disorders [1–3].

Self-stigma mediates the relationship between perceived stigma and psychosocial outcomes. The reduction of self-stigma can improve the various outcomes [4]. Self-stigma is related to negative clinical and functional outcomes. 31, 3% of individuals with severe mental health problems report increased self-stigma. Anti-stigma interventions and psychotherapeutic interventions contribute to a decrease in self-stigma [5]. Stigma is associated with negative health outcomes, such as depression, anxiety, poor quality of life, social withdrawal, poor functioning, and decreased self-esteem and self-efficacy [6–10].

Evidence-based treatments in the context of CBT and rehabilitation and recovery programs, as were presented in the previous chapter and psycho-education about the etiology and the treatment of disorders, change dysfunctional beliefs and behaviors, improve the insight into problems as well as coping strategies with mental health disorders, and enhance the reintegration into society and the recovery process. Psychotherapy treats, in other words, the stigma as well as the disorder. People learn to live with the problems with a new perspective of the recovery process, and this procedure decreases the stigma towards the disorder.

Additionally, there are various anti-stigma campaigns, which have been implemented in the last years in many countries. There are three strategies to fight against stigma: protest against public announcements and advertisements; educational programs, such as books, videos, and structured teaching programs, which provide anti-stigma information; and contact with persons with mental health disorders [3].

Individuals with mental health disorders have the right to live like all other people. They are not dangerous or strange, but different. If we accept their vulnerability and difference and if we try to engage in their own world helping them, when they need, they will coexist with us without any problems. Empathy with these people presents a safe road to build long-term communication with them.

In conclusion, there are different models of stigma. Stigma worsens mental health. Evidence-based treatments and anti-stigma campaigns improve mental health and reduce stigma.

3.3 Discussion

Mental health disorders coexist with stigma—a public stigma about mental health illness, which is adopted as a self-stigma. Stigma can be evaluated as the consequence of a mental health disorder or as a different disorder which coexists with mental health illness.

Stigma is related to low self-esteem and low self-efficacy, to social withdrawal, to anxiety and depression, to poor quality of life, and to poor functioning.

Evidence-based treatments in the context of pharmacotherapy, CBT, psycho-education, and rehabilitation and recovery programs lead to the recovery process and decrease the burden of mental health disorders and stigma. Anti-stigma campaigns [11] with protest against public stigmatized comments, educational programs, and contact with individuals with mental health problems also contribute to a decrease in stigma.

The Universal Declaration of Human Rights presents the best reaction to stigma. According to Article 3, every person has the right to life and to secure liberty and security [12].

A democratic society with the appropriate values, such as parity and respect to the Universal Declaration of Human Rights, is obliged to fight against stigma and any discrimination for, which is related to stigma. Stigma for people with mental health disorders presents a form of aggression and fascistic behavior. The failure to cope with the stigma is a failure of a democratic society to be an authentic democratic society. All the democratic countries have the appropriate laws to fight against stigma and to protect people with mental health disorders.

Psychotherapists should train people with mental health disorders to cope with stigma and mental illness and to be assertive against any stigmatized action towards them using the legal framework of each country.

Let's build a big communication and openness bridge to public stigma and to people with self-stigma and mental health disorders.

In sum, stigma can be reduced in the context of a democratic society.

3.4 Conclusions

There is a dynamic relationship between stigma and mental health disorders. Stigma coexists with mental health problems. Stigma leads to anxiety, depression, low self-esteem, social withdrawal, poor quality of life, and poor functioning. Evidence-based treatments in the context of pharmacotherapy, CBT, psycho-education, rehabilitation and recovery programs, as well as anti-stigma campaigns decrease the burden of stigma and mental health disorder. A main duty of a democratic society is to struggle with stigma and discrimination and to implement the Universal Declaration of Human Rights.

3.5 Revision Questions

1. How do you define stigma?
2. What are the forms of stigma?
3. What is the relationship between stigma and mental health disorder?
4. What is the influence of stigma on mental health?
5. How can we decrease stigma?
6. Why is it important to a democratic society to fight against stigma?

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Recovery

4

4.1 Introduction

The end goal of every psychotherapy in mental health and specifically the cognitive behavioral psychotherapy and rehabilitation and recovery programs is the activation of the recovery process and the reintegration into society for individuals with mental health problems.

There are some crucial factors which are very important to the psychotherapeutic process and have to be taken into consideration: the treatment response, if the people respond with compliance with the therapy; the remission, the decrease of symptoms and impairments; the relapse, the return to the phase before the beginning of psychotherapy; the relapse prevention; and the recovery, the social functioning and reintegration into society. The above situations can be evaluated with the appropriate psychometric tests of the various mental health disorders.

The definitions of the recovery process, the recovery processes itself, and the importance of it in the context of a democratic society will be discussed.

4.2 Recovery

Recovery is a procedure that begins after giving a diagnosis of mental health illness [1].

A person with a diagnosis of mental health disorder should find a new way of living and cope with it. That means that the person should find a new meaning of life, although various barriers are there as a consequence of the disorder. Life should go on, and the individual should be positive, optimistic, and flexible.

Recovery as an outcome [1] displays the point of view of the experts and means that the person is functional and without psychopathology. The recovery process will be evaluated by the experts on psychometric tests and is defined also as

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objective recovery. Recovery as a process or being in recovery [1] presents the point of view of the persons with mental health disorder and their families and is a dynamic procedure which is going on. Recovery as a process will be evaluated by the person himself with the appropriate experiences, and it is defined as subjective recovery [2–5]. In other words, recovery in the process means that the individual tries to decrease, step by step, the vulnerability at specific levels, has an active role in this process, and is responsible for him/her aiming at more empowerment and resilience in his/her own life. For example, a person with a psychotic episode has decreased anxiety and depression as a consequence of the psychotic episode, but he still hears voices. The person needs more training to cope with the voices, but it can enjoy the reduction of depression and anxiety. This active role leads to more optimism about the future and to a new purpose in life. The whole process presents a dynamic process of life.

The two points of view should be taken into consideration. There should be no antagonism between these different definitions. In the context of a democratic society, different points of view about the progress of mental health disorders contribute to pluralism and to intensive cooperation between mental health experts and clients. The protagonists in this process are the individuals with mental health issues.

Recovery is welcomed in healthcare systems, but the implementation and evaluation of recovery concepts require more stability and commitment [6, 7].

4.3 Discussion

Recovery and reintegration into society display the end goal of every evidence-based psychotherapy. Recovery as an outcome (objective recovery) and recovery as a process (subjective recovery) should be taken synchronically into consideration. The synthesis of them leads to a very positive, creative, and resource-oriented therapeutic result. The protagonists of this combination are people with mental health problems.

Evidence-based psychiatric treatment and psychotherapy should contribute in reducing the days of hospitalization and to increase the process of rehabilitation in different areas, of stabilization, and of relapse prevention, enhancing the recovery process (Fig. 4.1).

Individuals with mental health disorders are the protagonists of the above recovery process. They develop personal responsibility and the self-determination towards their vulnerability, and they can cope with it, improving step by step in empowerment and resilience.

Psychotherapy should train people for the recovery process. People should know with transparency from the beginning of psychotherapy, which is the road to recovery and how the recovery can be expressed by achieving specific therapeutic goals. CBT and its further developments, rehabilitation and recovery programs offer the above transparency.

Further research protocols with the combination of evidence-based interventions, as they described in Chap. 1 and how and in which percentage this

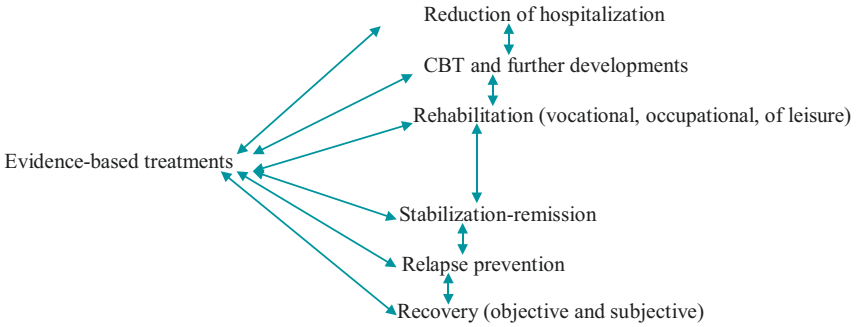

Fig. 4.1 The recovery process

combination contributes to the recovery process (objective and subjective recovery), are needed.

It is also very important to evaluate the recovery process via the appropriate psychometric scales. The Recovery Assessment Scale presents, for example, a good instrument for this purpose [8].

The recovery processes showed the road from dependence and weakness on the mental health disorder to autonomy, self-determination, self-responsibility, and peaceful coexistence with the disorder. This procedure takes greater importance in the case of chronic mental health disorders, such as psychotic disorders, bipolar disorder, and chronic trauma.

Lastly, the recovery process presents the best example of implementing democratic principles in the context of mental health. Vulnerable people should be protected and cured in the long term enhancing self-responsibility, autonomy, and resilience, which are the best expression of democracy.

In sum, the recovery process enhances autonomy and self-responsibility towards mental health disorders and should be an active part of a democratic society.

4.4 Conclusions

The main goal of every evidence-based pharmacotherapy and psychotherapy is the activation of the recovery process. Recovery as an outcome and recovery as a process display two points of view which they should be taken into consideration through a synthesis of them. Recovery leads to autonomy, self-determination, self-responsibility, and resilience towards the disorder. A democratic society should show the road to recovery of people with mental health disorders.

4.5 Revision Questions

1. How do you define recovery?
2. Why is recovery important to psychotherapy?
3. What is the relationship between recovery and democracy?

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Part II

Anxiety Disorders

Specific Phobia

5

5.1 Introduction

Anxiety disorders are very common disorders, which activate people negatively to cope with a dysfunctional situation. Adrenalin increases and leads to preparation to cope with the danger. A dangerous situation can be a realistic one, for example, a war or an abuse, or can be the consequence of a subjective interpretation of the situation as dangerous. Anxiety disorders lead people to seek professional help from mental health experts, and it is a trigger, when something is not normal or under control.

This chapter will present specific phobia: a phobia about a situation or an object. Clinical characteristics of the disorder as well as the evidence-based interventions will be discussed.

5.2 The Clinical Features of the Disorders

5.2.1 Diagnostic Procedure

Specific phobia is characterized according to DSM 5 by anxiety about an object or a situation (flying, heights, blood, injection, and dentist). The trigger activates fear or anxiety immediately and is avoided, and the anxiety is greater in comparison to the actual danger. Anxiety and avoidance last 6 months or more and have a negative impact on functioning. Specific phobia is not the consequence of a medical condition or other mental health disorder. A differential diagnosis should be made from agoraphobia, social phobia, separation anxiety disorder, panic disorder, obsessive-compulsive disorder, trauma disorders, eating disorders, schizophrenia, and other psychotic disorders [1].

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Additionally, the following psychometric tests can be given: the SCAARED [2], SCL-90-R [3], Acrophobia Questionnaire, Blood-Injection Symptom Scale, Claustrophobia General Cognitions Questionnaire, Claustrophobia Situations Questionnaire, Claustrophobia Questionnaire, Dental Anxiety Inventory, Dental Cognitions Questionnaire, Dental Fear Survey, Fear of Spiders Questionnaire, Fear Survey Schedule, Medical Fear Survey, Mutilation Questionnaire, Snake Questionnaire, Spider Phobia Beliefs Questionnaire, and Spider Questionnaire [4].

5.2.2 Epidemiology

The prevalence of specific phobia is 7–9% in the USA, 6% in Europe, and 2–4% in Asian, African, and Latin American countries. Specific phobia develops after a confrontation with a traumatic situation usually between 7 and 11 years, but it can be developed at any age [1]. The 12-month prevalence rates of specific phobia were 5.5%, higher in females than in males and higher in high-income countries than in low-income countries [5].

5.2.3 Comorbidity

There is a comorbidity of specific phobia with other disorders, such as other anxiety disorders, depressive and bipolar disorders, substance-related disorders, somatic disorders, and personality disorders (dependent personality disorder). The suicide risk is 60% due to comorbidity with other disorders [1, 5, 6]. 18.7% reported severe dysfunction, and comorbid disorders were observed in 60.2%. Specific phobia is a first and warning sign of other mental health disorders which are going to arise [5]. Risk factors for specific phobia are the female sex, low education, and the status of being ex-married [7].

5.2.4 Etiological Psychological Models

5.2.4.1 Behavioral Models

Classical conditioning displays an etiological model. The fear of a neutral stimulus (e.g., a dog) is the consequence of the coexistence of this stimulus with a highly stressful situation (e.g., an attack by a dog). Fear can be transformed into a conditional stimulus by mating this stimulus with an unconditional stimulus (stressful situation) [8].

Operant conditioning presents the relationship between behavior and its consequences. Individuals learn from the consequences of their behavior [9].

The two-stage theory of Mowrer shows that avoidance involved two processes or stages: classical and instrumental-operant conditioning. The first stage presents a mating of a neutral conditional stimulus and a stressful unconditional stimulus to a conditioned fear of the conditional stimulus. In the second stage, the

individual learns that fear of the conditional stimulus can be decreased from the parrying of it [8].

The conditioning models and especially the operant conditioning explain partially the specific phobias.

5.2.4.2 The Model Learning

The learning of behavior is the consequence not only of conditioning but also of watching the behavior [10]. A person in a specific context serves as a model for another person to learn a specific behavior. In other words, when the mother suffers from a specific phobia, there is an increased possibility that her child could adopt the same behavior through the model learning process.

5.2.4.3 The Cognitive Model

The main principles of the cognitive model are represented by the cognitive therapy of Beck and the rational-emotive therapy of Ellis. The beliefs of the individuals present a main element between the situations and the consequences (emotional, cognitive, and behavioral) and determine the reactions of the person towards the situation. Cognitive schema determines the way a person processes information. Persons with anxiety and specific phobia act with vulnerability [11, 12].

In other words, various etiological models explain the specific phobias. Behavioral and cognitive factors play an important role and contribute to the persistence of the disorder. Operant conditioning can partially explain the etiology of specific phobias. The model learning and the cognitive model display evidence-based etiological models of specific phobias.

5.3 Case Formulation

The model of Kirk and Roof explains the development, the expression, and the maintenance of specific phobia. A development factor, such as a learning experience or memory from the past, leads to beliefs with high vulnerability. When the person is confronted with a trigger, such as an object or a situation, that causes phobia, cognitions of anxiety are expressed, which overestimate the threat and the consequences and underestimate the coping potential for the person. This leads to anxious mood, to anxiety cognition, and to safe behaviors to avoid triggers. Additionally, it leads to physiological symptoms, to anxiety cognitions about physiological symptoms (fear of fear), and to safety behaviors to avoid triggers that increase fear of fear. All the above procedures lead to secondary negative cognition, which are related to depression, hopelessness, and low self-esteem [13].

The main questions about the case formulation of specific phobia are the following: Which vulnerable and traumatic experience from the past activates the vulnerability in the present? Which trigger in the present activates the hypervigilance vulnerability of the individual with a specific phobia? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What is the role of safety behaviors? (Fig. 5.1).

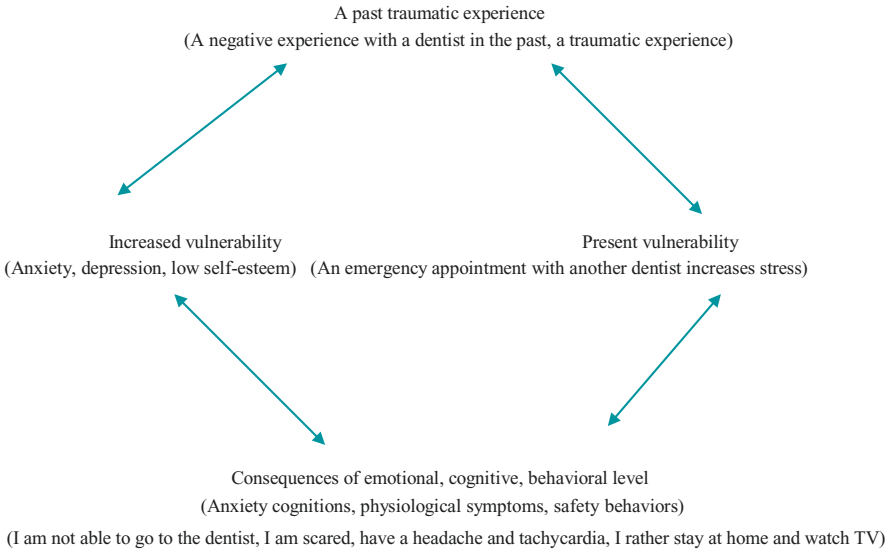

Fig. 5.1 The vicious circle of a specific phobia

It is very crucial to focus on the past as well as on the present, in order to understand the origins of the development process of the specific phobia. A life event or a traumatic experience in the past plays an important role in the present. The safety behaviors present an arduous issue, which contributes to the chronic process of specific phobia. These are avoidance behaviors, which give relief from anxiety in the short term but maintain the specific phobia in the long term.

5.4 Interventions

Animals, heights, blood, and doctors, such as the dentist, are some examples of specific phobia. CBT displays effective as well as efficacious intervention in all the types of specific phobia. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be implemented in the therapy of this disorder.

A psychiatric evaluation and potential treatment should be taken into consideration. The cooperation between clinical psychologists and CBT psychotherapists and psychiatrists is always in favor of individuals with mental health disorders.

CBT presents an efficacious treatment for specific phobia [14–21]. Virtual reality exposure and in vivo exposure were both equally efficacious for specific phobia [14, 15, 22].

The therapeutic relationship and alliance presents the switch to implement behavioral and cognitive interventions through the therapy of specific disorder.

A psycho-education [23] of this disorder, which means a presentation of the symptoms of the disorder and its consequences along with the case formulation and therapy options, contributes to a better understanding towards the disorder and towards the main principles of the intervention. The high distress caused by a phobic object or situation and safety behaviors as a consequence of the anxiety should be clearly displayed.

Regarding behavioral interventions, exposure therapy [14, 24] presents the treatment of choice of all the categories of specific phobia. Exposure to the imagination or in sensu or virtual or in virtuo through the computer and in real life or in vivo helps the person to confront, in a long term and repetitively, the phobic object or situation decreasing anxiety and safety behaviors.

Additionally, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [25] and autogenic training [26], could be offered, especially to resistant specific phobias. A high amount of stress due to this disorder could lead to mood disorders, such as depression. Behavior activation through activities which improves mood contributes to a good balance between positive and negative activities in the daily routine.

Cognitive interventions, according to Beck, lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema, which are related to specific phobias. The vulnerability schema can be decreased, which has a positive impact on behavior, such as the interruption of safe behaviors. Cognitive interventions also restructure the beliefs and schemata of possible comorbid disorders.

It is also very crucial for persons with specific phobias to confront in the context of CBT the traumatic situation in the past, which contributed to the development of specific phobia. An exposure to this situation in combination with cognitive interventions of reattribution of thoughts and beliefs regarding this traumatic situation could be an important relief and could have a great impact on specific phobia in the present. In other words, CBT focuses on the present as well as on the past. The duration of CBT for specific phobia is up to 20 sessions, but it depends on the comorbid disorders as well as on the resistance of the phobia.

If a person suffers long term from a specific phobia which causes problems, then it is useful to evaluate whether this person suffers from a grief as a cause of specific phobia. A grief process [27–29] means that negative thoughts and emotions about what a person has lost after many years of coexistence with a specific phobia should be expressed. The famous five stages of the grief process (denial, anger, bargaining, depression, and acceptance) of Kübler-Ross [27] should be preceded.

Yalom [29] proposes the empowerment of interpersonal relationships and a new relationship with oneself. It isn't worth focusing only on what was wrong with life. It is better to accept that and go on. Health-life and loss are two parts of our lives. This leads to relief and to a new beginning in life focusing on what a person can do better in the future and how the quality of life can be improved.

Relapse prevention is a part of CBT and presents strategy which decreases the possibility of a relapse. Relapse prevention means that the person should take

measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, as they have been taught in CBT, in order to deal with possible dysfunctions, such as safe behaviors. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could empower the recovery process.

Comorbidity with a personality disorder, which may explain the existence of a specific phobia, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Acceptance and commitment therapy [30] and mindfulness-based interventions, such as mindfulness-based cognitive therapy [31, 32], could be combined with CBT for specific phobias. People learn to accept their vulnerability and prepare themselves for small steps towards decreasing their vulnerability.

The mentioned third-wave therapies could be especially effective by resistant specific phobias and regarding the comorbid disorders, such as other anxiety disorders and depression. Studies regarding the efficacy of acceptance and commitment therapy and mindfulness-based interventions in specific phobia are needed.

MC Therapy could be a potential intervention for a specific phobia [33]. Studies regarding the efficacy of MC Therapy on this disorder are needed.

Anxiety process based on cognitive behavioral therapy displays a promising treatment. It focuses on processes of change and not on symptoms [34, 35]. Studies regarding the efficacy of this treatment option for specific phobia are needed.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for specific phobia. Relapse prevention is a part of CBT, in which people with specific phobias should be trained. ACT and mindfulness-based therapies could be effective, especially for comorbid disorders of this disorder. MC Therapy and anxiety process based on CBT need further evidence for the efficacy of specific phobias.

5.5 Discussion

Anxiety presents the first reaction against an arduous moment or crisis in life. It should be taken into consideration, in order to seek psychotherapy. Anxiety is like a bell for a further dysfunction in mental health.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of specific phobia. This disorder arises early in life, but can arise at any age and could be the first sign of a further psychopathology.

Comorbid disorders, such as anxiety, depressive disorder, bipolar disorder, and substance-related disorder, are very common by specific phobia. The suicide risk is soaring. The earlier psychotherapy begins, the better, so that comorbid disorders don’t arise.

The model learning and the cognitive model present evidence-based etiological models for this disorder. The case formulation of specific phobia explains how the specific phobia is developed, how it is expressed in the present, and what the consequences of it are in a real life. This formulation serves as well as an explanation for the treatment options.

Psycho-education, CBT, ACT, and MBCT presents evidence-based psychotherapies for specific phobia. Psycho-education is an analytical way of describing a mental health problem. Studies regarding the efficacy of MC Therapy and anxiety process based on specific phobia CBT are needed.

The plurality of behavioral and cognitive interventions in specific phobia about CBT enhances the flexibility in psychotherapy and activates resources to cope with the phobic object and situation. Relapse prevention serves as a protection for mental health.

The above procedure proves the democratic nature of CBT in specific phobias. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship (therapeutic alliance and consulting skills, collaborative empiricism, case formulation, and guided discovery through Socratic questions) is the appropriate context in which all the above interventions can be implemented [36, 37].

Cohesion and expectation play a crucial role in the therapeutic relationship in anxiety disorders. Collaboration, empathy, and alliance play an emerging role in the therapeutic relationship in anxiety disorders [38].

People with specific phobias need safety, transparency, and specific therapeutic goals, in order to cope with the phobic stimuli and avoidance.

Recovery presents the end goal of the therapy. Recovery as an outcome of the psychotherapy of a specific phobia is the point of view of the mental health experts as a consequence of psychotherapy and its evaluation through psychometric tests. Recovery as a process is the subjective point of view of the individuals in psychotherapy for specific phobia.

This point of view should be taken into consideration during therapy. Recovery from a specific phobia means that the person is confronted with a phobic situation or objects without implementing safety behaviors and has no high percentage of comorbidity, which should be mirrored as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapeutic process of specific phobia. For example, the person is confronted with phobic stimuli, but there are still anxiety and depressive mood, which need more time to deal with. The person is functional in the daily routine, but needs more psychotherapy. Both points of view are important.

Combinations of the interventions, as described above, serve as a recovery model for special phobias. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 5.2).

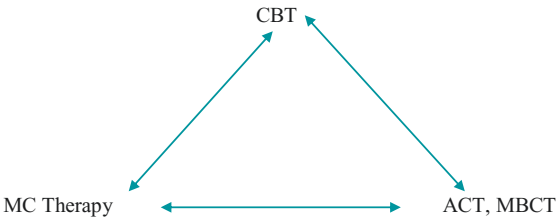

Fig. 5.2 The psychotherapy of specific phobia

5.6 Conclusions

Specific phobia displays an anxiety disorder, which arises early in life, but can arise at any age. It is an early sign of an upcoming psychopathology and is associated with comorbid disorders. Evidence-based treatments in the context of CBT are available for specific phobias and should be combined with each other in the future.

5.7 Revision Questions

1. How do you define specific phobia?
2. Which comorbid disorders arise from specific phobias?
3. What is the case formulation of specific phobia?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of a specific phobia.
6. What should be done in the future of the psychotherapy of specific phobia?

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Social Phobia

6

6.1 Introduction

Social phobia presents a type of anxiety, in which people show fear when they are confronted with social interactions or when they should perform or act in front of many people. They feel ashamed, vulnerable, and weak to cope with those interactions.

Clinical characteristics of the disorder as well as the evidence-based interventions will be discussed.

6.2 The Clinical Features of the Disorders

6.2.1 Diagnostic Procedure

Social anxiety disorder or social phobia is, according to DSM-5, an anxiety about a social situation with exposure to others. The person thinks that during the exposure, the person will be negatively evaluated. The situations cause fear and anxiety, and they are avoided. This situation lasts minimum 6 months. Social phobia is not the consequence of a medical condition or other mental disorder. A differential diagnosis of social phobia from normative shyness, agoraphobia, panic disorder, generalized anxiety disorder, separation anxiety disorder, specific phobias, selective mutism, major depressive disorder, body dysmorphic disorder, delusional disorder, autism spectrum disorder, and avoidant personality disorder, from other medical conditions, and from oppositional defiant disorder should be proceeded [1]. The Social Interaction Scale and the Social Phobia Scale are self-reporting psychometric tests of social phobia [2, 3].

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6.2.2 Epidemiology

The prevalence of social anxiety in the USA is 7% and in Europe 2.3%. Females show higher rates of social anxiety in comparison to males. Seventy-five percent develop the disorder between 8 and 15 years old [1]. The current prevalence is between 5% and 10%, and the lifetime prevalence is between 8.4% and 15% [4].

6.2.3 Comorbidity

Comorbid disorders of social anxiety disorder are other anxiety disorders, such as specific phobia with ranges between 14.1% and 60.8%, panic disorder, agoraphobia and generalized anxiety disorder, major depressive disorder, atypical depression, bipolar disorder, and substance use disorders [1, 4].

6.2.4 Etiological Psychological Models

6.2.4.1 Behavioral Models

The conditioning models and especially the operant conditioning explain partially the social phobia [5].

6.2.4.2 The Model Learning

The learning of behavior is the consequence of adopting the behavior from a model, for example, the child from a parent [6].

6.2.4.3 The Cognitive Models

Cognitive schema determines the way a person processes information. Persons with anxiety and social phobia act with vulnerability. This means that they are confronted with uncontrollable internal and external dangers. This leads to low self-esteem and to a permanent focus on weakness. By social phobia, individuals perceive a permanent danger in potential social interactions [7].

The cognitive model of social phobia of Wells [8] explains the cognitive processing of social phobia, as described by Beck [7]. A social situation activates the vulnerability schema, which activates further negative thoughts focusing on social danger. This process means that the person perceives itself as a social object, which increases safety behaviors and activates somatic and cognitive symptoms. All this procedure empowers the perception of the person as a social object [8].

The model learning and the cognitive models present evidence-based etiological models for social phobia.

6.3 Case Formulation

The cognitive model of Wells [8] serves as a good case formulation of the therapy procedure in CBT. The following questions should be taken into consideration: Which vulnerable and traumatic experience from the past activates vulnerability in

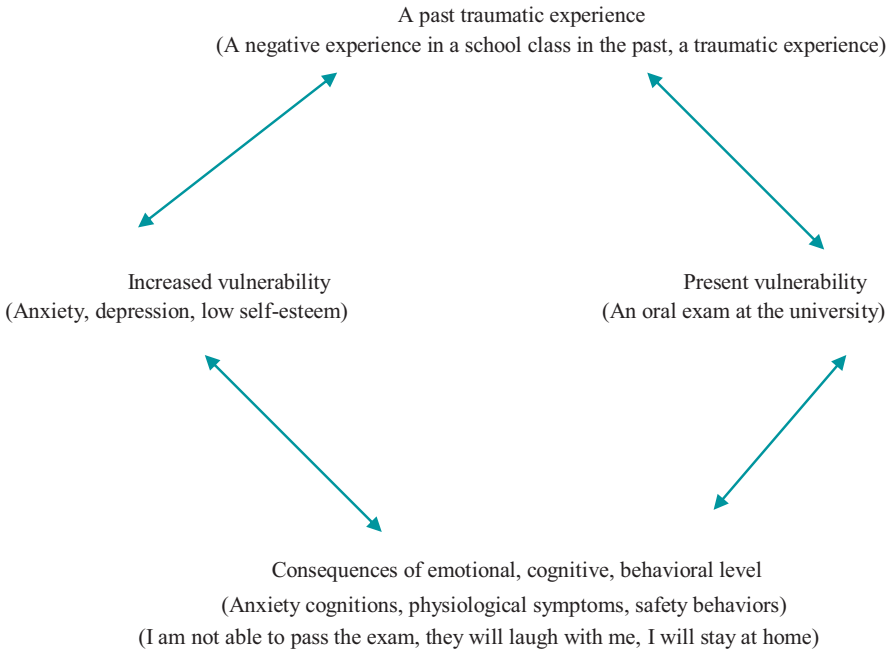

Fig. 6.1 The vicious circle of social phobia

the present? Which trigger in the present activates the vulnerability of the individual with social phobia? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What is the role of safety behaviors? (Fig. 6.1).

6.4 Interventions

CBT displays an effective as well as an efficacious intervention in social phobia. It is crucial to understand, according to the case formulation, the process of this disorder. Focusing negatively on social self activates negative beliefs regarding a big catastrophe in potential social interactions. Behavioral and cognitive interventions should be implemented in the therapy of social phobia. People learn to focus on assertiveness and action, which leads to a positive evaluation of social self.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions through the therapy of social phobia.

CBT presents an efficacious treatment for social phobia [9–13].

A psycho-education [14] of social phobia contributes to the improvement in understanding the disorder and its therapy. The high distress caused by social interaction and safe behaviors should be clearly presented.

Regarding behavioral interventions, exposure therapy [9, 10] displays an evidence-based intervention in social phobia. Exposure to the imagination or in

sensu or virtual or in virtuo through the computer and exposure in real life or in vivo decrease the anxiety towards social interactions.

Additionally, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [15] and autogenic training [16], could be offered, especially with resistant social phobia. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Assertiveness training presents a behavior intervention in which social competence and social skills can be learned through role-playing [17]. This training decreases the vulnerability in social interaction and enhances self-esteem.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema, which are related to social phobia. The social vulnerability schema can be decreased, which has a positive impact on behavior, such as the interruption of safe behaviors. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

It is also crucial for persons with social phobia to confront in the context of CBT the traumatic situation in the past, which contributed to the development of social phobia. An exposure to this situation in combination with cognitive interventions in reattribution of thoughts and beliefs could have a great impact on social phobia about the present. In other words, CBT focuses on the present as well as on the past. The duration of CBT for social phobia is up to 20 sessions, but it depends on the comorbid disorders and the resistance of the social phobia.

If a person suffers long term from social phobia, it will be useful to evaluate whether this person suffers from grief as a cause of social phobia. A grief process means that negative thoughts and emotions about what a person has lost after many years of coexistence with social phobia should be expressed.

Yalom [18] proposes the empowerment of interpersonal relationships. It isn't worth focusing only on what was wrong with life. It is better to accept that and go on.

Relapse prevention is a part of CBT and presents a strategy which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, as they have been taught in CBT, in order to deal with possible dysfunctions, such as safety behaviors. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder, which may explain the existence of social phobia, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

ACT [11, 19, 20] and mindfulness-based interventions [20], such MBCT, could be combined with CBT for social phobias. People learn to accept their vulnerability and prepare themselves for small steps towards decreasing their vulnerability. The mentioned third-wave therapies could be especially effective by resistant social phobias and regarding the comorbid disorders of social phobia, such as other anxiety disorders and depression. Further studies regarding the efficacy of ACT and mindfulness-based interventions in social phobia are needed.

MC Therapy [21] could be a potential intervention for a social phobia. Studies regarding the efficacy of this therapy for this disorder are needed.

Anxiety process based on cognitive behavioral therapy presents a promising treatment. It focuses on processes of change and not on symptoms [22]. Studies regarding the efficacy of this treatment option on social phobia are needed.

In conclusion, CBT with behavioral and cognitive interventions displays an efficacious treatment for social phobia. Relapse prevention is a part of CBT, in which people with social phobia should be trained. ACT and mindfulness-based therapies could be effective, especially for comorbid disorders of social phobia. MC Therapy and anxiety process based on CBT need further evidence for the efficacy in social phobia.

6.5 Discussion

Social phobia arises early in life and decreases the possibility to enhance social interactions and social competence. Social life presents an important part of our lives, which makes people happier and gives us the opportunity to further empowerment and development in life.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of social phobia. Comorbid disorders, such as specific phobia, panic disorder, agoraphobia and generalized anxiety disorder, major depressive disorder, atypical depression, bipolar disorder, and substance use disorders, should be treated properly.

The model learning and the cognitive model display evidence-based etiological models for this disorder. The case formulation of social phobia explains how the social phobia is developed, how it is expressed in the present, and what the consequences of it are in real life. This formulation serves as well as an explanation for the treatment options.

Psycho-education, CBT, ACT, and MBCT display evidence-based psychotherapies for social phobia. Studies regarding the efficacy of MC Therapy and anxiety process based on CBT in social phobia are needed.

The plurality of behavioral and cognitive interventions in social phobia of CBT gives more treatment options. Relapse prevention serves as a protection for mental health.

The above procedure proves the democratic nature of CBT in social phobia. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship (therapeutic alliance and consulting skills, collaborative empiricism, case formulation, and guided discovery through Socratic questions) is the appropriate context in which all the above interventions can be implemented.

People with social phobia need safety, transparency, and specific therapeutic goals, in order to cope with the phobic situation and the avoidance.

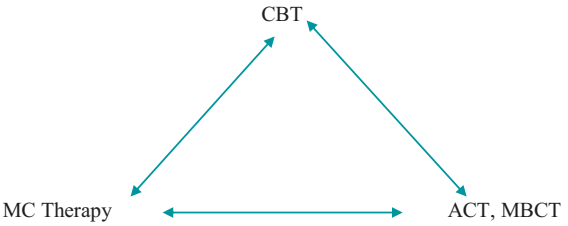

Fig. 6.2 The psychotherapy of social phobia

Recovery from social phobia means that the person is confronted with a phobic social situation without implementing safety behaviors, and there is no high percentage of comorbidity, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process displays the subjective evaluation of psychotherapy in social phobia. For example, the person is confronted with a phobic social situation, but there are still some safety behaviors there, which need more time to deal with. The person is functional in the daily routine, but needs more psychotherapy. Both points of view are important.

A combination of the interventions, as described above, serves as a recovery model for social phobia. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 6.2).

6.6 Conclusions

Social phobia presents an anxiety disorder, which arises early in life. Evidence-based treatments in the context of CBT are available for social phobia and should be combined with each other in the future.

6.7 Revision Questions

1. How do you define social phobia?
2. Which comorbid disorders arise from social phobia?
3. What is the case formulation of social phobia?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of social phobia.
6. What should be done in the future of the psychotherapy of social phobia?

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Panic Disorder

7

7.1 Introduction

Panic is a very common reaction of all the people in this world. Adrenaline increases and somatic symptoms arise. Persons feel that they are going to lose control or to die and that their vulnerability increases. They are not able to cope with the situation.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

7.2 The Clinical Features of the Disorders

7.2.1 Diagnostic Procedure

According to DSM-5, panic disorder is characterized as repeated and unexpected panic attacks with the following symptoms: palpitations, sweating, trembling, shortness of breath, feelings of choking, chest pain, nausea, feeling dizzy, heat sensations, paresthesia, derealization, fear of losing control, and fear of dying. Four or more of them should arise. The person is confronted for 1 month or more with anxiety about new panic attacks and avoids situations which can lead to an attack. That means that a person is not functional. Panic disorder is not the consequence of a medical condition or other mental disorder. A differential diagnosis should be made from other specified or unspecified anxiety disorder, from anxiety disorder due to a medical condition, from substance-induced anxiety disorder, and from other mental disorders with panic attacks [1]. The Panic Disorder Severity Scale can also be administered [2].

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7.2.2 Epidemiology

The 12-month prevalence is about 2–3% in adults and adolescents. Lifetime panic disorder was 8.5% [3]. Lifetime prevalence for panic attacks was 13.2% and for panic disorder 12.8% [4]. The age of onset of the disorder is 20–24 years old, and it is rare in childhood and after 45 years old [1, 3].

7.2.3 Comorbidity

Panic disorder shows comorbidity with other disorders, such as other anxiety disorders, usually agoraphobia, major depression, bipolar disorder, and alcohol use disorder. A suicide risk is high [1, 3]. There are also comorbidities with other organic disorders, such as dizziness, cardiac arrhythmia hyperthyroidism, asthma, and irritable bowel syndrome [1].

7.2.4 Etiological Psychological Models

Clark proposed the following cognitive model. External or internal stimuli are interpreted as a perceived threat. This leads to anxiety, which provokes physical and cognitive symptoms, which are evaluated as something dangerous. This evaluation leads to avoidance and safety behaviors, in order to avoid panic attacks. The person is in a vicious circle. Avoidance and safety behaviors prevent a panic attack [5, 6].

The psychophysiological model of Ehlers and Margraf describes a psychophysiological vicious circle. Internal or external stress stimuli lead to organic and cognitive symptoms, which are interpreted as dangerous. This leads to a panic attack, which produces more symptoms, increasing anxiety and general vulnerability. This repeated building up process leads to a vicious circle [7].

Both models are evidence-based psychological and etiological models.

7.3 Case Formulation

The above cognitive models [5–7] can be used as a good case formulation of the therapy procedure in CBT. The following questions should be taken into consideration: Which are the internal or external stimuli that increase the vulnerability now? Is there any vulnerable and traumatic experience from the past which activates vulnerability in the present? What are the consequences of this activation at emotional, physiological, cognitive, and behavioral levels? What is the role of safety behaviors? (Fig. 7.1).

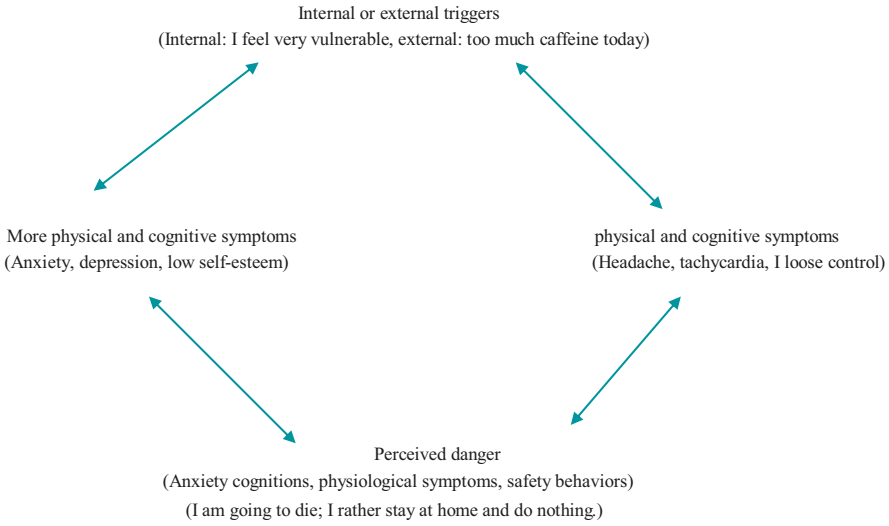

Fig. 7.1 The vicious circle of panic disorder

7.4 Interventions

CBT presents an effective as well as an efficacious intervention in panic disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be implemented in the therapy of panic disorder.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions in the therapy of panic disorder.

CBT displays an efficacious treatment for panic disorder [8–12].

A psycho-education [13] in panic disorder contributes to the improvement in understanding the disorder and its therapy.

Regarding behavioral interventions, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [14] and autogenic training [15], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and the vulnerability schema, which are related to panic disorder. The vulnerability schema can be decreased, which has a positive impact on behavior, such as the restructuring of the

vulnerability schema and the interruption of safety behaviors. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

It is also crucial for persons with panic disorder to confront in the context of CBT a possible traumatic situation in the past which contributed to the development of the disorder. An exposure to this situation in combination with cognitive interventions of reattribution of thoughts and beliefs is recommended. In other words, CBT focuses on the present as well as on the past. The duration of CBT for panic disorder is up to 20 sessions, but it depends on the comorbidity disorders and the resistance of the panic disorder.

If a person suffers long term from a panic disorder, it will be useful to evaluate whether this person suffers from grief. A grief process means that negative thoughts and emotions about what a person has lost after many years of coexistence with a panic disorder should be expressed.

Relapse prevention is a part of CBT and displays strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, as they have been taught in CBT, in order to deal with possible dysfunctions, such as safety behaviors. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder, which may explain the existence of panic disorder, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

ACT [16] and mindfulness-based interventions [17], such as MBCT [18], could be combined with CBT for panic disorder and especially in major depression as comorbid disorder. People learn to accept their vulnerability and prepare themselves for small steps towards decreasing their vulnerability. Further studies regarding the efficacy of ACT and mindfulness-based interventions in panic disorder are needed.

MC Therapy could be a potential intervention for panic disorder, especially caused by comorbid disorder major depression [19, 20]. Further studies regarding the efficacy of MC Therapy for panic disorder are needed.

Anxiety process based on cognitive behavioral therapy presents a promising treatment. It focuses on processes of change and not on symptoms [21]. Studies regarding the efficacy of this treatment option for panic disorder are needed.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for panic disorder. Relapse prevention is a part of CBT, in which people with panic disorder should be trained. ACT, mindfulness-based therapies, and MC Therapy could be effective in panic disorder as well as in comorbid

disorders of panic disorder. The anxiety process based on CBT needs further evidence for the efficacy of panic disorder.

7.5 Discussion

A panic attack and further panic disorder arise suddenly in life and lead to loss of control. The person thinks that life has changed rapidly from the new expression of vulnerability via somatic and cognitive symptoms.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of panic disorder. Comorbid disorders, such as agoraphobia, major depression, bipolar disorder, and alcohol use disorder, should be treated properly. Comorbid organic disorders, such as dizziness, cardiac arrhythmia hyperthyroidism, asthma, and irritable bowel syndrome, need the cooperation of other health experts.

The cognitive models present evidence-based etiological models for this disorder. The case formulation of panic disorder explains how panic is expressed in the present and what the consequences of it are in real life. This formulation serves as well as an explanation for the treatment options.

Psycho-education, CBT, ACT, MBCT, and MC Therapy display evidence-based psychotherapies for panic disorder. Studies regarding the efficacy of the anxiety process based on CBT in panic disorder are needed.

The plurality of behavioral and cognitive interventions in panic disorder in CBT gives more treatment options. Relapse prevention serves as a protection for mental health.

The above procedure proves the democratic nature of CBT in panic disorder. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship is the appropriate context in which all the above interventions can be implemented. People with panic disorder need safety, transparency, and specific therapeutic goals, in order to cope with the panic and safety behaviors.

Recovery from panic disorder means that the person is confronted with somatic and cognitive symptoms of the panic without implementing safety behaviors and no high percentage of comorbidity, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of psychotherapy for panic disorder. For example, the person is confronted with the symptoms of panic, but there are still some safety behaviors there, which need more time to deal with. The person is functional in the daily routine, but needs more psychotherapy. Both points of view are important.

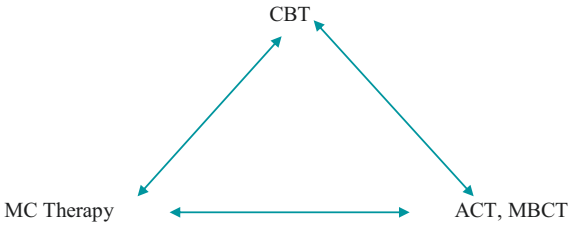

Fig. 7.2 The psychotherapy of panic disorder

A combination of the interventions, as described above, serves as a recovery model for panic disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 7.2).

7.6 Conclusions

Panic disorder displays an anxiety disorder, which arises suddenly in life. Evidence-based treatments in the context of CBT are available for panic disorder and should be combined with each other in the future.

7.7 Revision Questions

1. How do you define panic disorder?
2. Which comorbid disorders arise out of panic disorder?
3. What is the case formulation of panic disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of panic disorder.
6. What should be done in the future of the psychotherapy of panic disorder?

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Agoraphobia

8

8.1 Introduction

Agoraphobia is the fear of being with many people together. The person prefers isolation. Many people live with this disorder many years before they decide to seek psychotherapeutic help.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

8.2 The Clinical Features of the Disorders

8.2.1 Diagnostic Procedure

According to DSM-5, agoraphobia is characterized as the following: anxiety of two or more of five specific situations (public transportation, open spaces, enclosed places, standing in line or being with a lot of people, being outside the house alone). The person avoids situations because of the fear of not being able to escape from them and developing anxiety symptoms, such as panic symptoms. The situations lead to intensive fear, are avoided, or are tolerated with high anxiety or with the presence of other people. The anxiety is exaggerated in comparison to the actual danger, and all the situation lasts minimum 6 months. Agoraphobia is not the consequence of a medical condition or other mental disorder. Agoraphobia with or without panic disorder should be classified. A differential diagnosis of agoraphobia from specific phobia (situational type), separation anxiety disorder, social phobia, panic disorder, major depressive disorder, and other medical conditions should be proceeded [1]. The following psychometric scales are available for evaluating agoraphobia: Agoraphobic Cognitions Questionnaire, Agoraphobic Cognitions Scale, Agoraphobic Self-Statements Questionnaire, Mobility Inventory for Agoraphobia, and Panic and Agoraphobia Scale [2].

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8.2.2 Epidemiology

Every year, 1.7% of adolescents and adults are confronted with agoraphobia, more often females than males. The prevalence for people older than 65 years old is 0.4% [1]. Lifetime prevalence is 0.8% for panic attack of agoraphobia and 1.1% for panic disorder with agoraphobia [3].

8.2.3 Comorbidity

Comorbid disorders in agoraphobia are other anxiety disorders, such as panic disorders, social and specific phobia, and depressive disorders, such as major depressive disorders, post-traumatic stress disorder, and alcohol use disorder. Anxiety disorders arise before agoraphobia, and other disorders, such as depression and alcohol use disorders, arise later as a consequence of agoraphobia [1, 4].

8.2.4 Etiological Psychological Models

8.2.4.1 Family

Maternal overprotection and the loss of a parent can contribute to the development of agoraphobia [5].

8.2.4.2 Behavioral Models

According to the two-stage theory of Mowrer, the first stage presents a mating of a neutral conditional stimulus and a stressful unconditional stimulus to a conditioned fear of the conditional stimulus. In the second stage, the individual learns that fear of the conditional stimulus can be decreased from the parrying of it [6]. This theory partially explains the agoraphobia in individuals.

8.2.4.3 The Cognitive Model

Cognitive schema determines the way a person processes information. Persons with anxiety and agoraphobia act with vulnerability [7]. Clark's cognitive model explains how a person with agoraphobia reacts cognitively, especially when agoraphobia coexists with a panic attack. External or internal stimuli (places with many people) are interpreted as a perceived threat. This leads to anxiety, avoidance, and safety behaviors. The person is in a vicious circle [8]. The above theories are evidence-based.

8.3 Case Formulation

The above cognitive models serve as a good case formulation of agoraphobia.

The main questions about the case formulation of agoraphobia are the following: Is there any vulnerable and traumatic experience from the past which activates

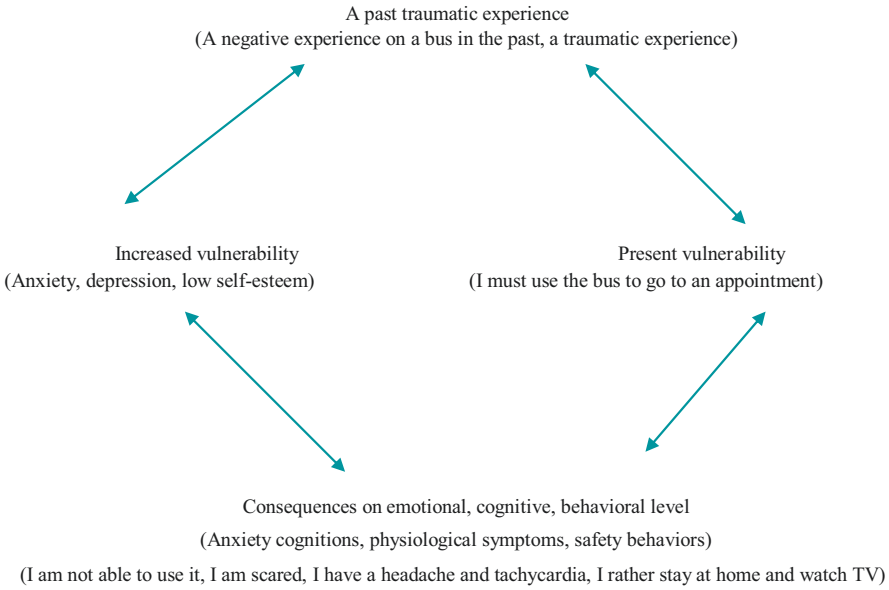

Fig. 8.1 The vicious circle of agoraphobia

vulnerability in the present? Which trigger in the present activates the hypervigilance vulnerability of the individual with agoraphobia? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What is the role of safety behaviors? (Fig. 8.1).

It is crucial to focus on the past as well as on the present, in order to understand the origins of the development process of agoraphobia. The safety behaviors present an arduous issue, which contribute to the chronic process of agoraphobia.

8.4 Interventions

CBT displays effective as well as efficacious intervention in agoraphobia. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be implemented in the therapy of agoraphobia.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions in the therapy of agoraphobia.

CBT displays an efficacious treatment for agoraphobia [9–13].

A psycho-education [14] of agoraphobia contributes to the improvement of understanding the disorder and its therapy.

Regarding behavioral interventions, exposure therapy [9] presents an evidence-based intervention in agoraphobia.

Additionally, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [15] and autogenic training [16], could be offered, especially for resistant agoraphobia. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema which are related to agoraphobia. The vulnerability schema can be decreased, which has a positive impact on behavior, such as the interruption of safety behaviors. Cognitive interventions also restructure the beliefs and schemata of possible comorbid disorders.

It is crucial for persons with agoraphobia to confront in the context of CBT the traumatic situation in the past which contributed to the development of agoraphobia. An exposure to this situation in combination with cognitive interventions in reattribution of thoughts and beliefs could have a great impact on agoraphobia in the present. In other words, CBT focuses on the present as well as on the past. The duration of CBT for agoraphobia is up to 20 sessions, but it depends on the comorbid disorders and the resistance of agoraphobia.

If a person suffers long term from agoraphobia, it will be useful to evaluate whether this person suffers from grief as a cause of agoraphobia and to integrate that into the therapy process.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, as they have been taught in CBT, in order to deal with possible dysfunctions, such as safety behaviors. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder, which may explain the existence of agoraphobia, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

ACT [17] and MBCT [18] could be combined with CBT for agoraphobia. The mentioned third-wave therapies could be especially effective for resistant agoraphobia and regarding the comorbid disorders of agoraphobia, such as depression. Further studies regarding the efficacy of ACT and MBCT in agoraphobia are needed.

MC Therapy [19] could be a potential intervention for agoraphobia. Further studies regarding the efficacy of MC Therapy on this disorder are needed.

Anxiety process based on cognitive behavioral therapy presents a promising treatment. It focuses on processes of change and not on symptoms [20]. Studies regarding the efficacy of this treatment option on agoraphobia are needed.

In conclusion, CBT with behavioral and cognitive interventions displays an efficacious treatment for agoraphobia. Relapse prevention is a part of CBT, in which people with agoraphobia should be trained. ACT, MBCT, and MC Therapy are

effective therapies, especially for comorbid disorders of agoraphobia. Anxiety process based on CBT needs further evidence for the efficacy of agoraphobia.

8.5 Discussion

Agoraphobia arises early in life and enhances the isolation from other people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of agoraphobia. Comorbid disorders, such as panic disorders, social and specific phobia, major depressive disorders, post-traumatic stress disorder, and alcohol use disorder, should be treated appropriately.

The cognitive models present evidence-based etiological models for this disorder. The case formulation of agoraphobia explains how it was developed, how it is expressed in the present, and what the consequences of it are in real life. This formulation serves as well as an explanation for the treatment options.

Psycho-education, CBT, ACT, MBCT, and MC Therapy display evidence-based psychotherapies for agoraphobia.

The plurality of behavioral and cognitive interventions in agoraphobia in CBT gives more treatment options. Relapse prevention serves as a protection for mental health.

The above procedure proves the democratic nature of CBT in agoraphobia. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship is the appropriate context in which all the above interventions can be implemented.

Recovery from agoraphobia means that the person is confronted with phobic stimuli without implementing safety behaviors and no high percentage of comorbidity, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of psychotherapy in agoraphobia. For example, the person is confronted with a phobic situation, but there are still some safety behaviors there which need more time to deal with. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model of agoraphobia. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 8.2).

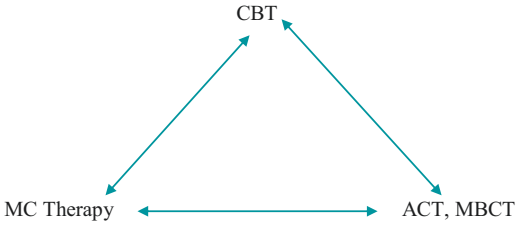

Fig. 8.2 The psychotherapy of agoraphobia

8.6 Conclusions

Agoraphobia presents an anxiety disorder, which arises early in life. Evidence-based treatments in the context of CBT are available for agoraphobia and should be combined with each other in the future.

8.7 Revision Questions

1. How do you define agoraphobia?
2. Which comorbid disorders arise out of agoraphobia?
3. What is the case formulation of agoraphobia?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of agoraphobia.
6. What should be done in the future of the psychotherapy of agoraphobia?

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Generalized Anxiety Disorder

9

9.1 Introduction

GAD presents an intense anxiety and worry, which has a negative impact on the quality of life of people who suffer from it.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

9.2 The Clinical Features of the Disorders

9.2.1 Diagnostic Procedure

According to DSM-5, GAD presents intensive anxiety, which exists for at least 6 months. The person cannot control this worry, which is expressed with at least three of the six following symptoms: restlessness, fatigue, concentration problems, irritability, tension of the muscles, and problems with sleep. This anxiety has a negative impact on functioning, and it is not explained through a medical condition or substance abuse or through another mental health disorder. A differential diagnosis of GAD should proceed with anxiety disorder due to a medical condition, substance medication-induced anxiety disorder, social phobia, and obsessive-compulsive disorder, from post-traumatic stress disorder, and from depressive, bipolar, and psychotic disorders [1]. The Generalized Anxiety Disorder-7 is used frequently as a psychometric test to evaluate this disorder [2].

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9.2.2 Epidemiology

The 12-month prevalence is 0.9% in adolescents and 2.9% in adults in the USA and 0.4–3.6% in other countries. GAD arises more often in females than in males, and the age at onset is 30 years old [1]. Anxiety disorders increased all over the world from 31.13 million in 1990 to 45.82 million in 2019 [3]. The lifetime prevalence for GAD is 6.2% [4].

9.2.3 Comorbidity

Comorbid disorders of GAD are mostly other anxiety disorders and unipolar depressive disorders [1, 5].

9.2.4 Etiological Psychological Models

9.2.4.1 Cognitive Models

Cognitive schema determines the way a person processes information. Persons with generalized anxiety disorder act with vulnerability [6].

9.2.4.2 The Metacognitive Model

The metacognitive model of GAD of Wells presents an evidence-based etiological model for this disorder. According to this model, a trigger or a situation activates firstly positive meta-beliefs, which lead to Type I worry. For example, if I worry about a situation, that means I will be able to cope with the problem. When the person deals with a difficult situation, then anxiety decreases. GAD arises when negative meta-beliefs or Type II worries are activated. Beliefs about the lack of control over worry and beliefs about the dangers of worrying about functioning are two categories of Type II worry. This negative interpretation leads to the belief that the person is not able to cope with the situation. Type II worries lead to negative emotions and behaviors, such as avoidance of situations, which activates GAD and to thought control. These elements contribute to the maintenance of GAD [7].

9.3 Case Formulation

The above cognitive models serve as a good case formulation of GAD.

The main questions on the case formulation of GAD are the following: Is there any vulnerable and traumatic experience from the past which activates the vulnerability in the present? Which trigger in the present activates the hypervigilance vulnerability of the individual with GAD? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What is the role of avoidance?

9.4 Interventions

CBT presents an effective as well as an efficacious intervention in GAD. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance displays the appropriate conditions to implement the behavioral and cognitive interventions through the therapy of GAD.

CBT presents an efficacious treatment for GAD [8–10].

A psycho-education [11] of GAD contributes to the improvement in understanding the disorder and its therapy.

Regarding behavioral interventions, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [12] and autogenic training [13], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema, which are related to GAD. Cognitive interventions can also restructure the beliefs and schema by possible comorbid disorders.

The duration of CBT for GAD is up to 20 sessions, but it depends on the comorbid disorders.

If a person suffers long term from GAD, it will be useful to evaluate whether this person suffers from grief as a cause of GAD and to integrate that into the therapy process.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder, which may explain the existence of GAD, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

ACT [14–16] and MBCT [16] could be combined with CBT for GAD. The mentioned third-wave therapies could be especially effective for resistant GAD and regarding the comorbid disorders of GAD, such as depression. Further studies regarding the efficacy of ACT and MBCT in GAD are needed.

MC Therapy [17] presents an efficacious intervention in GAD. Further studies regarding the efficacy of MC Therapy for this disorder are needed.

Anxiety process based on cognitive behavioral therapy displays a promising treatment. It focuses on processes of change and not on symptoms [18]. Studies regarding the efficacy of this treatment option on GAD are needed.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for GAD. Relapse prevention displays a part of CBT in which people with GAD should be trained. ACT, MBCT, and MC Therapy are effective therapies, especially for comorbid disorders of GAD. Anxiety process based on CBT needs further evidence for its efficacy in GAD.

9.5 Discussion

GAD presents an intensive anxiety disorder, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of GAD. Comorbid disorders, such as other anxiety disorders and major depressive disorder, should be treated appropriately.

The cognitive and the metacognitive models display evidence-based etiological models for this disorder, and they serve as a case formulation of GAD.

Psycho-education, CBT, ACT, MBCT, and MC Therapy present evidence-based psychotherapies for GAD.

Relapse prevention serves as a protection for mental health.

The above procedure proves the democratic nature of CBT in GAD. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship and alliance is the appropriate context in which all the above interventions can be implemented.

Recovery from GAD means that the person copes with the anxiety effectively, decreasing the whole vulnerability, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of psychotherapy in GAD. For example, the person copes with anxiety, but there is comorbidity with depression, which needs more time to deal with. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for GAD. Research studies regarding the efficacy of this combination should be proceeded in the future (Fig. 9.1).

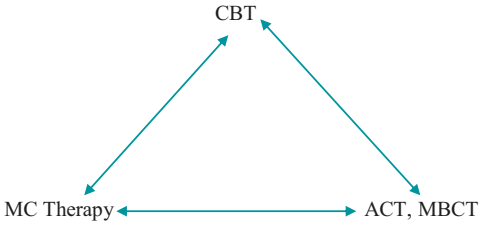

Fig. 9.1 The psychotherapy of GAD

9.6 Conclusions

GAD is an anxiety disorder, which presents an intensive burden on the person. Evidence-based treatments in the context of CBT are available for GAD and should be combined with each other in the future.

9.7 Revision Questions

1. How do you define GAD?
2. Which comorbid disorders arise out of GAD?
3. What is the case formulation of GAD?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of GAD.
6. What should be done in the future of the psychotherapy of GAD?

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Part III

Obsessive Compulsive and Related Disorders

Obsessive-Compulsive Disorder

10

10.1 Introduction

Obsessive-compulsive disorder presents an intensive and repetitive anxiety, which has a negative impact on the functioning and quality of life of people who suffer from it.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

10.2 The Clinical Features of the Disorders

10.2.1 Diagnostic Procedure

According to DSM-5, obsessive-compulsive disorder shows obsessions (persistent thoughts or images), compulsions or repetitive behaviors (washing, checking, etc.), or both of them. The person tries to reduce anxiety through these behaviors. They take a lot of time of the day, which has a negative impact on functioning, and they cannot be explained through a substance, a medical condition, or another mental health condition. A differential diagnosis should be made from anxiety disorders, major depressive disorder, other obsessive-compulsive-related disorders, and body dysmorphic disorder; from eating disorders; from tics; from psychotic disorders; from other compulsive-like behaviors, such as gambling; and from obsessive-compulsive personality disorder [1]. The Yale-Brown Obsessive-Compulsive Scale and other structured clinical interviews present reliable and valid psychometric scales for this disorder [2].

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10.2.2 Epidemiology

The 12-month prevalence internationally is 1.1–1.8%. Females show the disorder more often in adulthood than males. The mean age at onset is 19.5 years [1].

10.2.3 Comorbidity

Comorbid disorders of obsessive-compulsive disorder are other anxiety disorders, such as panic disorder, social phobia, generalized anxiety disorder and specific phobia, depressive or bipolar disorder, obsessive-compulsive personality disorder, tic disorder, and suicidality, especially caused by depression [1, 3].

10.2.4 Etiological Psychological Models

10.2.4.1 Behavioral Models

The two-stage model of Mowrer can explain how obsessive-compulsive behavior continues. In the first stage, an anxiety reaction will be through classical conditioning developed through connection of a neutral stimulus with a stressful traumatic situation. In the second stage, the anxiety will be confronted with operant conditioning, decreasing the anxiety via negative reinforcement. For example, washing reduces in a short term obsessive-compulsive anxiety [4].

10.2.4.2 Cognitive Models

The cognitive model of Salkovskis describes the following procedure. A situation or stimuli leads to obsessive-compulsive intrusions, which evoke automatic thoughts about the importance of the intrusion. This leads to affective vulnerability (anxiety, vigilance, depression), which is coped with neutralization of the intrusions. An intrusion is an indication that people might be responsible for harm to themselves or others. They have to take measures to avoid that. Neutralization is a process of suppressing intrusions into obsessive-compulsive, cognitions, and behaviors reducing perceived responsibility [5].

In other words, neutralizing beliefs relieves people in the short term, but maintains the problem on a cognitive level and at a behavioral level, like negative reinforcement of the model of Mowrer. The model of Salkovskis highlights the focus on the perception of danger in a negative situation and the perception of responsibility for the person towards others.

The network structure theory of Foa and Kozak describes the emotions as data structures in memory. A focus on emotion and information processing is, in other words, the main element of this model. Anxiety is described as a network structure of memory, which contains the following information: data about stimuli activating anxiety; data about verbal, physiological, and behavioral reactions; and, finally, information about the meaning of these stimuli and reactions [6]. This theory displays a good addition to the cognitive model through focusing on emotion processing.

The metacognitive model of obsessive-compulsive disorder shows how intrusions activate negative metacognitive beliefs and how they are evaluated as dangerous. These beliefs belong to the following categories: (1) thought event fusion, the belief that thoughts and feelings mean that something bad has happened; (2) thought action fusions, the belief that thoughts will lead to an uncontrollable action; and (3) thought object fusion, the belief that thoughts can be transferred to objects through contact [7].

The above cognitive models present evidence-based etiological models for obsessive-compulsive disorder.

10.3 Case Formulation

The cognitive models [5–7] serve as an interesting case formulation of obsessive-compulsive disorder, which clarify how the disorder arises, how it is maintained, and what consequences this has on cognitive, emotional, and behavioral levels. It is crucial to search for a traumatic experience in the past which probably contributed to the development of the disorder. It is usually a moment in which a person should take responsibility for something, although the individual is not ready for that due to, for example, a young age, or in which a person loses control in life.

10.4 Interventions

CBT presents an effective as well as an efficacious intervention in obsessive-compulsive disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance displays the appropriate conditions to implement the behavioral and cognitive interventions. A person with obsessive-compulsive disorder needs transparency and safety in the therapeutic process, so that the therapy can be evaluated as something that can be controlled. It is crucial to proceed step by step and to express negative thoughts and emotions regarding danger and responsibility.

CBT presents an efficacious treatment for obsessive-compulsive disorder [8–13].

A psycho-education [14] of the disorder contributes to the improvement in understanding the disorder and its therapy.

The main behavioral intervention in OCD is exposure and response prevention [15]. For example, a woman suffers from control obsessions and compulsions. It takes 2–3 h to leave the house, because she has to control and check whether every electrical appliance is switched on or off. She perceives a great danger and a high responsibility for her apartment. She thinks about controlling the kitchen, and then, through neutralizing, she controls the power button of the kitchen. Furthermore, she repeats this process seven times for every electrical appliance.

The exposure in vivo or in sensu with response prevention leads to confrontation with the situation, which activates obsessive thoughts and behaviors, in order to decrease anxiety. Additionally, the neutralizing (compulsive behavior) will not occur (response prevention). The person can distract the attention on neutralizing with other positive activities, which improve the mood and decrease the anxiety.

If only obsessive thoughts arise and not compulsive behaviors, then the exposure will be made to them by writing them down many times or recording and hearing the thoughts [15, 16]. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [17] and autogenic training [18], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema, which are related to obsessive-compulsive disorder. The possibility of danger and responsibility should be reduced. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

The duration of CBT for obsessive-compulsive disorder is up to 20 sessions, but it depends on the chronicity of the disorder and its comorbid disorders.

If a person suffers from long-term obsessive-compulsive disorder, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder and to integrate that into the therapy process.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder, which may explain the existence of obsessive-compulsive disorder, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

MCT and MC Therapy display evidence-based psychotherapies for obsessive-compulsive disorder [19–21].

ACT and MBCT [22] could be combined with CBT for this disorder. The mentioned third-wave therapies could be especially effective against resistant obsessive-compulsive disorder and regarding the comorbid disorders of it, such as depression.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for the obsessive-compulsive disorder. Relapse prevention is a part of CBT, in which people should be trained. ACT and MBCT as well as MCT and MBCT are effective interventions.

10.5 Discussion

Obsessive-compulsive disorder presents an intensive repetitive anxiety disorder, which has a negative impact on the quality of life of people.

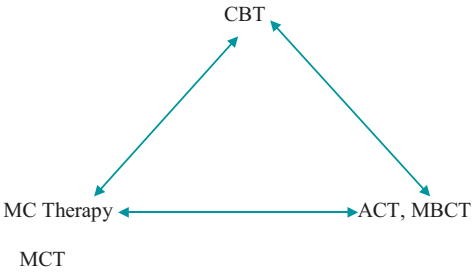

Fig. 10.1 The psychotherapy of obsessive-compulsive disorder

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as other anxiety disorders, depressive disorder, and bipolar disorder, should be treated appropriately.

The cognitive and the metacognitive models display evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, ACT, MBCT, MCT, and MC Therapy present evidence-based psychotherapies for obsessive-compulsive disorders. Further studies regarding the efficacy of MCT, MC Therapy, ACT, and MBCT are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in obsessive-compulsive disorder. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship and alliance is the appropriate context of transparency, safety, and healthy control over the changes in therapy. The possible danger and responsibility for situations can be restructured via a safety basis.

Recovery from obsessive-compulsive disorder means that the person copes with the obsessive thoughts and compulsive behaviors, effectively decreasing the whole vulnerability, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the majority of the obsessions and compulsions. There are two cases of obsessions and compulsions, which need more time to deal with. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 10.1).

10.6 Conclusions

Obsessive-compulsive disorder is a repetitive anxiety disorder which isolates people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

10.7 Revision Questions

1. How do you define obsessive-compulsive disorder?
2. Which comorbid disorders arise in this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of obsessive-compulsive disorder?

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Trichotillomania (Hair-Pulling Disorder) 11

11.1 Introduction

Trichotillomania presents an intensive repetitive pulling out of own hair, which has a negative impact on the functioning and quality of life of people who suffer from it.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

11.2 The Clinical Features of the Disorder

11.2.1 Diagnostic Procedure

According to DSM-5, trichotillomania is the repeated pulling out of one's hair, which leads to hair loss and to problems with functioning. The person tries to stop this phenomenon without success. The hair loss cannot be explained through other medical problems or other mental disorders. A differential diagnosis should be made from hair removal for cosmetic reasons and other obsessive-compulsive disorders, such as body dysmorphic disorder and neurodevelopmental disorders, and from psychotic disorders, other medical disorders, and substance-related disorders [1]. The National Institute of Mental Health Trichotillomania Symptom Severity Scale and the National Institute of Mental Health Trichotillomania Impairment Scale display psychometric measures, which can be used in clinical praxis [2].

11.3 Epidemiology

The 12-month prevalence in adults and adolescents is 1–2% [1]. The prevalence of trichotillomania was 1.7%, and the mean age of onset was 17.7 years old [3].

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11.3.1 Comorbidity

Comorbid disorders of trichotillomania are major depressive disorder, anxiety, obsessive-compulsive disorder, skin-picking disorder, post-traumatic stress disorder, and ADHD [1, 3].

11.3.2 Etiological Psychological Models

11.3.2.1 Behavioral Model

Classical and operant conditioning can explain partially trichotillomania. An anxiety reaction will be developed through connecting of a neutral stimulus with a stressful traumatic situation (classical conditioning). The anxiety will be decreased from trichotillomania via negative reinforcement (operant conditioning).

11.3.2.2 Cognitive Model

A cognitive model suggests that specific cognitions, such as perfectionism, overaction, and overpreparation, such as working all day and not relaxing at all, play an important role in the development of trichotillomania. The above beliefs lead people to an inability to cope with negative emotions, such as frustration or dissatisfaction, as a consequence of not realistic expectations. This cognitive and emotional vulnerability and distress lead to trichotillomania [4].

11.3.2.3 Emotion Regulation Model

Individuals with trichotillomania are vulnerable to emotional distress and dysregulation, and in order to cope with that, they develop this dysfunctional behavior, which contributes to the regulation of intensive emotions [5].

11.4 Case Formulation

The above models combined present a case formulation of trichotillomania. Dysfunctional cognitions and emotions contribute to dysfunctional behavior, such as trichotillomania. Unrealistic expectations, such as perfectionism and intensive negative emotions, which cannot be regulated, lead to trichotillomania. This dysfunctional cognitions and behaviors serves as negative reinforcement, because people are relieved from intensive emotions after that, but the problem continues.

The main questions about the case formulation are the following: Is there any vulnerable and traumatic experience from the past which activates vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

11.5 Interventions

CBT presents an effective as well as an efficacious intervention in trichotillomania. It is very crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance displays the appropriate conditions to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that intensive emotions can be coped. It is very crucial to proceed step by step and to express negative thoughts and emotions regarding perfectionism and overpreparation.

CBT presents an efficacious treatment for trichotillomania [2, 4, 6].

A psycho-education [7] of the disorder contributes to the improvement in understanding the disorder and its therapy.

The habit reversal therapy—a behavioral therapy—displays the treatment of choice of trichotillomania. The following elements are implemented: self-monitoring (pulling hair), awareness (bringing hair back), competing response training (a response that prevents hair pulling, e.g., relaxation), and encouraging social support. Additionally, stimulus control procedures (reducing triggers for pulling hair) could be implemented [6]. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [8] and autogenic training [9], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The cognitive beliefs about perfectionism and overpreparation [4] should be restructured. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

It is also very crucial for persons with trichotillomania to confront in the context of CBT with the traumatic situation in the past which contributed to the development of this disorder. An exposure to this situation in combination with cognitive interventions in reattribution of thoughts and beliefs could have a great impact on hair pulling in the present. In other words, CBT focuses on the present as well as on the past.

The duration of CBT for trichotillomania is up to 22 sessions, but it depends on the chronicity of the disorder and its comorbid disorders.

If a person suffers long term from this, it will be useful to evaluate whether this person suffers from a grief as a cause of the disorder and to integrate that in the therapy process.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Comorbidity with a personality disorder, which may explain the existence of trichotillomania, should be considered in psychotherapy, as is described in the last chapter about personality disorders.

MC Therapy in combination with habit reversal therapy displays evidence-based psychotherapies for trichotillomania [10].

ACT [11, 12] and DBT [12, 13] could be combined with CBT for this disorder. The above third-wave therapies could be especially effective for resistant trichotillomania and regarding emotional distress.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for trichotillomania. Relapse prevention is a part of CBT, in which people should be trained. ACT, DBT, and MC Therapy are effective therapies.

11.6 Discussion

Trichotillomania presents an intensive repetitive anxiety disorder, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as major depressive disorder, anxiety, obsessive-compulsive disorder, skin-picking disorder, posttraumatic stress disorder, and ADHD, should be taken into consideration.

The behavioral and cognitive models display evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, ACT, DBT, and MC Therapy present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of MC Therapy, ACT, and DBT are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in trichotillomania. People understand from the first session what is going on and how the therapy proceeds.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing perfectionism and emotional distress in life.

Recovery from trichotillomania means that the person copes effectively with hair pulling, perfectionism, and emotional distress, which leads to hair pulling decreasing the whole vulnerability, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with hair pulling and perfectionism in most cases. More time is needed, in order to cope with emotional distress. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model after this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 11.1).

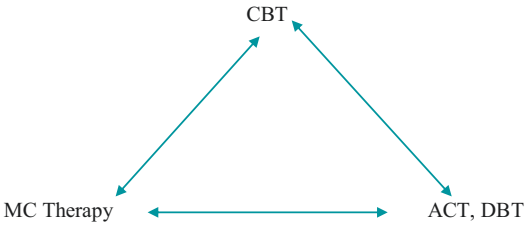

Fig. 11.1 The psychotherapy of trichotillomania

11.7 Conclusions

Trichotillomania is a repetitive disorder which isolates people and leads to hair loss. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

11.8 Revision Questions

1. How do you define trichotillomania?
2. Which comorbid disorders arise from this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of trichotillomania?

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Part IV

Trauma

Post-traumatic Stress Disorder and Acute Stress Disorder

12

12.1 Introduction

Post-traumatic stress disorder is divided into two categories: Trauma I and Trauma II. Trauma I presents situations in which people are confronted with trauma with short duration, which are characterized as acute danger to life, suddenness, and surprise. Trauma II presents situations in which individuals are confronted with repetitive trauma with a long duration, which begin in childhood [1]. An injury or a traumatic loss is an example of Trauma I, and repetitive and long-term abuse (physical, emotional, and sexual) is a good example of Trauma II. Trauma leaves its mark. The sooner psychotherapy starts, the better.

Post-traumatic stress disorder and acute stress disorder present mental health disorders as a consequence of a confrontation with trauma, which has a negative impact on functioning and quality of life of people in the short and in the long term.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

12.2 The Clinical Features of the Disorders

12.2.1 Diagnostic Procedure

According to DSM-5, individuals with post-traumatic stress disorder are exposed to death, injury, or violence and show intrusions related to trauma, such as memories, dreams, or psychological distress at exposure. They avoid stimuli related to trauma. They show negative cognitions and emotions, for example, persistent negative emotions, and feelings of detachment from others; they show changes in arousal related to trauma.

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The duration of the disorder is more than 1 month, it has a negative impact on functioning, and the disorder cannot be explained from a medical condition or a substance abuse.

A differential diagnosis should be made from adjustment disorders; from acute stress disorder, anxiety disorders and obsessive-compulsive disorders, major depressive disorder, and personality disorders; from dissociate disorders, conversion disorder, and psychotic disorders; and from traumatic brain injury [2].

According to DSM-5, individuals with acute stress disorder are exposed to death, injury, and abuse. They show 9 symptoms of specific categories, such as intrusions, arousal, negative mood, dissociate symptoms, and avoidance, which has a negative impact on functioning, the duration of the disorder is 3 days to 1 month, and it is not explained from substance abuse, a medical condition, or a brief psychotic disorder. A differential diagnosis should be made from adjustment disorders, panic disorder, dissociate disorders, post-traumatic stress disorder, obsessive-compulsive disorder, psychotic disorders, and traumatic brain injury [2].

Psychometric scales of post-traumatic stress disorder are the Clinician-Administered PTSD Scale of DSM-5 (CAPS-5) and the Treatment Outcome Post-traumatic Stress Disorder Scale (TOP-8) and for acute stress the Acute Stress Disorder Scale [3–5].

12.2.2 Epidemiology

The 12-month prevalence of post-traumatic stress disorder in adults in the USA is 3.5% and in other countries, 0.5–1%. Higher rates of PTSD are registered for groups of high risk of exposure to trauma, such as veterans, police, firefighters, and medical personnel. This disorder can arise at any age. Females are more often confronted with it [2]. 106,713 individuals were exposed to trauma as a result of COVID-19, and 28.34% reported post-traumatic stress disorder [6].

19.83% was the prevalence of symptoms of post-traumatic stress disorder in adult critical care survivors [7].

Acute stress disorder arises in less than 20% of people who are confronted with traumatic events which are not associated with interpersonal contact, such as accidents and brain injury. Acute stress disorder arises from 20% to 50% after trauma with interpersonal contact, such as abuse. Females are more often confronted with it [2].

12.2.3 Comorbidity

Post-traumatic stress disorder is related to suicidal ideation and attempts. Comorbid disorders are anxiety disorders, depression, bipolar disorder, substance use disorders, neurocognitive disorder, and physical illness [2, 8].

Comorbid disorders of acute stress disorder are panic attacks, impulsive behavior, and grief reactions [2].

12.2.4 Etiological Psychological Models

12.2.4.1 Behavioral Model

Trauma is stored in memory as a life experience. It destroys security beliefs and reinforces negative threat perceptions. The post-traumatic reaction is stored in memory as a fear structure representing a program for fight or escape. The following information is included: information about the trauma and about the people's reactions and the meaning of the threatening stimuli and reactions. Avoidance and safety behavior represents the negative reinforcement and prevents corrective experiences. Avoidance explains the maintenance of post-traumatic stress disorder [9].

This model presents an evidence-based etiological model and explains why the exposure technique is implemented by this disorder.

The above model was further developed. Pre-traumatic cognitive schema is taken into consideration and especially the conviction of one's own incompetence and the overgeneralization of danger. These beliefs contribute to the development of post-traumatic stress disorder [10].

12.2.4.2 Cognitive Model

Individuals with post-traumatic stress disorder report a persistent current threat even though the trauma has ended. This is the starting point of the model. This is influenced by three components: trauma memory, dysfunctional interpretations of trauma, and its consequences, dysfunctional safety, and avoidance behavior. The current threat leads to intrusions, symptoms, and strong reactions and to cognitive and behavioral strategies (safety behaviors) to deal with it. These strategies prevent changes in trauma memory and in interpretations of the trauma [11].

12.3 Case Formulation

The above behavioral and cognitive models serve as a case formulation model in the therapy process.

The main questions about the case formulation are the following: Is there any vulnerable and traumatic experience from the past which activates the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What are the safety behaviors?

12.4 Interventions

CBT presents an effective as well as an efficacious intervention in post-traumatic stress disorder and acute stress disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration, especially for Type II trauma, which leads to post-traumatic stress disorder.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that intensive emotions can be expressed.

It is crucial to proceed step by step and to express negative thoughts and emotions regarding one's own incompetence and the overgeneralization of danger. Individuals with acute stress and post-traumatic stress disorder feel insecure, anxious, and abandoned and have many problems to trusting others. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for interpersonal contact with more security, trust, and support in the long term.

CBT displays an efficacious treatment for acute stress and post-traumatic stress disorder [12–17].

A psycho-education [18] of the disorder contributes to the improvement of understanding the disorder and its therapy.

The exposure [19] in the trauma presents an evidence-based intervention in these disorders. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [20] and autogenic training [21], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

EMDR [19, 22–24] displays an evidence-based intervention and can be combined with exposure to trauma or can be implemented alone, especially by cases in which exposure is not possible.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The vulnerability schema and the cognitive beliefs about one's own incompetence and the overgeneralization of danger should be restructured. Cognitive interventions can also restructure the beliefs and schema of comorbid disorders.

The exposure to trauma displays a safe road going back to trauma memory, which decreases anxiety. The cognitive reattribution of beliefs related to trauma presents relief from many negative emotions, such as anxiety, depression, disgust, shame, and guilt. Especially with chronic post-traumatic stress disorder (e.g., after sexual abuse), it is very common that the victims avoid speaking about the trauma and seeking legal and psychotherapeutic help. They feel anxious, guilty, and shamed about what happened and develop most of the time a dependent relationship with the perpetrator. That means that psychotherapy should help the victims to decrease their dependent relationship to them and not to live in the same house or to have any contact with them. This way contributes to avoidance of revictimization of the victims. After that, CBT can begin with exposure to trauma.

Refugees from war zones present an excellent example of people with acute stress and post-traumatic stress disorder, who can benefit from CBT.

It is also crucial for persons with acute and post-traumatic stress disorder to confront in the context of CBT with all the traumatic situations in the past which contributed to the development of this disorder.

The duration of CBT for acute and post-traumatic stress disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbid disorders.

If a person suffers long term from this, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder and to integrate that into the therapy process.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Comorbidity with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Recovery-oriented therapy displays a new and a very promising evidence-based treatment for post-traumatic stress disorder, especially caused by persistent and chronic trauma that enhances resilience and the positive beliefs regarding progress in life [25].

MC Therapy presents evidence-based psychotherapy for post-traumatic stress disorder [26].

DBT [27]; ACT, especially for comorbid disorders of the post-traumatic stress disorder, such as depression [28]; and MBCT [29] could be combined with CBT for acute and post-traumatic stress disorder. The mentioned third-wave therapies could be especially effective in resisting post-traumatic stress and regarding the acceptance of the trauma and emotional distress.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for acute and post-traumatic stress disorder. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, DBT, ACT, and MBCT are effective therapies.

12.5 Discussion

Acute and post-traumatic stress disorder presents an intensive anxiety disorder as a consequence of a confrontation with trauma, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as anxiety disorders, depression, bipolar disorder, substance use disorders, neurocognitive disorder, physical illness, panic attacks, impulsive behavior and grief reactions, should be treated properly.

The behavioral and cognitive models display evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, DBT, MBCT, and MC Therapy present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, DBT, and MBCT are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in acute stress and post-traumatic stress disorder. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way for relief from trauma is to go back to it, to work with it with transparency, and to learn to cope with it for the rest of life.

The therapeutic relationship and alliance is the appropriate context for transparency, safety, and decreasing incompetence and the overgeneralization of danger.

Recovery from acute stress and post-traumatic stress disorder means that the person copes effectively with the trauma, his own incompetence, and the overgeneralization of danger. The whole vulnerability decreases, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the trauma, the incompetence, and the overgeneralization of danger and emotional distress in most cases. More time is needed, in order to cope with the grief process as a consequence of the trauma. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 12.1).

It takes a second or a minute to traumatize a vulnerable person. On the other hand, it takes years to find the power to talk about the trauma, which has led to many complications, as they have been described above. The history of repeated trauma in combination with difficult life circumstances, which activate the trauma and a long-term stress period, increases the possibility of developing post-traumatic stress disorder. The sooner psychotherapy begins, the better it is for the person that suffers.

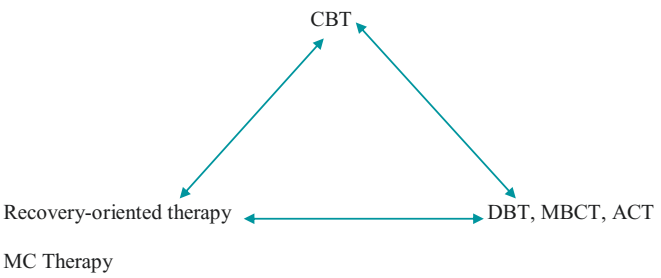

Fig. 12.1 The psychotherapy of acute and post-traumatic stress disorder

Some victims of abuse choose the road to silence for many years due to a great fear for the abuser, but they find a moment in which they decide to talk about trauma and to proceed in evidence-based psychotherapy. Other victims choose to follow the behavior of the abuser and become abusers themselves. The only way to help victims is to persuade them to talk honestly about the trauma and what they have done all the years and to activate their motivation for proceeding in psychotherapy.

In case the victims decide to seek legal health, they have to cooperate with lawyers, who are experienced in cases of abuse, and they have to search for elements which approved the abuse all these years, for example, the application of the removal of telephone and electronic privacy.

#MeToo presents an international social movement against abuse and violence and supports the victims to fight against that phenomenon and to be assertive towards their human rights.

A war, such as the war between Ukraine and Russia, the war on Vietnam, or the Holocaust in World War II, leads to a great possibility of a post-traumatic stress disorder. People suffer many years from these traumatic memories of a confrontation with death as a consequence of racism, hate, grandiosity, and expansive visions. Cognitive behavioral psychotherapy displays a necessary and an essential condition, which cures trauma and helps people from war regions who survive to make a new beginning in life without forgetting the past. Psychotherapy enhances internal peace and mental health. Psychotherapy can also support politicians to show better diplomacy, in order to avoid a war, which will be an ideal condition and the best prophylaxis for the mental health of people in war regions. This social role of psychotherapy should be taken into consideration, in order to implement effective politics in all over the world.

Finally, the central message of this chapter is don't be afraid to talk about the trauma and proceed with evidence-based psychotherapy as soon as possible. Trauma could be treated, and this activates new resources and a new meaning in life. A post-traumatic growth helps people reconsider their whole lives. A new life can begin with more freedom, dignity, safety, and a quality of life!

12.6 Conclusions

Post-traumatic stress disorder and acute stress disorder present a consequence of the confrontation with trauma. Evidence-based treatments in the context of CBT are available for these disorders and should be combined with each other in the future.

The author offers every year a seminar about the evidence-based treatments of CBT and its further developments for acute stress disorder and post-traumatic stress disorder for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists. For more information, please see https://www.linkedin.com/in/stavroula-rakitzi-0b512b45/ and http://orcid.org/0000-0002-5231-6619 or email srakitzi@gmail.com.

12.7 Revision Questions

1. How do you define post-traumatic stress disorder and acute stress disorder?
2. Which comorbid disorders arise out of these disorders?
3. What is the case formulation of these disorders?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of these disorders.
6. What should be done in the future of the psychotherapy of post-traumatic stress disorder and acute stress disorder?

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Part V

Somatic Disorders

Somatic Symptom Disorder

13

13.1 Introduction

Somatic symptom disorder presents a mental health disorder that involves the preoccupation with somatic symptoms and their seriousness, which has a negative impact on the functioning and quality of life of people.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

13.2 The Clinical Features of the Disorder

13.2.1 Diagnostic Procedure

According to DSM-5, somatic symptom disorder is characterized as the existence and preoccupation with one or more somatic symptoms of a negative impact on daily life with repetitive thoughts about the seriousness of the somatic symptoms, with high anxiety about the symptoms, in which high energy is invested. This disorder lasts more than 6 months, and it must be specified whether these symptoms are accompanied by pain and if they are persistent. A differential diagnosis should be made from other medical conditions, panic disorder, generalized anxiety disorder, depressive disorders, illness anxiety disorders, conversion disorders, delusional disorder, body dysmorphic disorder, and obsessive-compulsive disorder [1]. The Somatic Symptom Scale-8 presents a psychometric scale of the somatic symptom disorder [2].

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13.2.2 Epidemiology

The prevalence of somatic symptom disorder in the adult population is 5–7%, and it is higher for females as for males [1]. The prevalence rate in young people is 11–21%, in middle-age people 10–20%, and in older people 1.5–13% [3].

13.2.3 Comorbidity

Comorbid disorders of somatic symptom disorder are medical disorders, anxiety, and depressive disorders [1].

13.2.4 Etiological Psychological Models

13.2.4.1 A Cognitive Model

Organic changes, such as somatic symptoms and emotional arousal, in combination with representations of symptoms in memory and other factors from the past, such as chronic stress, childhood trauma, and beliefs about and experiences of illnesses, lead to more somatic symptoms, to increased focus on these symptoms, and to interpretation of symptoms as serious illness. This has consequences on behavioral level, such as checking the body, help-seeking, avoidance at an emotional level, such as anxiety, depression, anger, on social level, such as stigma and interpersonal isolation, and on cognitive level, such as worry and cognitive distortions. All these lead to consequences of physiological level, such as increased arousal, sleep disturbance, and muscle tension [4, 5]. It is crucial to focus on childhood trauma and on experiences with illnesses in the past. These experiences explain the present vulnerability. CBT focuses on the past as well as on the present.

13.3 Case Formulation

The above evidence-based model serves as a case formulation of the therapy.

The main questions about the case formulation are the following: Is there any vulnerable and traumatic experience from the past which activates the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What are the safety behaviors?

13.4 Interventions

CBT presents an effective as well as an efficacious intervention in somatic symptom disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the general vulnerability towards somatic symptoms. The person feels vulnerable and focuses on somatic symptoms, which have no organic psychopathology, and on misinterpretations of them. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from worrying about somatic symptoms and more quality of life in the long term.

CBT presents an efficacious treatment for somatic symptom disorder [6–10].

A psycho-education [11] of the disorder contributes to the improvement on understanding the disorder and its therapy.

The exposure to the first traumatic experience in the past, which contributed to the development of somatic symptom disorder, presents a good choice, so that the present can be dealt with more easily.

The exposure to chronic pain in combination with other CBT interventions presents a treatment of choice, decreasing fear of movement and improving the quality of life and the coping with pain [8].

Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [12] and autogenic training [13], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The vulnerability schema and the increased focus on somatic symptoms of organic problems and the interpretation of symptoms as serious illness should be restructured. Cognitive interventions can also restructure the beliefs and schemata of possible comorbid disorders.

The duration of CBT for somatic symptom disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbid disorders.

If a person suffers long term from this, it will be useful to evaluate whether this person suffers from a grief as a cause of the disorder and to integrate that in the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy could be a promising treatment for chronic somatic symptom disorder, which enhances resilience and positive beliefs regarding progress in life [14].

MC Therapy displays a potential psychotherapy for somatic symptom disorder, especially for comorbid depression [15].

ACT [16], mindfulness-based stress reduction [17], and MBCT [18] present effective interventions for somatic symptom disorders and comorbid disorders, such as depression, and they could be combined with CBT. The above third-wave therapies could also be effective for resistant somatic symptom disorders.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for somatic symptom disorder. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, MBCT, and mindfulness-based stress reduction are potential therapies.

13.5 Discussion

Somatic symptom disorder displays a chronic disorder focusing on somatic symptoms, which are related cognitively to a serious illness, and has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as medical disorders, anxiety, and depressive disorders, should be treated properly.

The cognitive model displays an evidence-based etiological model for this disorder, and it serves as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy for chronic somatic disorder, MC Therapy, ACT, MBCT, and mindfulness-based stress reduction present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, mindfulness-based stress reduction, and MBCT for somatic symptom disorder are appropriate.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in somatic symptom disorder. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way of relief from this disorder is to talk about it and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema to it.

The therapeutic relationship and alliance is the appropriate context of transparency and safety and for decreasing vulnerability and focus on somatic symptoms and for improving the quality of life.

Recovery from somatic symptom disorder means that the person copes effectively with this vulnerability, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the vulnerability of focusing on somatic symptoms which are related to a serious illness. More time is needed, in

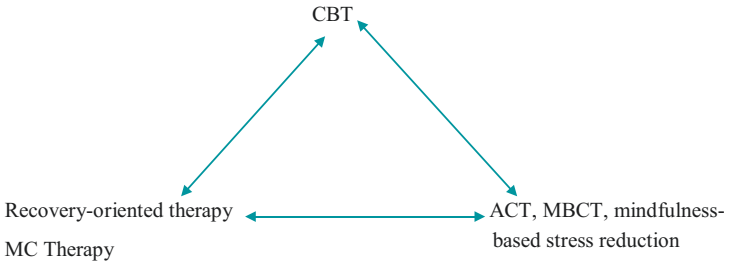

Fig. 13.1 The psychotherapy of somatic symptom disorder

order to cope with the grief process as a consequence of this chronic disorder. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 13.1).

13.6 Conclusions

Somatic symptom disorder presents a preoccupation with somatic symptoms. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

13.7 Revision Questions

1. How do you define somatic symptom disorder?
2. Which comorbid disorders arise out of this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future regarding the psychotherapy of somatic syndrome disorder?

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Illness Anxiety Disorder

14

14.1 Introduction

Health anxiety disorder is a mental health disorder that involves intensive anxiety about having a serious illness, which has a negative impact on the functioning and quality of life of people in a long term.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

14.2 The Clinical Features of the Disorder

14.2.1 Diagnostic Procedure

According to DSM-5, illness anxiety disorder is characterized as intensive anxiety about having a serious illness, which leads to health-related behaviors, such as visits to physicians or checking the body for signs of illness. Somatic symptoms are mild when they arise. This situation lasts at least 6 months, and it is not explained by somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder. A differential diagnosis should be made from other medical conditions, adjustment disorders, somatic symptom disorder, anxiety disorders, obsessive-compulsive disorders and related disorders, major depressive disorders, and psychotic disorders [1]. Y-BOCS-M presents a modified version of the hypochondriasis Y-BOCS scale, which evaluates the illness anxiety disorder [2].

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14.2.2 Epidemiology

The 1–2-year prevalence is 1.3–10%. The age at onset is early and middle adulthood [1]. Clinical health anxiety is up to 13% in the adult population [3].

14.2.3 Comorbidity

Comorbid disorders of illness anxiety disorders are anxiety disorders, especially GAD, obsessive-compulsive disorder and panic disorder, depressive disorders, somatic symptom disorder, and personality disorders [1].

14.2.4 Etiological Psychological Models

14.2.4.1 The Cognitive Model

Symptoms and signs in the body are evaluated as more dangerous as they really are. An illness is more probable. The person feels vulnerable, unable to prevent the illness and to have an impact on its course. Anxiety is the multiplication of illness and perceived cost and burden, with it divided into the ability to cope with the illness plus the perception of possible external factors which can help. Experiences of illnesses contributed to the development of the above beliefs about health anxiety. Factors which contribute to the maintenance of health anxiety are seeking for medical information, which leads to physiological arousal and mood changes and safety behaviors, such as reassurance-seeking or checking [4].

14.3 Case Formulation

The above model also serves as a case formulation of the health anxiety disorder in the therapy process.

The main questions about the case formulation are the following: Is there any vulnerable and traumatic experience from the past (a traumatic experience with an illness), which activates vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels? What are the safety behaviors?

14.4 Interventions

CBT presents an effective as well as an efficacious intervention in illness anxiety disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration due to the chronicity of the disorder and the comorbidity as a consequence of that.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the general vulnerability towards an illness, which is probable. The person feels vulnerable, unable to prevent the illness and to have an impact on its course. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from illness anxiety and better quality of life in the long term.

CBT presents an efficacious treatment for the illness anxiety disorder [5–8].

A psycho-education [9] of the disorder contributes to the improvement of understanding the disorder and its therapy.

The exposure to the first traumatic experience in the past, which contributes to the development of health anxiety, presents a good choice, so that the present can be dealt with more easily.

Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [10] and autogenic training [11], could be offered. When depression like comorbid disorder arises, then behavior activation presents a possible intervention.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The vulnerability schema and the cognitive beliefs about weakness to prevent the illness and to have an impact on its course should be restructured. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

The duration of CBT for illness anxiety disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbidity disorders.

If a person suffers long term from this, it will be useful to evaluate whether this person suffers from a grief as a cause of the disorder and to integrate that in the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic disorders, which enhances resilience and positive beliefs regarding progress in life [12]. It could be a possible intervention in chronic illness anxiety disorder.

MC Therapy displays potential psychotherapy for health anxiety and for comorbid depression [13].

ACT [14] and MBCT [15] present effective interventions for health anxiety and comorbid disorders, and they could be combined with CBT. The above third-wave therapies could also be effective for resistant health anxiety and for comorbid disorders of health anxiety.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for health anxiety disorder. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, and MBCT are potential therapies.

14.5 Discussion

Illness anxiety disorder presents an intensive and many times chronic anxiety about having a serious illness, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as anxiety disorders, especially generalized anxiety disorder, obsessive-compulsive disorder and panic disorder, depressive disorders, somatic symptom disorder, and personality disorders, should be treated properly.

The cognitive model presents an evidence-based etiological model for this disorder, and it serves as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MBCT, and MC Therapy display evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, and MBCT for illness anxiety disorder are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in illness anxiety disorder. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way of relief from this anxiety is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema to it.

The therapeutic relationship and alliance is the appropriate context of transparency, safety, and decreasing the vulnerability to having a serious illness.

Recovery from illness anxiety disorder means that the person copes effectively with this vulnerability, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the vulnerability of having a serious illness and has stopped the majority of safety behaviors, such as having contact with a physician. More time is needed, in order to cope with the grief process as a consequence of this chronic disorder. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 14.1).

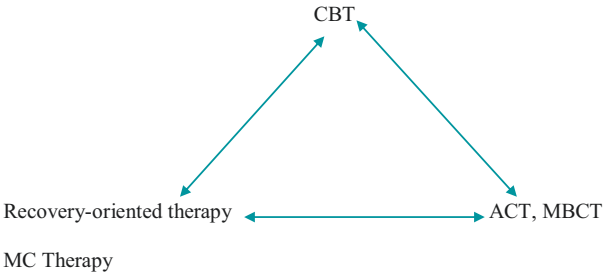

Fig. 14.1 The psychotherapy of illness anxiety disorder

14.6 Conclusions

Illness anxiety disorder presents a preoccupation with being seriously ill, which can be chronic and with a high emotional burden for people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

14.7 Revision Questions

1. How do you define illness anxiety disorder?
2. Which comorbid disorders arise out of the disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of illness anxiety disorder?

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Part VI

Depressive Disorders

Major Depressive Disorder

15

15.1 Introduction

Major depressive disorder presents a mental health disorder that involves depressive mood and decreasing functioning, which has a negative impact on the functioning and quality of life of people in a long term.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

15.2 The Clinical Features of the Disorder

15.2.1 Diagnostic Procedure

According to DSM-5, the person shows depressive mood or loss of interest with five or more symptoms for 2 weeks, such as depressed mood, loss of interest, weight loss (more than 5% in a month), insomnia or hypersomnia, psychomotor agitation, loss of energy, exaggerated worthlessness or guilt, concentration problems, repetitive thoughts of death, and suicide attempt or a plan for dying by suicide. These symptoms have a negative impact on functioning, and the episode is not explained through substance or another medical condition. A differential diagnosis should be made from manic episodes of irritable mood or mixed episodes, mood disorder due to another medical condition, substance medication-induced depressive or bipolar disorder, attention-deficit/hyperactivity disorder, adjustment disorder with depressive mood, and sadness. It is important to evaluate whether it is a single episode or a recurrent episode [1]. The Beck Depression Inventory, Hamilton Depression Rating Scale, and EQ-5D present psychometric scales for the evaluation of depression [2–4].

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15.2.2 Epidemiology

The 12-month prevalence of major depressive disorder in the USA is 7%, and females show higher rates than males. This disorder can arise at any age [1]. The lifetime prevalence is 2–21% with the highest scores in some European countries and lower scores in some Asian countries [5].

15.2.3 Comorbidity

Comorbid disorders with major depressive episodes are substance abuse, panic disorder, obsessive-compulsive disorder, anorexia and bulimia nervosa and borderline personality disorder, schizophrenia, stress-related and somatoform disorders, and personality disorders. The suicide risk is soaring during a major depressive episode [1, 6]. There is also a high comorbidity with somatic disorders, such as dorsopathies, hypertensive diseases, metabolic disorders, and diseases of the central nervous system, such as multiple sclerosis, migraine, epilepsy, and sleep disorders [6]. Cognitive dysfunction arises as a consequence of major depressive disorder, especially because of chronic depression [7].

15.2.4 Etiological Psychological Models

15.2.4.1 The Behavioral Model

The behavioral model of Lewinsohn presents a model for depression. Low levels of positive reinforcement lead to organic symptoms and mood changes (depressive symptoms), which explain depression. Positive reinforcement depends on the number of activities that reinforce the person, the availability of them, and the behavior of the person to follow these activities. A low rate of activities, which potentially improve the mood, leads to depression, social isolation, and avoidance [8].

15.2.4.2 The Cognitive Model

The cognitive model of depression from Beck explains the development and maintenance of depression. The biological and psychological symptoms of depression are the result of the negative cognitive triad-negative thoughts about self, the world/others, and the future, which are maintained by many cognitive distortions. These negative thoughts or images are activated by depressive schema, which can be activated through life events related to loss [9]. The above model was further developed. Life events in the past, which enhance vulnerability, contribute to the development of beliefs and depressive schema. This schema determines the way people think and activates negative thoughts about self, the world/others, and the future. This leads to depressive symptoms of behavioral, affective, physiological, cognitive, and motivational levels [10].

15.3 Case Formulation

The above psychological models serve as a case formulation of the therapy.

The main questions in the case formulation are the following: Is there any vulnerable and traumatic experience from the past (a traumatic depressive experience) which activates vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

15.4 Interventions

CBT presents an effective as well as an efficacious intervention in major depressive disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and potential treatment should be taken into consideration due to the chronicity of the disorder and the comorbidity as a consequence of that.

The positive therapeutic relationship and alliance presents the appropriate condition to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the negative cognitive triad towards self, the world, and the future. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness and weakness, with more optimism and more quality of life in the long term.

The above therapeutic context is also safe for treating suicidal thoughts. People who express suicidal thoughts or want to die by suicide are characterized through hopelessness, weakness, lack of problem-solving ability, and lack of cognitive flexibility. They feel very isolated from others. Therapy should give them the opportunity to talk about suicidal thoughts or thoughts about dying by suicide without stigma. Afterwards, CBT helps suicidal depressive patients through the reattribution of the cognitive triad and through interventions, which enhance problem-solving ability and cognitive flexibility. Suicidality is the first priority in the therapy of a major depressive episode. The cooperation with important people of person with suicidal thoughts and plans is crucial to coping effectively with suicidality or preventing suicide.

CBT presents an efficacious treatment for major depressive disorder [11–13].

A psycho-education [14] of the disorder contributes to the improvement in understanding the disorder and its therapy.

Behavior activation [8] in order to find the appropriate activities which improve the mood on a daily basis is recommended. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [15] and autogenic training [16], could be offered.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The depression schema with the negative cognitive triad should be restructured. Cognitive interventions can also restructure the beliefs and schema of possible comorbid disorders.

The duration of CBT for major disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbid disorders.

If a person suffers long term from recurrent major depressive episodes, it will be useful to evaluate whether this person suffers from a grief as a cause of the disorder and to integrate that in the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder should be considered in the psychotherapy, as it is described in the last chapter about personality disorders.

Relapse prevention is a part of CBT and presents a strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures, when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for recurrent and chronic major depressive episodes, which enhances resilience and the positive beliefs regarding progress of life [17].

MC Therapy presents an effective psychotherapy for recurrent major depressive episodes [18].

ACT [13], MBCT [19], and MCT [20, 21] present effective interventions for major depressive episodes, and they could be combined with CBT. The above third-wave therapies could be also effective for recurrent major depressive episodes and for comorbid disorders of depression.

Cognitive remediation is efficacious in enhancing cognitive function [22].

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for major depressive episode. Relapse prevention presents a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, MBCT, MCT, and cognitive remediation are effective therapies.

15.5 Discussion

Major depressive disorder presents an intensive and many times chronic disorder, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as substance abuse, panic disorder, obsessive-compulsive disorder, anorexia and bulimia nervosa, borderline personality disorder, schizophrenia, stress-related and somatoform disorders, personality disorders, suicidal risk, cognitive dysfunction and somatic disorders, such as dorsopathies, hypertensive diseases, metabolic disorders and

diseases of the central nervous system, such as multiple sclerosis, migraine, epilepsy and sleep disorders, should be treated properly in cooperation with other health and mental health experts.

The behavioral and cognitive models present evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MBCT, MCT, MC Therapy, and cognitive remediation present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, MBCT, MCT, and cognitive remediation for depressive disorder are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in major depressive disorder. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way to relieve from this depression and suicidality is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schemata, which improves daily the mood.

The therapeutic relationship and alliance is the appropriate context of transparency and safety and for decreasing the depressive cognitive triad.

Recovery from major depressive disorder means that the person copes effectively with the depression, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the depression effectively in cognitive and behavioral level. More time is needed, in order to cope with the grief process as a consequence of a chronic depressive disorder. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model on this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 15.1).

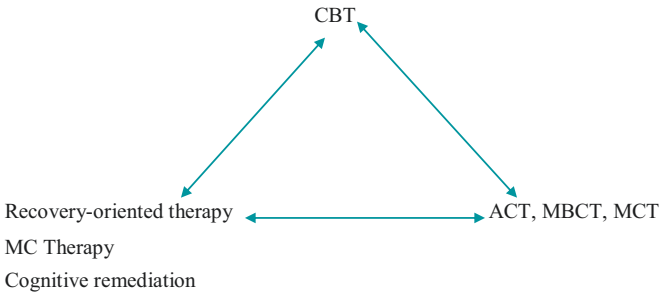

Fig. 15.1 The psychotherapy of major depressive disorder

International social crisis, which changes rapidly the life of people, leads to major depressive episodes. For example, living in a country in which a war takes place and the people are frightened every day of their own death or in a country in which a socioeconomic crisis determines negatively the life of people. The pandemic COVID-19 as well as a war presents also excellent examples of social crisis which lead to depression. The common element of these social crises is that the life of the people changes rapidly within hours, days, weeks, and months. Nothing is the same as before. A new context of life will be activated, which is characterized as many lost and new beginnings in life.

The Greek socioeconomic crisis between 2010 and today leading to the bank rot of Greece leads to increased rates of unemployment, suicidality, and depression in the general population and in people with mental health disorders [23–27]. Greek people were treated in the beginning of crisis with negative stereotypes from many countries. Social resources, such as family and friends, and the solidarity between the Greek people, in combination with evidence-based treatments, enhance all these years the cohesion of the Greek society and decreased the depression and suicidality.

A socioeconomic crisis leads with high possibility to a decreased income, to high unemployment, to interpersonal conflicts, to depression, and to high suicidality. A cognitive behavioral psychotherapy should begin as soon as possible in order to restructure life in accordance with the new social context and to achieve functional outcome and higher motivation for making a new restart in life. Psychotherapy in these circumstances should be combined with supported employment programs, in order to enhance the reintegration into society.

15.6 Conclusions

Major depressive disorder presents a mood disorder, which can be chronic and with high emotional burden for the people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

15.7 Revision Questions

1. How you define major depressive disorder?
2. Which comorbid disorders arise in this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of major depressive disorder?

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Depressive Episode Due to Another Medical Condition

16

16.1 Introduction

Depressive episode due to a medical condition displays a mental health disorder that involves depressive mood and decreasing functioning due to a medical disorder, which has a negative impact on the functioning and quality of life of people in the long term.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

16.2 The Clinical Features of the Disorder

16.2.1 Diagnostic Procedure

According to DSM-5, a person with this disorder shows depressive mood or decreased pleasure, which is the result of a medical condition. The mood disorder has a negative impact on functioning, and it cannot be explained through another mental disorder or delirium. A differential diagnosis should be made from depressive disorders not due to different medical conditions, medication-induced depressive disorder, and adjustment disorders [1]. The Beck Depression Inventory, Hamilton Depression Rating Scale, and EQ-5D display psychometric scales for the evaluation of depression [2–4].

16.2.2 Epidemiology

Depression arises directly after the diagnosis of a medical condition [1]. The lifetime prevalence is 2–21% with the highest scores in some European countries and lower scores in some Asian countries [5].

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16.2.3 Comorbidity

Comorbid disorders of depression due to a medical condition are other medical conditions and GAD. A suicide risk is high because of depressive episodes, and there is a direct association with suicide and a serious medical illness, especially after the arising of the illness [1]. Cognitive dysfunction arises as a consequence of depressive disorder, especially from chronic depression [6].

16.2.4 Etiological Psychological Models

The etiological psychological models of depression have been described in Chap. 11.

16.3 Case Formulation

The above psychological models serve as a case formulation of the therapy.

The main questions in the case formulation are the following: Are there any vulnerable and traumatic experiences from the past (a traumatic depressive experience regarding a difficult medical condition) which enhances vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

16.4 Interventions

CBT presents an effective as well as an efficacious intervention in major depressive disorder due to a medical condition. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

A psychiatric evaluation and a potential treatment should be taken into consideration due to the comorbidity with a medical condition.

The positive therapeutic relationship and alliance displays the appropriate condition to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the negative cognitive triad towards self, the world, and the future of the presence of the medical condition. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness and weakness, with more optimism and more quality of life in the long term.

The above therapeutic context is also safe for treating suicidal thoughts or dying by suicide, especially after the diagnosis of a medical condition. CBT helps suicidal depressive patients through the reattribution of the cognitive triad and through

interventions, which enhance problem-solving ability and cognitive flexibility. Suicidal thoughts are the first priority in the therapy of depressive episodes due to a medical condition. The cooperation with important persons of the people with suicidal thoughts and plans is crucial to cope effectively with suicidality or preventing suicide.

CBT presents an efficacious treatment for depressive disorder due to a medical condition [7–11].

A psycho-education [12] of the disorder contributes to the improvement in understanding the disorder and its therapy.

Behavior activation [13] in order to find the appropriate activities which improves mood on a daily basis is recommended. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [14] and autogenic training [15], could be offered.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The depression schema with the negative cognitive triad should be restructured. Cognitive interventions can also restructure the beliefs and schema by possible comorbid disorders.

The duration of CBT for major disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbidity disorders.

If a person suffers long term from recurrent major depressive episodes due to a medical condition, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder and to integrate that into the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidity with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for recurrent and chronic major depressive episodes due to a medical condition, which enhances resilience and positive beliefs regarding progress of life [16].

MC Therapy displays effective psychotherapy for recurrent major depressive episodes [17].

ACT [18], MBCT [19], and MCT [20] present effective interventions for major depressive episodes, and they could be combined with CBT. The above third-wave therapies could also be effective for recurrent major depressive episodes due to medical conditions and for comorbid disorders of depression.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for major depressive episodes. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, MBCT, and MCT are effective therapies.

16.5 Discussion

Depressive disorder due to a medical condition presents an intensive mood disorder, which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as medical conditions, GAD, and suicide risk, should be treated properly in cooperation with other health and mental health experts.

The behavioral and cognitive models present evidence-based etiological models for this disorder, and it serves as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MBCT, MCT, and MC Therapy present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, MBCT, and MCT for depressive disorder are essential.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in depressive disorder due to a medical condition. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way to relieve from this depression and suicidality is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema. Additionally, learning to cope and leave with a medical condition and cope with the grief relating to it also presents an important perspective on therapy.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the depressive cognitive triad and grief as a consequence of coexistence with a medical illness.

Recovery from major depressive disorder means that the person copes effectively with the depression and the medical condition, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with depression effectively at a cognitive and behavioral level. More time is needed, in order to cope with the grief process regarding a medical illness. The person is functional in the daily routine, but needs more psychotherapy.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 16.1).

There are two excellent examples of medical conditions which often lead to depressive episodes.

Cancer and metastases cause depression due to the danger of death and difficulty in their daily routine as a consequence of difficult medical therapy. A cooperation between oncologists and mental health experts leads to the best possible circumstances of coping with cancer without a high amount of death anxiety. When something negative arises in life, there are two options: The first option is to collapse and catastrophize everything. The second option is to perceive this difficulty as a new

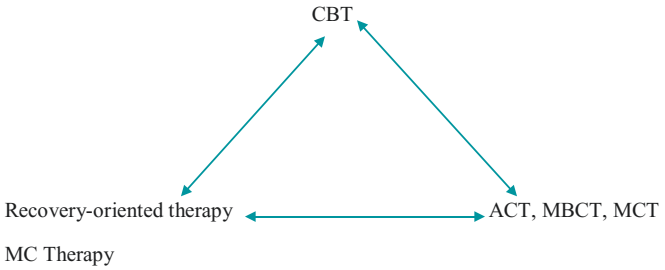

Fig. 16.1 The psychotherapy of depressive disorder due to a medical condition

chance to cope with this difficulty and to learn to live with it. The person gains more wisdom after that. CBT should begin at the earliest after the diagnosis of cancer.

Cystic fibrosis is a genetic disease characterized as pulmonary infections, which leads to difficulties in breathing and other medical problems. Anxiety and depression arise as a consequence of difficulties with breathing and other medical complications, of death anxiety, and of decreased quality of life. Today, many revolutionary new medical therapies are available for these people, which decrease death anxiety and depression and improve their quality of life. CBT should begin at the earliest.

In Greece, for example, the Hellenic Cystic Fibrosis Association (http://www.cysticfibrosis.gr/en/) presents a very positive social model in Greece, which was very active in the last 40 years, asserting the human and medical rights of patients with cystic fibrosis in Greece and focusing on the importance of health of patients with cystic fibrosis. People without medical illnesses could be inspired by these associations, which prove that health is something not always available to us and that people should enjoy life every day and take care of their health, for example, through vaccinations during COVID-19.

A medical condition which changes the health status of a person and his/her ability to be functional in life presents a negative situation with low or high disability. This situation must be transformed into a new challenge to psychotherapy leading to acceptance of the problem, to reattribution of negative beliefs, and to an activation of resources. A new horizon in life must be perceived.

Dr. Stavroula Rakitzi cooperates with the Hellenic Cystic Fibrosis Association and offers voluntarily a group cognitive behavioral psychotherapy once a year, which lasts 13 sessions once a week. This group therapy aims at improving anxiety, depression, the coping process with grief related to the disease, and assertiveness by patients and by caregivers of patients with cystic fibrosis. The first pilot studies were implemented between May and July 2022, and the results will be presented.

The following psychometric tests were administered before and after the intervention by both groups: Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), SCL-90-R, FAF (Fehlerschlagangstfragebögen), and U (Unsicherheitsfragebögen) [21–24].

The patient group initially had 11 members. Six discontinued therapy. Reasons for stopping were the following: lack of time due to commitments (2), were stressed

by treatment (2), one person preferred to continue with individual therapy only (1), and one person declared participation but did not come at all (1). Five participated and completed treatment without exceeding the allowable limit of three absences. One subject did not return the questionnaires after treatment without giving reasons. Four people were included in the statistical analysis (Table 16.1).

The group of caregivers initially consisted of nine people. Four subjects discontinued treatment—three subjects due to lack of time and one subject showed up for only one session and then discontinued without giving reasons. The caregiver group finally consisted of five people, of which one person did not complete the post-treatment questionnaires without giving reasons. Thus, the four subjects were included in the statistical analysis (Table 16.2).

SPSS version 13 was used to carry out the statistical analysis. *T*-paired test, one-sample *T*-test, and effect sizes were used in the statistical analysis [25] (Tables 16.3 and 16.4).

The effect sizes of the patient group were evaluated, which showed how big the effect of psychotherapy is on the group members. According to Cohen, the effect size is 0.2 small, 0.5 medium, and 0.8 large [26]. Results indicated medium to large effect sizes for all variables.

Depression −0, 57-2, 07
Anxiety −0, 62-2, 40
Phobic anxiety −0, 66-2, 14
Anger −0, 74-2, 22
Fear of rejection −1, 03-0, 55
Fear of contact −0, 66-0, 29
Assertiveness −1, 73-0, 73
Difficulty in saying no −1, 92-0, 86
Guilt −1, 30-0, 60
Decency −1, 54-0, 84

Table 16.1 Characteristics of patients with cystic fibrosis

	4 people		
	M (SD)	*t*/chi. sq.	*p*
Sex (100% Γ)	1.00 (0.00)		
Age	40 (35.50)	20.78	0.00
Family status (50% married)	1.25 (0.50)	4.0	0.26
Work (50% retired)	1.25 (0.50)	8.0	0.23

Table 16.2 Characteristics of caregivers

	4 people		
	M (SD)	t/chi. sq.	*p*
Sex (75% Γ)	1.25 (0.50)	4.0	0.26
Age	39.00 (1.15)	67.55	0.00
Family status (75% married)	1.25 (0.50)	4.0	0.26
Work (75% employees)	1.25 (0.50)	4.0	0.26

Table 16.3 *T*-paired test patients

	N = 4		
	M (SD)	*t* (df)	*p*
Depression before	24.25 (29.51)		
Depression after	7.00 (7.74)	0.99 (3)	0.39
Anxiety before	19.25 (20.75)		
Anxiety after	2.25 (2.62)	1.29 (3)	0.28
Phobic anxiety before	14.25 (20.00)		
Phobic anxiety after	3.00 (2.94)	1.03 (3)	0.37
Anger before	12.50 (19.15)		
Anger after	1.75 (0.95)	1.09 (3)	0.35
Fear of rejection before	23.00 (11.74)		
Fear of rejection after	26.00 (11.74)	0.27 (3)	0.80
Fear of contact before	22.00 (9.20)		
Fear of contact after	24.25 (13.59)	0.19 (3)	0.85
Assertiveness before	30.50 (16.66)		
Assertiveness after	37.00 (3.91)	0.90 (3)	0.43
Difficulty in saying no before	26.50 (11.67)		
Difficulty in saying no after	31.25 (1.70)	0.77 (3)	0.49
Guilt before	6.75 (6.02)		
Guilt after	8.75 (4.77)	0.80 (3)	0.48
Decency before	9.50 (7.00)		
Decency after	11.75 (4.50)	0.64 (3)	0.56

Table 16.4 One sample *T*-test patients

	N = 4		
	M (SD)	*t* (df)	*p*
Anger	1.75 (0.95)	3.65 (3)	**0.03**
Fear of rejection	26.00 (11.74)	4.42 (3)	**0.02**
Fear of contact	24.25 (13.59)	3.56 (3)	**0.03**
Assertiveness	37.00 (3.91)	18.89 (3)	**0.00**
Difficulty in saying no	31.25 (1.70)	36.59 (3)	**0.00**
Guilt	8.75 (4.57)	3.82 (3)	**0.03**
Decency	11.75 (4.50)	5.22 (3)	**0.01**

The effect sizes of the caregivers group are the following:

Depression −0, 13-3, 05
Anxiety −0, 27-2, 07
Phobic anxiety −0, 52-1, 35
Anger −0, 11-3, 43
Fear of rejection −0, 01-1, 86
Fear of contact 0, 2-1, 60
Assertiveness 0, 77-1, 68
Difficulty in saying no −0, 70-2, 34
Guilt −1, 05-0, 09
Decency 0, 03-3, 06

The pilot application of group cognitive psychotherapy in people with cystic fibrosis revealed statistically significant results of anger, fear of criticism, fear of contact, assertiveness, difficulty in saying no, guilt, and decency after treatment. The improvement on the above variables is directly related to the nature of a group therapy (Fiedler 2005), which increases group cohesion and expressiveness.

We have small-large effect sizes for almost all variables, which were evaluated, namely, for depression, anxiety, phobic anxiety, anger, fear of criticism, fear of contact, assertiveness, difficulty in saying no, guilt, and decency.

A pilot application of group cognitive psychotherapy to caregivers of people with cystic fibrosis revealed statistically significant results of fear of criticism, fear of contact, assertiveness, guilt, and decency at post-treatment (Tables 16.5 and 16.6). The improvement on the above variables is directly related to the nature of a group therapy [27], which increases group cohesion and expressiveness.

We have small-large effect sizes for almost all variables which were evaluated, namely, for depression, anxiety, phobic anxiety, anger, fear of criticism, fear of contact, assertiveness, difficulty in saying no, guilt, and decency.

The results of the patient and caregiver group are in accordance with other studies [28–30].

Reduced assertiveness is associated with anxiety and depression. Improving assertiveness can lead to improved anxiety, depression, and self-confidence [30].

The dropout was high in both pilot studies, which is related to anxiety towards psychotherapy and the possible difficulty of committing to it for 3 months.

The group size for both groups was small, which always negatively affects the statistical analysis as well. There is no comparison of a control group, something that was not possible to implement, because more volunteer psychotherapists are required.

We have the first positive results of the first pilot application in Greece, and this is important. Members themselves reported the following impressions of the treatment: I relaxed, I calmed down, my mood and self-confidence were improved, I managed my fear of death better, I am not alone, we are a family, and the acceptance, courage, and resilience were increased.

Table 16.5 *T*-paired test caregivers

	N = 4		
	M (SD)	*t* (df)	*p*
Depression before	9.50 (7.50)		
Depression after	1.25 (1.89)	2.66 (3)	0.07
Anxiety before	6.50 (5.80)		
Anxiety after	2.25 (2.62)	1.99 (3)	0.14
Phobic anxiety before	0.75 (1.50)		
Phobic anxiety after	0.25 (0.50)	1.00 (3)	0.39
Anger before	3.50 (2.64)		
Anger after	0.25 (0.50)	2.75 (3)	0.07
Fear of rejection before	21.50 (12.92)		
Fear of rejection after	11.25 (8.09)	3.12 (3)	**0.05**
Fear of contact before	26.50 (12.39)		
Fear of contact after	16.00 (10.69)	12.12 (3)	**0.001**
Assertiveness before	36.50 (12.04)		
Assertiveness after	32.00 (4.69)	0.61 (3)	0.58
Difficulty in saying no (before)	23.00 (8.20)		
Difficulty in saying no (after)	14.75 (10.56)	1.24 (3)	0.30
Guilt (before)	5.00 (3.74)		
Guilt (after)	6.75 (3.30)	2.33 (3)	0.10
Decency (before)	14.50 (4.43)		
Decency (after)	7.00 (5.03)	3.38 (3)	**0.04**

Table 16.6 One sample *T*-test caregivers

	N = 4		
	M (SD)	*t* (df)	*p*
Assertiveness	32.09 (4.89)	13.06 (3)	**0.001**
Guilt	6.75 (3.30)	4.08 (3)	**0.02**

Further studies regarding the effectiveness of this group's cognitive behavioral therapy in cystic fibrosis with a larger sample and a large follow-up are needed.

A democratic society must provide evidence-based treatments for vulnerable people!

16.6 Conclusions

Depressive disorder due to a medical condition presents a mood disorder as a consequence of a medical disorder, which is related to emotional burden of people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

16.7 Revision Questions

1. How do you define depressive disorder due to a medical condition?
2. Which comorbid disorders arise out of this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of depressive disorder due to a medical condition?

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Part VII

Bipolar and Related Disorders

Bipolar I Disorder

17

17.1 Introduction

Bipolar I disorder is a mental health disorder which begins early in life and involves depressive, manic episodes and decreasing functioning, which has a negative impact on the functioning and quality of life of people in a long term.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

17.2 The Clinical Features of the Disorders

17.2.1 Diagnostic Procedure

According to DSM-5, bipolar I disorder is characterized as manic episodes, which prelude or arise after hypomanic and major depressive episodes. A manic episode is characterized as a period of irritable mood and increased goal-oriented energy, which lasts minimum 1 week and presents most of the day. During this period, three or more symptoms are available: grandiosity, decreased need for sleep, pressure to keep talking, flight of ideas, distractibility, goal-oriented activity or psychomotor agitation, and involvement in activities with high risk, such as risky investments or spending a lot of money. All this has a negative impact on functioning and can lead to hospitalization, and it is not explained through another medical condition or through the effects of a substance. A hypomanic episode shows the above criteria, but there are some differences. The episode causes no severe decrease in functioning or does not lead to hospitalization. The episode is not explained through the effects of a substance. If psychotic symptoms arise, then the episode is coded as a manic episode.

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A differential diagnosis should be made from major depressive episode and other bipolar disorder; from GAD, panic disorder, post-traumatic stress disorder, and other anxiety disorders; from substance-induced bipolar disorder and attention-deficit/hyperactivity disorder; from personality disorders, such as borderline personality disorders; and from disorders with irritability [1]. The semi-structured interview, the schedule for affective disorder and schizophrenia is recommended for the evaluation of bipolar disorder. There are also self-report tests, which are recommended, such as the General Behavior Inventory and the Mood Disorder Questionnaire. The Young Mania Rating Scale, the Bech-Rafaelsen Mania Rating Scale, the Altman Self-Rating Mania Scale, and the Self-Rating Mania Inventory are recommended for evaluating the severity of manic symptoms [2].

17.2.2 Epidemiology

The lifetime prevalence of bipolar I disorder is between 0.0% and 0.6%. The age at the onset is 18 years old [1].

17.2.3 Comorbidity

Comorbid disorders of bipolar I disorder are anxiety disorders, such as panic attack, social phobia, and specific phobia; post-traumatic stress disorder; ADHD; impulse control or conduct disorder; substance use disorder, such as alcohol use disorder; and other medical conditions, such as migraine, metabolic syndrome, and high rates of suicidality and cognitive dysfunctions. Anxiety disorders arise very frequently because of bipolar disorder and have a negative impact on the course of the disorder regarding remission and recovery. Neurocognitive dysfunction in attention, verbal learning, and memory and executive functions and in social cognition (theory of mind) arises frequently in bipolar disorders. 40%–60% of people with bipolar disorder show neurocognitive dysfunction [1, 3, 4].

17.2.4 Etiological Psychological Models

17.2.4.1 The Vulnerability Stress Model

A person has a biological vulnerability as a consequence of a neurotransmitter dysfunction. When critical events or stress arise, biological vulnerability is influenced negatively. This leads to a prodromal stage of an episode, which means decreased coping strategies. This situation activates a full depressive or manic episode, which means more stigma and interpersonal problems. There are other factors which contribute to a full episode, such as the high levels of expressed emotion from partners or family members [5].

17.2.4.2 The Cognitive Model

The cognitive model takes into consideration the vulnerability stress model. A psychological factor which contributes to bipolar disorder along with biological vulnerability is the activation of the cognitive triad (the negative beliefs about self, others, and the future) [6]. Appraisals of the emotional states and dysfunctional emotion regulation strategies contribute to the development of bipolar disorder. The integrative cognitive model shows how appraisals and behaviors interact and contribute to depression and mania. Positive appraisals of an activated mood activate people with bipolar disorder and lead to mania. It is useful to focus on the reattribution of positive appraisals of activated mood during a manic phase [7].

17.3 Case Formulation

The above psychological models serve as a case formulation in therapy.

The main questions in the case formulation are the following: Is there any biological vulnerability? Is there any vulnerable and traumatic experience from the past which enhances the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

17.4 Interventions

CBT presents an effective as well as an efficacious intervention for bipolar I disorder, a chronic mental health disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

Pharmacotherapy is the main therapy for individuals with bipolar disorder. Evidence-based psychotherapy is an adjunct to pharmacotherapy. A psychiatric evaluation and treatment must be taken into consideration due to the high suicide risk and comorbidity.

The therapeutic relationship with a chronic mental health disorder, such as bipolar I disorder, means that psychotherapists are available in the context of long-term therapeutic goals and interventions. A case formulation will explain this process and that psychotherapists try in every session to enhance the motivation for change and restart in life. The positive therapeutic relationship and alliance displays the appropriate conditions to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the negative cognitive triad towards self, the world, and the future, so that dysfunctional and dangerous behaviors can be treated. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness, weakness, and manic dangerous behaviors with more optimism and more quality of life in the long term.

The above therapeutic context is safe for treating suicidal thoughts. People who express suicidal thoughts or want to die by suicide are characterized by hopelessness, weakness, lack of problem-solving ability, and lack of cognitive flexibility. They feel very isolated from others. Therapy should give them the opportunity to express suicidal thoughts or thoughts about dying by suicide without stigma.

Finally, CBT helps suicidal bipolar I patients through the reattribution of the cognitive triad and through interventions, which enhance problem-solving ability and cognitive flexibility. Suicidality is the first priority in therapy. Cooperation with important people of individuals with suicidal thoughts and plans is pivotal for coping effectively with suicidality or precluding suicide.

The following factors are associated with increased possibility for suicide in bipolar disorder: early age of illness onset, longer duration of illness, depression during the first episode, the presence of an episode (depressive or mixed) during the suicide attempt, substance use, anxiety, increased weight and metabolic parameters, eating disorders, personality disorders and especially borderline personality disorder, family history of suicide or mood disorders, other suicidal attempts in the past, and early-life trauma, such as childhood abuse, stress, and sexual dysfunction [8].

CBT presents an efficacious treatment for bipolar I disorder in improving mood symptoms and functioning and in reducing the relapse rates [9, 10].

A psycho-education of bipolar disorder contributes to a reduction of new affective episodes, to reduction of the length of hospitalization, and to better adherence to therapy [11].

During a depressive episode, a behavior activation [12] in order to find the appropriate activities which improve the mood on a daily basis is recommended. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [13] and autogenic training [14], is recommended. The majority of persons with bipolar disorder show poor social functioning [15]. Social skills and assertiveness training via CBT and DBT are also recommended [16]. These interventions should be combined with pharmacotherapy.

During a manic episode, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [13] and autogenic training [14], presents crucial behavioral interventions. These interventions in combination with pharmacotherapy will improve sleep and will contribute to the avoidance of risky behaviors, such as dangerous sexual activity or spending money.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The depression schema with the negative cognitive triad and the cognitive schema during the manic phase with positive appraisal of euphoria and grandiosity, which lead to risky behaviors, should be restructured. Cognitive interventions can also restructure beliefs and schema because of possible comorbid disorders.

Persons with bipolar I disorder learn to cope with depressive and manic episodes and to recognize the switch between the two phases.

The duration of CBT for bipolar I disorder is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbidity and should be implemented in difficult phases of the disorder in the long term.

In the case of bipolar I disorder, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder and to integrate that into the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidities with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Cognitive behavioral family therapy [17], which evaluates the family dynamic, reduces highly expressed emotions, such as critical comments or emotional overinvolvement in members towards people with bipolar disorder, improving the communication between them and restructures the dysfunctional schema of the family members.

Cognitive behavioral couple therapy [18] improves the communication between partners and changes the dysfunctional schema in the context of bipolar disorder. The above interventions can be combined with the individual CBT.

Relapse prevention is a part of CBT and presents a strategy which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic mental health disorders, which enhances resilience and positive beliefs regarding progress in life [19].

MC Therapy presents an effective psychotherapy for depression [20].

ACT is effective for depression [21]; DBT for mood regulation [22]; MBCT for depression, anxiety, and mood regulation, but not for mania [23]; and MCT for improving psychosocial functioning [24].

40–60% of individuals with bipolar disorder show cognitive dysfunctions [4]. Functional remediation for bipolar I disorder presents a treatment of choice for cognitive dysfunction, focusing on attention, memory, and executive functions, has been implemented in the last years, and presents an efficacious treatment. Cognitive dysfunctions, depressive symptoms, and functioning were improved [25].

Persons with bipolar disorder with a history of trauma show a poorer clinical course of the disorder. There is an association between trauma and psychosis, vulnerability and trauma, and cognitive dysfunction in individuals with bipolar disorder [26]. Trauma-focused interventions for people with chronic and severe mental health disorders in the context of CBT were not preferred. Experts believe that those interventions can lead to relapse. In the last years, many experts have been trying to cope with trauma in severe mental health disorders with cognitive restructuring without exposure [27]. EMDR presents an alternative for trauma therapy in bipolar disorder [28].

In other words, trauma-focused interventions, such as exposure, in chronic severe mental health disorders, such as bipolar I disorder, are associated with a high possibility for a relapse. Cognitive restructuring presents a safer intervention. EMDR has been implemented in the last few years in bipolar I disorder. When trauma exposure is implemented in CBT in individuals in the future frequently, it must probably

be combined with intensive resource activation along with cognitive behavioral therapy in many contexts, such as couples and family.

In conclusion, CBT with behavioral and cognitive interventions and cognitive behavioral couple and family therapy present efficacious treatments for bipolar I disorder. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, MBCT, DBT, MCT, and functional remediation are promising therapies.

17.5 Discussion

Bipolar I disorder is a chronic mental health disorder which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as anxiety disorders, such as panic attack, social phobia, specific phobia, post-traumatic stress disorder, ADHD, impulse control or conduct disorder, substance use disorders, such as alcohol use disorder, other medical conditions, such as migraine and metabolic syndrome and high rates of suicidality and cognitive dysfunctions should be treated properly in cooperation with other health and mental health experts.

The stress vulnerability model and the cognitive model present evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MBCT, DBT, MCT, MC Therapy, and cognitive remediation display evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, MBCT, MCT, and cognitive remediation for bipolar I disorder are essential. Further studies regarding the efficacy of the above interventions in mania are necessary.

The possibility of implementation of exposure to trauma in individuals with bipolar I disorder should be taken carefully into consideration in cooperation with the psychiatrist. Cognitive restructuring displays a safer method for coping with trauma. EMDR has been implemented in the last few years. Further studies regarding the efficacy of EMDR in trauma of individuals with bipolar disorder are needed.

Persons with bipolar I disorder are hospitalized frequently, not voluntarily, during a depressive or a manic episode. This kind of hospitalization is associated with transport to the hospital from the police. The above experience is very traumatic but sometimes necessary to avoid a suicidal attempt and reactivates other psychological trauma from the past. It is also crucial to implement all the above mentioned interventions, in order to follow an ambulant treatment in the long term and to avoid hospitalization.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in bipolar disorder. People understand from the first session what is going on and how the therapy proceeds.

They understand that the only way to relieve from manic and depressive episodes as well as suicidality is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema in depression and mania.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the dysfunctional cognitive schema in depression and mania. This safety context presents a procedure to cope with those switches between depression and mania, to cope with the episodes, and to learn to take early measures, so that relapse can be avoided.

Recovery from bipolar I disorder means that the person copes effectively with the depression and mania, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with depression effectively at a cognitive and behavioral level. The person shows some psychotic symptoms during the manic phase, which are not so easy to cope with. Additionally, the person has long-term grief as a consequence of chronic bipolar disorder. The person is functional in the daily routine, but needs more psychotherapy to cope with the psychotic elements and grief.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be carried out in the future (Fig. 17.1).

Bipolar I disorder displays a chronic mental health disorder. People are regularly exhausted from the switch between depression and mania. All the above interventions contribute to coping with episodes and suicidality, to decreasing burnout, and to the acceptance of the disorder. A reintegration into society via long-term ambulant recovery-oriented therapy presents the most important goal. The protagonists in this context are the people who suffer from bipolar I disorder. Recovery-oriented

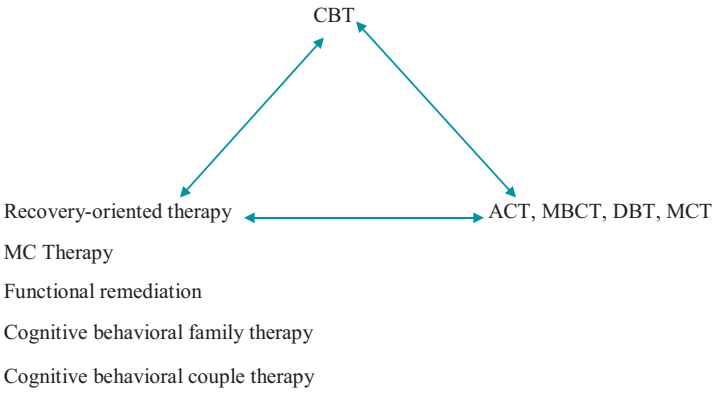

Fig. 17.1 The psychotherapy of bipolar I disorder

pharmacotherapy, psychotherapy, and other interventions, such as healthy nutrition and exercise, help people to be very active towards their mental health problems and to play a protagonist role in their own life, which belongs to them.

Interventions on many levels, such as people, couples, and family, are necessary to help individuals, who suffer, to cope with this disorder and to help their environment to accept a new reality and to develop a new path of life together with the person who suffers. A new dimension of life should be activated.

17.6 Conclusions

Bipolar I disorder presents a mood disorder which can be chronic and with a high emotional burden on people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

17.7 Revision Questions

1. How do you define bipolar I disorder?
2. Which comorbid disorders arise in this disorder?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process of this disorder.
6. What should be done in the future of the psychotherapy of bipolar I disorder?

The author offers every year a seminar about the evidence-based treatments of CBT and its further developments for bipolar disorder for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists. For more information, please see https://www.linkedin.com/in/stavroula-rakitzi-0b512b45/ and http://orcid.org/0000-0002-5231-6619 or email srakitzi@gmail.com.

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Bipolar II Disorder

18

18.1 Introduction

Bipolar II disorder presents a chronic mental health disorder that begins early in life and involves depressive and hypomanic episodes, which have a negative impact on the quality of life of people in the long term.

This chapter will display the clinical characteristics of the disorder as well as the evidence-based interventions.

18.2 The Clinical Features of the Disorders

18.2.1 Diagnostic Procedure

According to DSM-5, a bipolar II episode should fulfill the criteria of a current or a past hypomanic episode and of a current or a past major depressive episode. There were no manic episodes in the past. The disorder is not better explained by other mental health disorders, such as schizophrenia, schizoaffective disorder, delusional disorder, and other psychotic disorders. A differential diagnosis should be made from major depressive episode; cyclothymic disorder; schizophrenia and other psychotic disorders; panic disorder and other anxiety disorders; substance use disorder; attention-deficit/hyperactivity disorder; personality disorders, such as borderline personality disorder; and other bipolar disorders [1]. The semi-structured interview, the schedule for affective disorder and schizophrenia is recommended for the evaluation of bipolar disorder. There are also self-report tests, which are recommended, such as the General Behavior Inventory and the Mood Disorder Questionnaire [2].

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18.2.2 Epidemiology

The 12-month prevalence is 0.3%. The age at onset is the mid-20s.

18.2.3 Comorbidity

Comorbid disorders of bipolar II disorder are anxiety disorders; substance use disorders; eating disorders, with binge-eating disorders the most common eating disorder; high suicidal risk; and cognitive dysfunction. Anxiety disorders arise very frequently because of bipolar disorder and have a negative impact on the course of the disorder regarding remission and recovery. Dysfunction in attention, verbal learning, and memory, in executive functions, and in social cognition (theory of mind) arises frequently in bipolar disorders. 40–60% of people with bipolar disorder show neurocognitive dysfunction [1, 3, 4].

18.2.4 Etiological Psychological Models

The etiological psychological models have been described in Chap. 13.

18.3 Case Formulation

The above psychological models serve as a case formulation in therapy.

The main questions in the case formulation are the following: Is there any biological vulnerability? Is there any vulnerable and traumatic experience from the past, which enhances vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

18.4 Intervention

CBT presents an effective as well as an efficacious intervention for bipolar II disorder, a chronic mental health disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen.

Pharmacotherapy displays the main therapy for individuals with bipolar disorder. Evidence-based psychotherapy is an adjunct to pharmacotherapy. A psychiatric evaluation and treatment must be taken into consideration due to the high suicide risk and comorbidity.

The therapeutic relationship with a chronic mental health disorder, such as bipolar II disorder, means that psychotherapists are available in the context of long-term therapeutic goals and interventions that a case formulation will explain this process

and that psychotherapists try in every session to enhance the motivation for change and restart in life. The positive therapeutic relationship and alliance presents the appropriate conditions to implement the behavioral and cognitive interventions. A person with this disorder needs transparency and safety in the therapeutic process, so that negative cognitions and emotions can be expressed regarding the negative cognitive triad towards self, the world, and the future, so that dysfunctional and dangerous behaviors can be treated. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness, weakness, and hypomanic dangerous behaviors with more optimism and more quality of life in the long term.

The above therapeutic context is safe for also treating suicidal thoughts. People who express suicidal thoughts or want to die by suicide are characterized by hopelessness, weakness, lack of problem-solving ability, and lack of cognitive flexibility. They feel very isolated from others. Therapy should give them the opportunity to express suicidal thoughts or thoughts about dying by suicide without stigma.

Finally, CBT helps suicidal bipolar II patients through the reattribution of the cognitive triad and through interventions, which enhance problem-solving ability and cognitive flexibility. Suicidality is the first priority in therapy. Cooperation with important people of individuals with suicidal thoughts and plans is pivotal for coping effectively with suicidality or precluding suicide.

The following associated factors are an increased possibility for suicide in bipolar disorder: early age of illness onset, longer duration of illness, depression during the first episode, the presence of an episode (depressive or mixed) during the suicide attempt, substance use, anxiety, increased weight and metabolic parameters, eating disorders, personality disorders and especially borderline personality disorder, family history of suicide or mood disorders, other suicidal attempts in the past, and early-life trauma, such as childhood abuse, stress, and sexual dysfunction [5].

CBT presents an efficacious treatment for bipolar II disorder in improving depressive symptoms, hypomanic symptoms, and functioning and in reducing the relapse rates [5–7].

A psycho-education of bipolar disorder contributes to a reduction of new affective episodes, to reduction of the length of hospitalization, and to better adherence to therapy [8].

During a depressive episode, a behavior activation [9] in order to find the appropriate activities which improve the mood on a daily basis is recommended. Stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [10] and autogenic training [11], is also recommended. The majority of persons with bipolar disorder show poor social functioning [12]. Social skills and assertiveness training via CBT and DBT are also recommended [13]. These interventions should be combined with pharmacotherapy.

During a hypomanic episode, stress management with problem-solving and relaxation techniques, such as progressive muscle relaxation [10] and autogenic training [11], presents crucial behavioral interventions. These interventions in combination with pharmacotherapy will improve sleep and will contribute to the avoidance of risky behaviors, such as dangerous sexual activity or spending money.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. The depression schema with the negative cognitive triad and the cognitive schema during the hypomanic phase with positive appraisal of euphoria and grandiosity, which leads to risky behaviors, should be restructured. Cognitive interventions can also restructure the beliefs and schema of possible comorbid disorders.

Persons with bipolar II disorder learn to cope with depressive and hypomanic episodes and to recognize the switch between the two phases.

The duration of CBT for bipolar II disorder is up to 25 sessions, but it depends on the chronicity and its comorbidity and should be implemented in difficult phases of the disorder in the long term.

In the case of bipolar II disorder, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder and to integrate that into the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Comorbidities with a personality disorder should be considered in psychotherapy, as is described in the last chapter about personality disorders.

Cognitive behavioral family therapy [14], which evaluates the family dynamic, reduces highly expressed emotions, such as critical comments or emotional overinvolvement in members towards people with bipolar disorder, improving the communication between them and restructures the dysfunctional schema of the family members.

Cognitive behavioral couple therapy [15] improves the communication between the partners and changes the dysfunctional schemata in the context of bipolar disorder. The above interventions can be combined with the individual CBT.

Relapse prevention is a part of CBT and displays a strategy which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic mental health disorders, which enhances resilience and positive beliefs regarding progress in life [16].

MC Therapy presents effective psychotherapy for depression [17].

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40–60% of individuals with bipolar disorder show cognitive dysfunctions [4]. Functional remediation for bipolar II disorder is a treatment of choice for cognitive dysfunction, focusing on attention, memory, and executive functions. It has been implemented in the last years and presents an efficacious treatment. Cognitive dysfunctions, depressive symptoms, and functioning were improved [22].

Persons with bipolar disorder with a history of trauma show a poorer clinical course of the disorder. There is an association between trauma and psychosis, vulnerability and trauma, and cognitive dysfunction in individuals with bipolar

disorder [23]. Trauma-focused interventions by persons with bipolar disorder can lead to relapse. In the last years, many experts have tried to cope with trauma in severe mental health disorders with cognitive restructuring without exposure [24]. EMDR presents an alternative for trauma therapy in bipolar disorder [25].

In other words, trauma-focused interventions, such as exposure, in bipolar II disorder, are associated with a high possibility for a relapse. Cognitive restructuring presents a safe intervention. EMDR has been implemented in the last few years in individuals with bipolar disorder. When trauma exposure is implemented in CBT for individuals in the future more frequently, it must probably be combined with intensive resource activation along with cognitive behavioral therapy in many contexts, such as couples and family.

In conclusion, CBT with behavioral and cognitive interventions and cognitive behavioral couple and family therapy display efficacious treatments for bipolar II disorder. Relapse prevention is a part of CBT, in which people should be trained. Recovery-oriented therapy, MC Therapy, ACT, MBCT, DBT, MCT, and cognitive remediation are promising therapies.

18.5 Discussion

Bipolar II disorder is a chronic mental health disorder which has a negative impact on the quality of life of people.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as anxiety disorders; substance use disorders; eating disorders, with binge-eating disorders the most common eating disorder; high suicidal risk; and cognitive dysfunction, should be treated properly in cooperation with other health and mental health experts.

The stress vulnerability model and the cognitive model display evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MBCT, DBT, MCT, MC Therapy, and cognitive remediation present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, MC Therapy, ACT, MBCT, MCT, and cognitive remediation for bipolar disorder are essential. Further studies regarding the efficacy of the above interventions in hypomania are necessary.

The possibility of implementation of trauma exposure to individuals with bipolar II disorder should be taken carefully into consideration in cooperation with the psychiatrist. Cognitive restructuring presents a safer method for coping with the trauma. EMDR has been implemented in the last years. Further studies regarding the efficacy of EMDR in trauma of individuals with bipolar II disorder are needed.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in bipolar II disorder. People understand from the first session what is going on and how the therapy proceeds. They understand that the only way to relieve themselves from hypomanic and depressive episodes as well as suicidality is to talk about that and to build a new

coping mechanism through the reattribution of dysfunctional beliefs and schema in depression and hypomania.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the dysfunctional cognitive schema in depression and hypomania. This safety context presents a procedure to cope with those switches between depression and hypomania, to cope with the episodes, and to learn to take early measures, so that relapse can be avoided.

Recovery from bipolar II means that the person copes effectively with the depression and hypomania, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with depression effectively at a cognitive and behavioral level. The person shows difficulties coping with the hypomanic phase. Additionally, the person shows long-term grief as a consequence of chronic bipolar disorder. The person is functional in the daily routine, but needs more psychotherapy to cope with hypomania and grief (recovery as a process).

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be carried out in the future (Fig. 18.1).

Bipolar II disorder is a chronic mental health disorder. People are regularly exhausted from the switch between depression and hypomania. All the above interventions contribute to coping with the episodes and suicidality and decrease of burnout from the disorder. A reintegration into society via long-term ambulant recovery-oriented therapy displays the most important goal. The protagonists in this context are the people who suffer from bipolar II disorder. Recovery-oriented pharmacotherapy, psychotherapy, and other interventions, such as healthy nutrition and exercise, help people to be very active towards their mental health problems and to play a protagonist role in their own life, which belongs to them.

Interventions on many levels, such as people, couples, and family, are necessary to help people who suffer, to cope with this disorder, and to help their environment

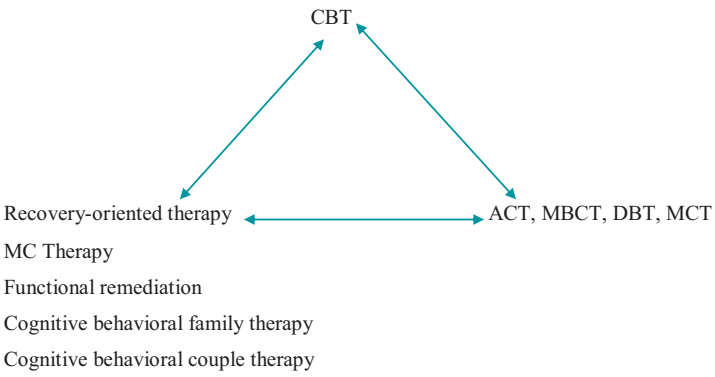

Fig. 18.1 The psychotherapy of bipolar II disorder

to accept a new reality and to develop a new path of life together with the person who suffers.

18.6 Conclusions

Bipolar II disorder is related with high suicidality as well as with emotional and financial burden on people. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

18.7 Revision Questions

1. How do you define bipolar II disorder?
2. What is the difference between bipolar I and bipolar II disorder?
3. Which comorbid disorders arise in bipolar II disorder?
4. What is the case formulation of this disorder?
5. Which evidence-based treatments in the context of CBT are available?
6. Describe the recovery process of this disorder.
7. What should be done in the future of the psychotherapy of bipolar II disorder?

The author offers every year a seminar about the evidence-based treatments of CBT and its further developments for bipolar disorder for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists. For more information, please see https://www.linkedin.com/in/stavroula-rakitzi-0b512b45/ and http://orcid.org/0000-0002-5231-6619 or email srakitzi@gmail.com.

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Part VIII

Schizophrenia and Other Psychotic Disorders

Schizophrenia

19

19.1 Introduction

Schizophrenia is a chronic mental health disorder which begins early in life and has a negative impact on the quality of life of people in the long term.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

19.2 The Clinical Features of the Disorders

19.2.1 Diagnostic Procedure

According to DSM-5, the following diagnostic criteria must be fulfilled: two or more of the following symptoms must be present during 1 month: delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms, such as diminished emotional expression, avolition (lack of motivation), alogia, anhedonia, and lack of interest in social interactions. Functioning is disturbed in many areas, such as work and interpersonal relationships, from the beginning of the disorder. Problems have been present for at least 6 months. A differential diagnosis should be made from schizoaffective disorders, depressive or bipolar disorder with psychotic features, schizophreniform disorder and brief psychotic disorder, delusional disorder, schizotypal personality disorder, obsessive-compulsive disorder, and body dysmorphic disorder, from post-traumatic stress disorder, and from autism spectrum disorder and other mental disorders with a psychotic episode [1].

Psychometric scales for schizophrenia are the Positive and Negative Symptoms Scale (PANSS), the Scales for the Assessment of Positive Symptoms (SAPS), the

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Scales for the Assessment of Negative Symptoms (SANS), the Clinical Global Impression-Schizophrenia (CGI-SCH), and the newer scales the Clinical Assessment Interview for Negative Symptoms (CAINS) and the Brief Negative Symptom Scale (BNSS). The MATRICS Consensus Cognitive Battery evaluates the cognitive functions in schizophrenia [2, 3].

Cognitive dysfunctions present a crucial problem in over 80% of individuals with schizophrenia, and they are present in the prodromal phase, during the first psychotic episode and every psychotic episode, after the psychotic episodes, and during the chronic phase of the disorder. Cognitive functions are categorized into neurocognition-speed of processing, attention/vigilance, verbal and visual memory, working memory, problem-solving and social cognition-emotion processing, social perception, theory of mind, social schema, and attribution. Social cognition is the ability to understand and to interpret the social behavior of other people. Social cognition mediates the relationship between neurocognition and functional outcome [4–6].

It is clear that neurocognitive and social cognitive functions are related to the functional outcome and the ability to reintegrate into society in many areas of life, such as in work and in interpersonal relationships. Cognitive functions determine the correctness of the appropriate actions in order to be functional in the daily routine. For example, social cognitive functions play an important role in social skills and assertiveness.

Treatment-resistant schizophrenia presents a distinct and higher burden disorder in individuals with schizophrenia, which is defined by specific criteria from the Treatment Response and Resistance in Psychosis Working Group. Persons with treatment-resistant schizophrenia show persistent positive and negative symptoms and cognitive dysfunctions, which have a negative impact on functioning, poorer prognosis, and increased hospitalization. One third of the people with schizophrenia or 30–60% of them belongs to the category of treatment-resistant schizophrenia [7–10].

Treatment-resistant schizophrenia is associated with a poorer outcome, which increases the possibility for suicidality. Experts should evaluate as soon as possible the existence of treatment-resistant schizophrenia and take the appropriate measures, so that the increased danger can be eliminated. Today, it is possible to fight against treatment-resistant schizophrenia through evidence-based medicine and evidence-based psychotherapy.

19.2.2 Epidemiology

The lifetime prevalence of schizophrenia is 0.3–0.7%. The disorder arises between the late teens and the mid-30s, in the early to mid-20s by males, and in the late 20s by females [1]. The prevalence of treatment-resistant schizophrenia is lower than 30% in the USA [11]. Other studies found a 12-month time prevalence of 0.17% [12].

19.2.3 Comorbidity

Comorbid disorders are substance use disorders, such as tobacco use disorder, and anxiety disorders with panic disorder and obsessive-compulsive disorder the most frequent. Other medical conditions, such as diabetes, metabolic syndrome, and unhealthy behaviors, such as avoidance of cancer screening or training, increase the risk of a chronic medical disease. The suicide risk is soaring. 5–6% of persons with schizophrenia die by suicide, and 20% attempt suicide or have significant suicidal ideation [1, 13].

19.2.4 Etiological Psychological Models

19.2.4.1 Stress Vulnerability Model

A biological vulnerability (neurotransmitters) for psychosis is a stable element. When the person with this vulnerability copes with a high amount of stress, which cannot be dealt with, then a psychotic episode arises as a collapse in the context of stressful circumstances [14].

19.2.4.2 Information Processing Model

Information processing focuses on the perception of stimuli, processing of the information, preparedness of the reaction, and reaction-behavior towards a stimulus. Information will be perceived and then saved in working memory, in short-term memory, and, lastly, in long-term memory. After that, the person is ready to prepare himself to react behaviorally towards a situation [15]. As presented in this chapter, over 80% of individuals with schizophrenia show cognitive deficits or deficits in the above information process model.

19.2.4.3 The Behavioral Model

Operant conditioning explains the psychotic behavior. People learn from the consequences of their behavior and react to social situations.

19.2.4.4 The Cognitive Model

The integrative cognitive model of schizophrenia takes into consideration the biological vulnerability through the neurotransmitters and shows that the disorganization of cognitive functions contributes to symptoms of schizophrenia. Stress leads to reduction of cognitive resources, which means decreased capacity for reality testing, limitation of thought processing, and decreased cognitive reserves. This reduction of cognitive capacity leads to symptoms of schizophrenia, such as delusions and hallucinations, disorganized thinking, and negative symptoms [16].

19.2.4.5 A Neuropsychiatric Model of Four Factors

The four-factor neuropsychiatric model includes the biological model and the cognitive model of psychosis. The first factor (bottom-up) is related to the activation of dysfunctional beliefs and perceptions. The second factor (top-down) is associated

with the explanation of strange experiences logically. Cognitive distortions are activated. The third factor mediates and is characterized by cognitive distortions. Individuals jump to conclusions and show selective attention. Socio-cognitive deficits contribute to misunderstandings in their social interactions. The fourth factor is related to processes, which consolidate the delusion and beliefs about voices. Waiting for danger leads to alertness and safety behaviors. All this leads to stigma [17].

19.2.4.6 The Expressed Emotion Model

The high negative expressed emotion (critic, aggression, emotional overinvolvement) increases the vulnerability of the person with schizophrenia and specifically the possibility for relapses and rehospitalization [18].

19.3 Case Formulation

The above psychological models serve as a case formulation in therapy.

The main questions in the case formulation are the following: Is there any biological vulnerability? Is there any vulnerable and traumatic experience from the past which enhances the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

19.4 Interventions

The clinical high-risk state for psychosis is being recognized as a crucial stage for evidence-based interventions. It focuses on a pre-psychotic phase with prodromal symptoms, which must be treated with evidence-based pharmacotherapy and psychotherapy, in order to delay the route of psychosis [19–23].

The treatment of the first psychotic episode and its evaluation in the long term represent nowadays a crucial therapeutic goal. A long duration of untreated psychosis is associated with more symptoms and poor functional outcome and quality of life [22–25]. Evidence-based pharmacotherapy and psychotherapy, such as psychoeducation, CBT, and family interventions, present the treatments of choice for a first psychotic episode [22, 24, 25].

It is crucial to avoid a big interval in the duration of untreated psychosis. It is very important to implement evidence-based pharmacological and psychotherapeutic therapies as early as possible. A long period of untreated psychosis is associated with dysfunctional development, social isolation, suicidality, and violence.

A diagnosis of schizophrenia is given with certainty when two to three psychotic episodes have occurred in combination with the diagnostic criteria for schizophrenia in DSM-5.

CBT presents an effective as well as an efficacious intervention for schizophrenia, a chronic mental health disorder. It is very important to understand, according

to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen. CBT focuses on specific therapeutic goals and specifically coping with positive and negative symptoms, with disorganized behavior, and with comorbid disorders, such as anxiety and depression.

Pharmacotherapy is the main therapy for individuals with schizophrenia. Evidence-based psychotherapy is an adjunct to pharmacotherapy.

The therapeutic relationship with a chronic mental health disorder, such as schizophrenia, means that psychotherapists are available in the context of long-term therapeutic goals and interventions that a case formulation will explain this process and that psychotherapists try in every session to enhance the motivation for change and restart in life. The positive therapeutic relationship and alliance presents the appropriate conditions to implement the behavioral and cognitive interventions. Individuals with schizophrenia are often suspicious towards psychotherapy and psychotherapists, they have no insight towards the disorder, or they are not able to cooperate effectively as a consequence of cognitive dysfunctions. That means that the therapeutic relationship and alliance with these persons in combination with the interventions should help them step by step to participate in a structured and goal-oriented psychotherapy with increased insight towards the disorder and decreased suspiciousness.

A person with this disorder needs transparency and safety in the therapeutic process, so that dysfunctional cognitions and emotions can be expressed and dysfunctional and dangerous behaviors can be treated. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness and weakness and with increased control over psychosis, as well as with more optimism and quality of life in the long term. This context increases the possibility for a better reintegration into life.

The above therapeutic context is safe for also treating suicidal thoughts. People with schizophrenia who express suicidal thoughts or want to die by suicide are characterized by hopelessness, weakness, lack of problem-solving ability, lack of cognitive flexibility, and lack of control over psychosis. They feel very isolated from others. Therapy should give them the opportunity to express suicidal thoughts or thoughts about dying by suicide without stigma.

Finally, CBT helps suicidal patients with schizophrenia through the reattribution of the cognitive triad and through interventions, which enhance problem-solving ability and cognitive flexibility. Suicidality is the first priority in therapy. Collaboration with important people of individuals with suicidal thoughts and plans is pivotal for coping effectively with suicidality or precluding suicide.

Male, younger age, and being married are associated with increased risk for suicide in schizophrenia [13].

CBT presents an efficacious treatment for schizophrenia and treatment-resistant schizophrenia in improving positive and negative symptoms, general psychopathological functioning, and quality of life and in reducing the relapse rates [26–32].

A psycho-education on schizophrenia contributes to a reduction of relapses and to a better adherence to therapy [26].

Positive symptoms, such as delusions and hallucinations, are related to cognitive distortions, dysfunctional beliefs, and attention disorders. People think during delusions that all that happens is related to them (egocentric point of view) and they show safety behaviors, in order to avoid danger. Additionally, external factors are attributed to internal psychological and somatic features, and they also show dysfunctional reality testing [16].

People express by hallucinations dysfunctional beliefs about them regarding the fact that they are uncontrollable in the case of a negative relationship between the person and the voice. When the relationship between voice and the person is positive, it makes sense to the person [16].

CBT for delusions should focus on changing these beliefs with reattribution of factors, rational reality testing, and stopping safety behaviors. CBT in hallucinations should offer strategies to cope with them, such as distracting attention from them with other activities or confronting them, focusing on features of them. This process leads to the assumption that hallucinations are controllable.

Negative symptoms activate dysfunctional beliefs regarding their own social performance [16]. Changing of these negative beliefs in combination with rehabilitation and social skills training contributes to the improvement of negative symptoms.

Social skills and assertiveness training in persons with schizophrenia [33] via CBT are also recommended.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. Cognitive interventions can also restructure the beliefs and schema of possible comorbid disorders.

Persons with schizophrenia learn to cope with the above categories of problems and to gain more control over psychosis.

The duration of CBT for schizophrenia is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbidity disorders and should be implemented in the long term.

In the case of schizophrenia, it will be useful to evaluate whether this person suffers from grief as a cause of the disorder or from a post-psychotic depressive episode and to integrate that into the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Cognitive behavioral family therapy, which evaluates the family dynamic, reduces highly expressed emotions, such as critical comments or emotional overinvolvement in members towards people with schizophrenia, improving the communication between them and restructures the dysfunctional schema of the family members [34].

The above interventions can be combined with the individual CBT.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic mental health disorders, which enhances resilience and positive beliefs regarding progress in life [35].

ACT, Metacognitive Reflection and Insight Therapy, and MCT are effective and efficacious for schizophrenia [36–39].

AVATAR therapy presents a new brief therapeutic approach targeting auditory hallucinations. AVATAR is the digital representation of the voice. Individuals with schizophrenia interact with AVATAR, and the therapist changes his role as therapist and AVATAR. This interaction aims to gain more control over auditory hallucinations. This therapy is effective in reducing auditory verbal hallucinations [40].

Over 80% of individuals with schizophrenia show cognitive dysfunctions [4]. There are many evidence-based rehabilitation programs, which are available for coping with cognitive dysfunctions and vocational, residence, and leisure rehabilitation, which lead to a reintegration into society. Some of them focus only on the improvement of cognitive functions and symptoms, such as cognitive remediation therapy. The Neuropsychological Educational Approach to Cognitive Remediation enhances the learning skills and the motivation of the participants for learning. There are other rehabilitation programs, which are integrative, focusing on the improvement of cognitive functions, symptoms, social skills, and problem-solving abilities gaining a better result in functional outcome and a generalized therapeutic result, such as the Integrated Psychological Therapy and the Integrated Neurocognitive Therapy [41–44].

The Integrated Psychological Therapy presents an integrative, efficacious group cognitive behavioral rehabilitation program, which improves cognitive functions, positive and negative symptoms and general psychopathology, social skills, and problem-solving skills. It is based on the theory that elementary cognitive dysfunctions have a pervasive impact on high levels of behavior, such as social skills and functioning. It contains five subprograms: cognitive differentiation, social perception, verbal communication, social skills, and problem-solving skills.

This rehabilitation program displays an example of an integrative rehabilitation program for individuals with schizophrenia, which was implemented in Greece during the last years and is today an evidence-based program in the Greek health system, as a consequence of our research program regarding the efficacy of this program in the Greek population [42, 43, 45–49].

A training program in the Integrated Psychological Therapy was developed by our group for psychiatrists and psychologists, who are trained in CBT and who have clinical experience with patients with schizophrenia. This program is offered once a year in Greece by the authors, Dr. Stavroula Rakitzi and Polyxeni Georgila, M.D. Psychiatrist, since 2012 and lasting 1 year [42, 43, 45–49].

Individuals with schizophrenia who participated in the Integrated Psychological Therapy in our study describe the following impressions from their experience with this therapy: my concentration and memory were improved, I could express myself more fluently, and the training with pictures (social cognition) was kind. It activated my memory, and I liked the coexistence with other people in the group [42, 43, 45–49].

According to another interesting research study in Greece, IPT had positive effects on functional brain connectivity in executive and social function, in psychopathology, and in functioning, which was evaluated through resting-state functional magnetic resonance imaging [50].

The Illness Management and Recovery Program (IMR) presents an excellent example of an evidence-based program for people with chronic mental health disorders, such as schizophrenia. Psycho-education and CBT enhancing the adherence to therapy, social skills, the coping of resistant symptoms, and relapse prevention are the main elements of the program [50].

Persons with schizophrenia with a history of trauma show a poorer clinical course of the disorder. Trauma-focused interventions for people with chronic and severe mental health disorders in the context of CBT were not preferred. Experts believe that those interventions can lead to relapse. In the last years, many experts have been trying to cope with trauma in severe mental health disorders through cognitive restructuring without exposure [51]. EMDR presents an alternative for trauma therapy in schizophrenia [52]. Other researchers present no negative effects of trauma-focused interventions in persons with psychosis and schizophrenia [53].

In other words, trauma-focused interventions, such as exposure, in chronic severe mental health disorders, such as schizophrenia, are associated with a high possibility for a relapse. Cognitive restructuring presents a safer intervention. EMDR has been implemented in the last few years in schizophrenia. When trauma exposure in schizophrenia is implemented in individual CBT in the future frequently, it must be probably combined with intensive resource activation along with cognitive behavioral therapy in many contexts, such as couple and family.

In other words, evidence-based interventions for people with schizophrenia in the context of CBT and rehabilitation focus on specific therapeutic goals: positive and negative symptoms and general psychopathology, cognitive dysfunctions (neurocognition and social cognition), social skills, problem-solving skills, metacognitive capacity, functional outcome, and quality of life. Insight [54] towards the disorder and its consequences in life also displays a crucial therapeutic goal. People with high insight can show depression or grief in the short term.

On the other hand, it is fatal to understand the impact of schizophrenia on their lives in the long term. They can make a new restart in their life, which is more realistic and adaptive in their situation under the recovery perspective.

In other words, insight has a positive impact on people's reintegration into society in the long term, avoiding reduced adherence. Therefore, insight should be an important therapeutic goal in the context of the above interventions.

Enhancing the intrinsic motivation of persons with schizophrenia to participate in evidence-based psychotherapy also displays an important goal before the beginning of psychotherapy. Intrinsic motivation can also be increased via the implementation of evidence-based psychotherapy. People learn to cope with problems and disabilities as a consequence of their own willingness. This leads to the fact that life has a new common sense for these people!

Finally, it is crucial to cooperate with other experts, so that people with schizophrenia can participate in a program for better health and weight management.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for schizophrenia. Relapse prevention is a part of CBT, in which people should be trained. Rehabilitation improves cognitive dysfunctions, symptoms, and functioning. Recovery programs enhance goal-oriented the recovery process. AVATAR, recovery-oriented therapy, ACT, MERIT, and MCT are effective therapies. A better weight and health management also present an important therapeutic goal.

19.5 Discussion

Schizophrenia is a chronic mental health disorder which has a negative impact on the quality of life of people.

An effective cooperation between psychiatrists and cognitive behavioral psychotherapists presents an important circumstance, which enhances the effectiveness of the interventions.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as anxiety disorders, should be treated properly in cooperation with other health and mental health experts.

The stress vulnerability model, the cognitive model, the information processing model, and the highly expressed emotion model present evidence-based etiological models for this disorder, and they serve as a case formulation.

Positive and negative symptoms and general psychopathology, cognitive dysfunctions, insight, intrinsic motivation, functional outcome, and quality of life present major therapeutic goals in the context of evidence-based interventions.

Psycho-education, CBT, AVATAR therapy, recovery-oriented cognitive therapy, ACT, MCT, MERIT, and rehabilitation and recovery programs, such as the Illness Management and Recovery Program, present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, AVATAR, ACT, and MERIT for schizophrenia are essential.

The possibility of implementation of exposure to trauma in individuals with schizophrenia should be taken carefully into consideration in cooperation with the psychiatrist. Cognitive restructuring presents a safer method for coping with the trauma. EMDR has been implemented in the last years. Further studies regarding the efficacy of EMDR in trauma of individuals with schizophrenia are needed.

Persons with schizophrenia are hospitalized frequently, not voluntarily, during a psychotic episode. This kind of hospitalization is associated with transport to the hospital from the police. The above experience is very traumatic but sometimes necessary to avoid a suicidal attempt and reactivates other psychological trauma from the past. It is also fatal to implement all the above mentioned interventions, in order to follow an ambulant treatment for the long term and to avoid no voluntary hospitalizations.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in schizophrenia. People understand from the first session what is going on and how the therapy proceeds.

They understand that the only way to relieve themselves from psychotic episodes and symptoms as well as suicidality is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema in psychosis and through the improvement of cognitive functions.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the dysfunctional cognitive schema in psychosis. This safety context presents a procedure to cope with psychotic episodes and to learn to take early measures, so that relapse can be avoided.

Recovery from schizophrenia means that the person copes effectively with the psychotic symptoms and has improved his cognitive functions, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the majority of psychotic symptoms effectively at a cognitive and behavioral level. The person shows some difficulties in coping with hallucinations. Additionally, the person shows long-term grief as a consequence of this chronic disorder. The individual is functional in the daily routine, but needs more psychotherapy to cope with the psychotic elements and grief (recovery as a process).

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be preceded in the future (Fig. 19.1).

Schizophrenia is a chronic mental health disorder. People are regularly exhausted from the relapses with many psychotic episodes. All the above interventions contribute to coping with the episodes and suicidality, to the improvement of cognitive functions, and to the acceptance of the disorder. A reintegration into society via

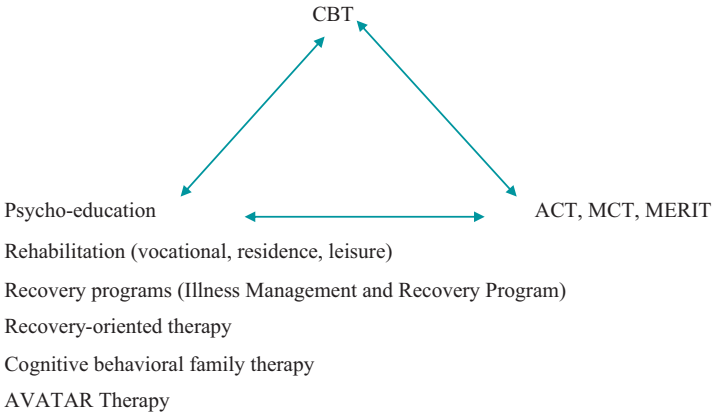

Fig. 19.1 The psychotherapy of schizophrenia

long-term ambulant recovery-oriented therapy and rehabilitation presents the most important goal. The protagonists in this context are the people who suffer from schizophrenia. Recovery-oriented pharmacotherapy, psychotherapy, and other interventions, such as healthy nutrition, exercise, and general health management, help people to be very active towards their mental health problems and to play a protagonist role in their own life, which belongs to them.

Interventions on many levels, such as people and family, are necessary to help people who suffer, to cope with this disorder, and to help their environment to accept a new reality and to develop a new path of life together with the person who suffers. A new dimension of life should be activated.

People with schizophrenia are confronted with the trauma of a chronic disease, which leads them to a possible danger of death. Evidence-based interventions, as they discussed above, train them to activate their resources to cope with this trauma and to be active and with autonomy towards disability. In other words, the trauma of a chronic disease is transformed into a big chance for a new restart in their own lives, for which they can be proud of themselves and mentors for other individuals who suffer from mental health disorders.

Research is going on. New therapies will be available to the scientific community, which can contribute in the future to new dimensions regarding the cure of schizophrenia. Experts, people who suffer, and their families should be optimistic and carry on with the recovery-oriented pharmacotherapy and psychotherapy.

19.5.1 A Case Study in Which IPT Was Combined with CBT Will Be Presented

19.5.1.1 Introduction

This study presents a case study, in which psychiatric treatment is combined with cognitive behavioral therapy and rehabilitation, which enhances the possibilities for an effective recovery of individuals with schizophrenia. The general hypothesis is that a combination of psychiatric treatment with evidence-based psychotherapeutic interventions leads to an improvement of neurocognition and social cognition, of symptoms, and of functional outcome. This is the first published case study, as far as is known, in which psychiatric treatment was combined with IPT and CBT. Advantages and disadvantages and future implications will be discussed.

19.5.1.2 Material and Methods

Compliance with Ethical Standards

This case study was approved by the ethical and scientific committee of the General Hospital G. Gennimatas in Athens, Greece, and has therefore been done in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. The patient has been given permission to use her data for the publication of this case study. Information that might reveal the identity of the subjects was removed. The author has complied with the APA ethical standards.

Case Presentation

Psychiatric Background and Psychological Problems

The 25-year-old patient was diagnosed as suffering from a schizophrenia disorder over the last 7 years according to DSM-5 (295.90 (F.20.9)). She fulfils some criteria of an avoidant personality disorder ((301.82) F60.6) and displays some criteria of a dependent personality (301.6, F60.7). Her total IQ [47] is 96 (90–102) (verbal IQ 112 (106–117) and performance IQ 79 (73–87)).

She had two acute psychotic episodes in the last 7 years, and in both cases, she was hospitalized by a public prosecutor through her family. The second hospitalization was in the psychiatric department of the General Hospital "G. Gennimatas" in Athens, where she stayed for 2 months.

During the acute psychotic episodes, she had hallucinations, delusions, disorganized behavior, and negative symptoms. She also refused to take her medicine. Furthermore, she suffered from persecutory delusions thinking that her father could harm her or abuse her and that the mother wanted to harm and manipulate her. She also shows many negative symptoms, such as social withdrawal and avolition.

She was born and raised in Athens. She performed well at school and went on to study physics. The individual described difficulties in performance during the first year at university, therefore interrupting her studies for 3 years. Furthermore, she began to be more active during the last year and aims to finish university studies. Her parents have been divorced for many years, and they have expressed highly negative emotions towards her.

Her mother, who is a 65-year-old, retired lawyer, suffers from another psychotic disorder, 298.8 (F28) (atypical psychotic disorder), and is under psychiatric treatment. The father, who supports her financially, is 70 years old and an active physician, who has been diagnosed with bipolar disorder II 296.89 (F31.81) and is also under psychiatric treatment.

The young woman grew up with her mother and grandmother until she was 18 years old and was confronted with conflicts between parents. As an adult, she has decided to live with her father due to his better social and financial conditions. She is not married and has no relationship with a partner.

Case Formulation

Dysfunctions in the processing of information, such as hallucinations or delusions in combination with dysfunctions in the arousal system and its regulation, lead to disturbances of perception and thought. Primary and secondary appraisals guide the interpretation of these experiences, giving them meaning and enabling the patient's reaction. This reaction leads to emotional, cognitive, and behavioral components and to low mood and anxiety in social situations. The long-term consequences of this appraisal include social isolation, low reinforcement, stigma, and disability. The cognitive model of negative symptoms presents a connection between neurocognitive impairment and emotional and behavioral deficits [16].

The psychopathology of her parents highlights a biological vulnerability. The tension and conflict between parents during childhood and adolescence show psychological vulnerability. These factors, in combination with the stress during the exams for university entrance and stress during the first year at university, increase the vulnerability, which explains how our patients under these stressful circumstances and a high biological and psychological vulnerability end up experiencing an acute psychotic episode. Her core beliefs are the following: "I am vulnerable, alone, weak and inferior in comparison to others." Positive symptoms and the cognitive beliefs that are associated with them reinforce suspicion and isolation, while negative symptoms and the cognitive beliefs that are associated with them reinforce isolation, stigma, social withdrawal, and avolition.

Psychiatric Treatment

The director of the psychiatric department and head of the psychiatric hostel of the psychiatric department, Mrs. Polyxeni Georgila M.D., was responsible for her psychiatric treatment and proposed that she should continue her therapy after a hospitalization of 2 months in the short-stay psychiatric hostel of the psychiatric department of the General Hospital G. Gennimatas, in which she stayed 7 months enhancing her autonomy in her daily routine and her rehabilitation and reintegration into society. The director offered psycho-education to the patient and her parents and organized interventions in the family, in order to minimize the high EE towards the patients.

Atypical antipsychotics have being given until the present time: olanzapine, aripiprazole, and sertindole. She is under monthly outpatient psychiatric treatment to date. Today, she is under aripiprazole. After the hostel treatment, she continued her therapy with CBT and IPT. The patient took aripiprazole during the implementation of CBT and IPT, and there has been no change in the medication.

Cognitive Behavioral Therapy

The patient participated in individual cognitive behavioral therapy [16]. The therapy was conducted once a week in 23 sessions from May 2015 to September 2016 by the author, Dr. Stavroula Rakitzi. In the first 12 sessions, the therapy focused on behavioral activation and social skills training, improving the negative symptoms, depression, and anxiety. In the next 11 sessions, the therapy was focused on the reattribution of delusions and dysfunctional attitudes, improving the positive symptoms, depression, and anxiety.

The improvement of positive symptoms in combination with pharmacotherapy was an important step in proceeding with the Integrated Psychological Therapy, a rehabilitation program focusing on the improvement of negative symptoms.

The Integrated Psychological Therapy

In this case study, the patient participated in the five subprograms of IPT in a group of four patients [42]. The therapy was conducted in 40 biweekly sessions from October 2015 to February 2016, by Dr. Stavroula Rakitzi. Each session lasted

60 min. The structure of these 40 sessions is the following: In the first 20 sessions, cognitive differentiation, social perception, and the first 2 levels of verbal communication were administered, focusing on the improvement of cognitive functions and verbal communication. In the next 12 sessions, the 3 levels of verbal communication and social skills were offered. Lastly, in the last 8 sessions, problem-solving was done.

Measures

Pre-treatment Assessment

All the measures were administered by a psychologist, who was a blind rater. PANSS was conducted by a well-experienced and a blind rater (M.D. degree).

Pre-treatment assessment was administered in May 2015. IQ was evaluated by the IQ test [55]. Neurocognition was evaluated through the Trail Making Test (TMT), Part A, which measures speed of processing [3] through the Letter-Number Span (LNS) [3] using the Greek translation [46], which measures the working memory, and through the Greek Verbal Memory Test measuring verbal memory [56].

Social cognition was evaluated by the Social Perception Scale [46], which measures social perception.

Positive and negative symptoms and general psychopathology were evaluated using the Greek version of PANSS [46].

Social skills were assessed through the Greek version of the German questionnaires FAF (fear of failure) and U (uncertainty questionnaire) [57, 58].

Functional outcome was assessed through the Greek version of the World Health Organization Quality of Life (WHOQOL) [46].

Post-treatment Assessment

The post-treatment assessment was conducted after the end of the implementation of CBT and IPT in March 2016 with all the above-described measures.

Follow-Up Assessment

The follow-up assessment was conducted in April 2018 with all the above-described measures.

Pre-treatment scores were compared to post-treatment and follow-up scores.

19.5.1.3 Results

The speed of processing has been improved after therapy and in the follow-up. Working memory remained at the same stable levels. Verbal memory was getting better after the therapy and in the follow-up. Social perception has improved after the therapy and in the follow-up. Positive and negative symptoms, the general psychopathology, and the total psychopathology were improved after therapy and in the follow-up (Table 19.1).

Social skills and competence were improved after therapy and in the follow-up. Specifically, fear of failure (FAF), fear of failure (U1), contact fear (U2), assertiveness (U3), and not say no (U4) were improved. Functional outcome and quality of

Table 19.1 Neurocognition and social cognition

Evaluation	TM	LNS	VM3	VM4	VM5	VM9	VMrec	SPSST (%)	SPSINT (%)	SPSTITLE (%)
May 2015 T0	53.76	17	10	11	11	12	12	38.8	75	50
March 2016 T1	44.12	17	14	15	16	16	16	74.6	83.3	100
April 2018 T2	38.12	17	14	15	16	16	16	85.6	85.6	100

TM Trail Making Test, *LNS* Letter-Number Span, *VM* verbal memory test, *SPS* Social Perception Scale, *SPSST* social perception stimulus, *SPSINT* social perception interpretation, *SPSTITLE* social perception title

life were improved in overall quality of life, in physical and psychological health, and in the environment after therapy and in the follow-up, whereas in the social relationships after therapy (Table 19.2).

19.5.1.4 Discussion

This is the first case report in which CBT was combined with IPT. The combination of the psychiatric treatment with CBT and IPT probably presents a very good example of a recovery-oriented therapy by people with schizophrenia. CBT enhances the improvement of symptoms, social skills, depression, and anxiety and functional outcome. IPT, on the other hand, improves cognition, symptoms, social skills, and problem-solving and functional outcomes.

The results show an improvement in neurocognition (speed of processing and verbal memory), social cognition, psychopathology (positive and negative symptoms, general psychopathology, and total psychopathology), social skills and competence (fear of failure, contact fear, assertiveness, and not say no), and quality of life (overall quality of life, physical and psychological health, social relationships, and environment).

The results of this case study are in accordance with studies regarding the efficacy of CBT and IPT, the combination of CBT with CRT [31, 42], and the importance of the implementation of long-term recovery-oriented cognitive behavioral psychotherapy [59]. The improvement of cognition, symptoms, social skills, and competence and of quality of life highlights the strengthening of the recovery process [60].

The introduction to recovery-oriented therapy gives hope and enhances the self-responsibility of the person towards schizophrenia.

Long-term recovery-oriented psychotherapies in the context of cognitive behavioral therapy present the appropriate therapy for individuals with schizophrenia. Psychotherapy for individuals with schizophrenia must be recovery oriented [59].

Table 19.2 Symptoms and quality of life, social skills, and competence

Evaluation	Panspos	Pansneg	Panssgp	Panstot	QOV	QPHH	QPSH	QSR	QEV	FAF	U1	U2	U3	U4	U5	U6
May 2015 T0	22	32	56	117	10	12.8	10.6	7.2	14.5	74	44	45	27	19	13	13
March 2016 T1	11	18	32	66	14	14.2	14	14	13.6	43	39	27	25	11	17	15
April 2018 T2	11	23	34	73	16	15.1	15.3	12.8	15.5	38	32	27	38	11	17	15

PANSS Positive and Negative Symptom Scale, *Panspos* positive symptoms, *pansneg* negative symptoms, *panstot* PANSS total score quality of life, *QOV* overall quality of life, *QPHH* physical health, *QPSH* psychological health, *QSR* social relationships, *QEV* environment, *FAF* fear of failure, *U* (uncertainty questionnaire): (U1, fear of failure; U2, contact fear; U3, assertiveness; U4, not say no; U5, guilt; U6, decency)

Experienced and well-trained experts are in demand for this complex rehabilitation. It is also probably difficult to keep patients for the long term in a very complex evidence-based rehabilitation, in which psychiatric treatment is combined with psychotherapeutic interventions.

This case report has its own limitations. We need longitudinal RCTs, in which the effectiveness and efficacy of psychiatric treatment in combination with CBT and IPT are investigated.

19.5.2 Metacognitive Training for Treatment-Resistant Schizophrenia: A Pilot Study

19.5.2.1 Introduction

Schizophrenia is a chronic mental health disorder. 30–60% of individuals with schizophrenia belong to the category of treatment-resistant schizophrenia. This category is associated with persistent positive and negative symptoms and cognitive dysfunctions, with high suicidality and more hospitalizations [9, 61].

Metacognitive training (MCT) presents a European and evidence-based treatment for individuals with schizophrenia and psychotic disorders [8], which should be implemented in Europe and other places in this world.

Evidence-based pharmacotherapy and psychotherapy in the context of cognitive behavioral therapy should be available to persons with mental health disorders. A democratic society has an obligation to make effective therapies available to people with chronic mental disorders.

The aim of private psychological and psychotherapeutic practice is the implementation of evidence-based psychotherapies in the context of cognitive behavioral therapy for people with mental health disorders and especially for schizophrenia [45–49]. MCT is to be integrated into this project. Therefore, a pilot study was carried out.

19.5.2.2 Material and Methods

Compliance with Ethical Standards

The study design was approved by the psychiatrists who treated persons with treatment-resistant schizophrenia in Athens, Greece, and was, therefore, performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki. All participants gave their informed consent prior to their inclusion in the study after the nature of the procedures had been fully explained. Information which might uncover the identity of the subjects was removed.

Study Population

Four outpatients with treatment-resistant schizophrenia, who were treated by different psychiatrists in private practice in Athens, took part in this pilot study. The psychiatrists cooperate with Dr. Stavroula Rakitzi and try to enhance their motivation

of these people for MCT. Dr. Rakitzi has also offered two individual sessions to each of the people to enhance the motivation and to take their informed consent. The medication was stable during the therapy and until the follow-up.

Study Design

This study included only an experimental group, the MCT group. Persons with treatment-resistant schizophrenia were assessed at baseline (T1) (September 2021), in the second phase 8 weeks after the intervention (T2) (December 2021), and in a follow-up after 3 months (T3) (March 2022).

Therapist

The MCT was applied by Dr. S. Rakitzi between October 2021 and December 2021, who has worked 19 years in private practice.

Intervention

MCT was performed according to the MCT manual [8]. The MCT group received 16 biweekly therapy sessions over 8 weeks, and each session lasted 60 min.

Measures

Intelligence was assessed in this pilot study at baseline by WAIS [55]. Positive and negative symptoms and general psychopathology were assessed by PANSS [62]. A blinded rater conducted the PANSS interview.

19.5.2.3 Data Analysis

SPSS version 13 was used. The Friedman test was used, and effect sizes were calculated [63–65] (Tables 19.3 and 19.4; Figs. 19.2 and 19.3).

Table 19.3 Characteristics of the patients

MCT (4)			
	M (SD)	t/chi. sq.	*p*
Age	31.25 (2.98)	20.93	0.00
IQ	88.00 (2.44)	71.85	0.00
Duration of illness	8.50 (1.00)	17.00	0.00
Medication			
(Chlor. equiv.)	467.50 (388.44)	2.40	0.09
Atypical (100%)	1.0 (0.00)	12.00	0.21
Sex (75% male)	1.75 (0.50)	4.00	0.26
Dropout			
(100% non-dropout)	1.0 (0.00)		
Marital status			
(100% not married)	1.0 (0.00)		

Clozapine, olanzapine, and risperidone were the medications of individuals with treatment-resistant schizophrenia

Table 19.4 Friedman test

MCT (4)						
			T1–T2		T1–T3	
	M (SD)	Mean rank	Chi. sq. (df)	*p*	Chi. sq. (df)	*p*
PanssP1	40.50 (2.38)	2.00	4.00 (1)	0.04	4.00 (1)	0.04
PanssP2	17.75 (2.50)	1.00				
PanssP3	17.25 (2.21)	1.00				
PanssN1	41.50 (3.00)	2.00	4.00 (1)	0.04	4.00 (1)	0.04
PanssN2	26.25 (3.30)	1.00				
PanssN3	26.25 (3.20)	1.00				
PanssGP1	69.25 (6.65)	2.00	4.00 (1)	0.04	4.00 (1)	0.04
PanssGP2	44.50 (2.51)	1.00				
PanssGP3	44.25 (2.50)	1.00				

PanssP positive symptoms, *PanssN* negative symptoms, *PanssGP* general psychopathology

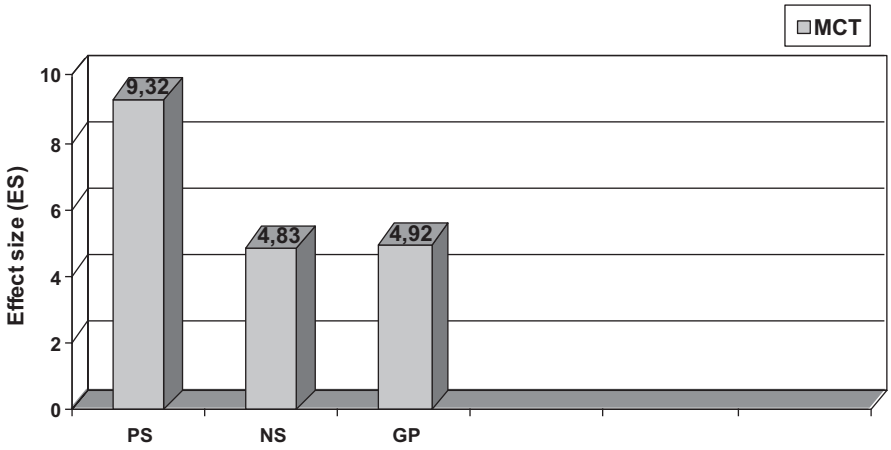

Fig. 19.2 Effect sizes in the therapy phase (T1–T2; 8 weeks): symptoms. *PS* positive symptoms, *NS* negative symptoms, *GP* general psychopathology

19.5.2.4 Results

19.5.2.5 Discussion

This is the first pilot study in Greece by a private psychological and psychotherapeutic practice, which evaluates the effectiveness of MCT in treatment-resistant schizophrenia.

The Friedman test showed significant improvements in positive and negative symptoms and general psychopathology after the therapy and in the follow-up. The effect sizes were very huge due to the small sample (Table 19.4, Figs. 19.2 and 19.3). The main hypothesis of this pilot study is answered. There was no dropout, which shows the acceptance of MCT by the participants. Participants reported that

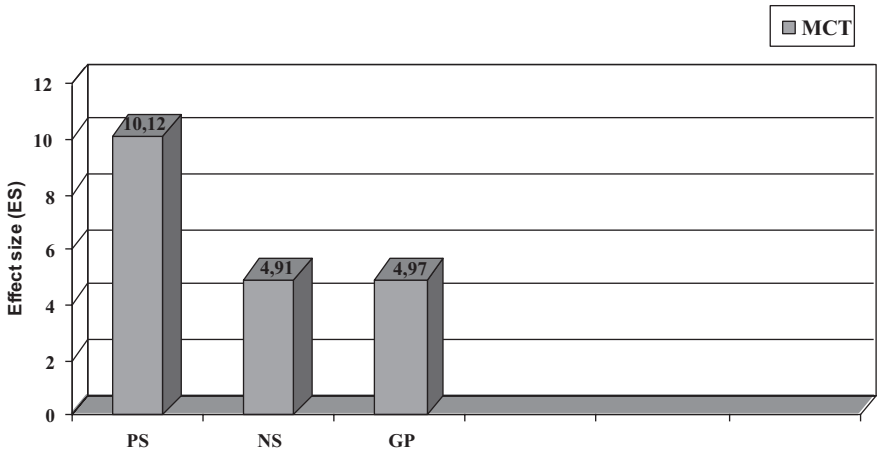

Fig. 19.3 Effect sizes in the therapy and follow-up phase (T1–T3; 5 months): symptoms. *PS* positive symptoms, *NS* negative symptoms, *GP* general psychopathology

MCT gave them a new point of view in their life and a new perspective, which leads to more optimism regarding coping with the disorder and their future.

The above results are in accordance with the studies regarding MCT [61].

Treatment-resistant schizophrenia needs more evidence-based treatments, which will be available to the people who suffer from it in public as well as in the private health system.

This pilot study has many disadvantages:

- The sample is very small.
- There is no comparison with a control group.
- Only symptoms were evaluated.
- The follow-up period was short.

Further, randomized controlled trials with larger samples, with the evaluation of more outcomes, such as functional outcome and a longer follow-up period are necessary to evaluate the efficacy of MCT in schizophrenia and in treatment-resistant schizophrenia in Greece and in other countries.

MCT can be implemented in treatment-resistant schizophrenia and in private practice.

I am grateful to Prof. S. Moritz for giving me the opportunity to implement MCT in Greece.

19.6 Conclusions

Schizophrenia presents a chronic psychotic disorder, which is associated with a high emotional and financial burden on people. Evidence-based treatments in the context of CBT and rehabilitation are available for this disorder and should be combined with each other in the future.

19.7 Revision Questions

1. How do you define schizophrenia?
2. Which comorbid disorders arise in schizophrenia?
3. What is the case formulation of this disorder?
4. Which evidence-based treatments in the context of CBT are available?
5. Describe the recovery process for this disorder.
6. What should be done in the future regarding psychotherapy for schizophrenia?

The author offers every year a seminar about the evidence-based treatments of CBT and its further development and of rehabilitation for schizophrenia for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists. The author offers yearly training in Integrated Psychological Therapy (schizophrenia) for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists in Greece. For more information, please see https://www.linkedin.com/in/stavroula-rakitzi-0b512b45/ and http://orcid.org/0000-0002-5231-6619 or email srakitzi@gmail.com.

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Delusional Disorder

20

20.1 Introduction

Delusional disorder is a chronic mental health disorder which has a negative impact on the quality of life of people in the long term.

This chapter will present the clinical characteristics of the disorder as well as the evidence-based interventions.

20.2 The Clinical Features of the Disorder

20.2.1 Diagnostic Procedure

According to DSM-5, the following criteria must be fulfilled: one or more delusions for 1 month or longer, such as erotomanic, grandiose, jealous, somatic, and persecutory (the person is being conspired, cheated, spied, followed, poisoned, or obstructed), the criterion of schizophrenia is never fulfilled, functioning is not markedly impaired, and the disorder is not explained through the effects of a substance or through a medical condition or through other mental health disorder, such as body dysmorphic disorder or obsessive-compulsive disorder. If manic or depressive episodes arise, they are brief in relation to the delusional periods. It should be specified whether the delusional disorder is bizarre or not. Bizarre means that the delusion is not at all logic or as a result of life experiences. A differential diagnosis should be made from obsessive-compulsive and related disorders, delirium, and major neurocognitive disorder and psychotic disorder due to substance abuse or to a medical condition, from schizophrenia and schizophreniform disorder, and from depressive, bipolar, and schizoaffective disorder [1]. The Simple Delusional Syndrome Scale (SDSS) presents a psychometric scale for this disorder [2].

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20.2.2 Epidemiology

The lifetime prevalence is 0.2%. It can arise in young and old adults [1]. It arises in 0.03–0.18% of the general population and in 0.4–4% of the clinical population [3].

20.2.3 Comorbidity

Suicidal behavior arises in delusional disorder in 8–21%, which is similar to schizophrenia [4]. Substance dependence, like alcohol and nicotine dependence, anxiety, and depression are comorbid disorders of delusional disorder [5].

20.2.4 Etiological Psychological Models

The stress vulnerability model, the cognitive model, and the expressed emotion model, as described in Chap. 15, present evidence-based etiological models for delusional disorder.

20.3 Case Formulation

The above psychological models serve as a case formulation in therapy.

The interaction between internal factors, such as biological factors, and external factors, such as stress, leads to psychotic experiences, such as delusions via arousal dysfunction and information processing dysfunction. This leads to primary and secondary appraisal of the psychotic experience with short-term consequences on emotional, cognitive, and behavioral level and with long-term consequences, such as isolation, disability, and stigma [6].

The main questions in the case formulation are the following: Is there any biological vulnerability? Is there any vulnerable and traumatic experience from the past which enhances the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

20.4 Interventions

CBT presents an effective as well as an efficacious intervention for delusional disorder, a chronic mental health disorder. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen. CBT focuses on specific therapeutic goals and specifically coping with delusions and with comorbid disorders, such as anxiety and depression.

Pharmacotherapy is the main therapy for individuals with delusional disorder. Evidence-based psychotherapy is an adjunct to pharmacotherapy.

A therapeutic relationship with a chronic mental health disorder, such as delusional disorder, means that psychotherapists are available in the context of long-term therapeutic goals and interventions, that a case formulation will explain this process, and that psychotherapists try in every session to enhance motivation for change and restart in life. The positive therapeutic relationship and alliance presents the appropriate conditions to implement the behavioral and cognitive interventions.

A person with this disorder needs transparency and safety in the therapeutic process, so that dysfunctional cognitions and emotions can be expressed and dysfunctional and dangerous behaviors can be treated. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness and weakness and with increased control over the psychotic symptoms, as well as with more optimism and quality of life in a long term.

The above therapeutic context is safe for also treating suicidal thoughts. People with delusional disorder who express suicidal thoughts or want to die by suicide are characterized through hopelessness, weakness, lack of problem-solving ability, lack of cognitive flexibility, and lack of control over psychosis and delusions. They feel very isolated from others. Therapy should give them the opportunity to express suicidal thoughts or thoughts about dying by suicide without stigma.

Finally, CBT helps suicidal patients with delusional disorder through the reattribution of the cognitive triad and through interventions, which enhance problem-solving ability and cognitive flexibility. Suicidality is the first priority in therapy. Collaboration with important individuals of people with suicidal thoughts and plans is pivotal for coping effectively with suicidality or precluding suicide.

CBT is efficacious for delusional disorder [7–12].

A psycho-education in delusional disorder contributes to a reduction of relapses and to a better adherence to therapy [13].

Delusions are related to cognitive distortions, dysfunctional beliefs, and attentional disorders. During delusions, people think that all that happens is related to them (egocentric point of view); they show safety behaviors, in order to avoid danger; external factors are attributed to internal psychological and somatic features; and they show also dysfunctional reality testing [14].

CBT for delusions should focus on changing these beliefs with reattribution of factors, rational reality testing, and stopping the safety behaviors.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema. Cognitive interventions can also restructure the beliefs and schema of possible comorbid disorders.

Persons with delusional disorder learn to cope with delusions and to gain more control over psychosis.

The duration of CBT for schizophrenia is up to 25 sessions, but it depends on the chronicity of the disorder and its comorbidity disorders and should be implemented in the long term.

It will be useful to evaluate whether this person suffers from a grief as a cause of the disorder and to integrate that in the therapy process.

A combination of individual and group CBT could enhance the recovery process.

Cognitive behavioral family therapy, which evaluates the family dynamic, reduces highly expressed emotions, such as critical comments or emotional overinvolvement in members towards people with psychosis, improving the communication between them and restructures the dysfunctional schema of the family members [15].

The above interventions can be combined with the individual CBT.

Relapse prevention is a part of CBT and presents strategy, which decreases the possibility of a relapse. Relapse prevention means that the person should take measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic mental health disorders, which enhances resilience and positive beliefs regarding progress in life [16].

ACT, Metacognitive Reflection and Insight Therapy, and MCT are effective and efficacious for delusional disorder [17–19].

Individuals with delusional disorder show cognitive deficits. Specifically, they show problems in attention and large threat perception. They reject information which doesn't approve the delusions, they show reasoning deficits, and they jump in that way to false conclusions. They also show attribution deficits, theory of mind (social cognition) deficits, and deficits in executive function [20]. Rehabilitation programs such as the cognitive remediation therapy or the Neuropsychological Educational Approach to Cognitive Remediation or programs, which focus on social cognitive deficits, could be a crucial intervention for the above cognitive dysfunctions of persons with delusional disorder [21].

Persons with delusional disorder with a history of trauma show a poorer clinical course of the disorder. Trauma-focused interventions for people with chronic and severe mental health disorders in the context of CBT are not preferred. Experts believe that those interventions can lead to relapse. In the last years, many experts have tried to cope with trauma in severe mental health disorders with cognitive restructuring without exposure [22]. EMDR presents an alternative for trauma therapy in delusional disorder [23].

In other words, trauma-focused interventions, such as exposure, in chronic severe mental health disorders, such as delusional disorder, are associated with a high possibility for a relapse. Cognitive restructuring presents a safer intervention. EMDR has been implemented in the last few years in psychotic disorders. When trauma exposure to delusional disorder is implemented in individual CBT in the future frequently, it must probably be combined with intensive resource activation along with cognitive behavioral therapy in many contexts, such as couples and family.

Dysfunctional beliefs and behaviors; comorbid disorders, such as anxiety and depression; cognitive dysfunctions; and the insight [24] into delusional disorder present the main therapeutic goals for delusional disorder in the context of CBT and rehabilitation. Insight into the disorder contributes to a better understanding of the origin and the consequences of the disorder.

In conclusion, CBT with behavioral and cognitive interventions presents an efficacious treatment for delusional disorder. Relapse prevention is a part of CBT, in which people should be trained. Rehabilitation improves cognitive dysfunctions, symptoms, and functioning. Recovery-oriented therapy, ACT, MERIT, and MCT are effective therapies.

20.5 Discussion

Delusional disorder is a chronic mental health disorder which has a negative impact on the quality of life of people.

An effective cooperation between psychiatrists and cognitive behavioral psychotherapists presents an important circumstance, which enhances the effectiveness of the interventions.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders, such as substance dependence, like alcohol and nicotine dependence, anxiety, and depression should be treated properly in cooperation with other health and mental health experts.

The stress vulnerability model, the cognitive model, and the highly expressed emotion model present evidence-based etiological models for this disorder, and they serve as a case formulation.

Psycho-education, CBT, recovery-oriented cognitive therapy, ACT, MCT, MERIT, and rehabilitation present evidence-based psychotherapies for this disorder. Further studies regarding the efficacy of recovery-oriented cognitive therapy, ACT, and MERIT for delusional disorder and its comorbidity are essential.

The possibility of implementation of exposure to trauma in individuals with delusional disorder should be taken carefully into consideration in cooperation with the psychiatrist. Cognitive restructuring presents a safer method for coping with the trauma. EMDR has been implemented during the last years. Further studies regarding the efficacy of EMDR in trauma of individuals with delusional disorder are needed.

Persons with delusional disorder can be hospitalized, sometimes not voluntarily. This kind of hospitalization is associated with transport to the hospital from the police. The above experience is very traumatic but sometimes necessary to avoid a suicidal attempt and reactivates other psychological trauma from the past. It is also fatal to implement all the abovementioned interventions, in order to follow an ambulant treatment in the long term and to avoid no voluntary hospitalizations.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in delusional disorder. People understand from the first session what is going on and how the therapy proceeds.

They understand that the only way to relieve from delusional disorder and its consequences as well as suicidality is to talk about that and to build a new coping mechanism through the reattribution of dysfunctional beliefs and schema in psychosis and through the improvement of cognitive functions.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the dysfunctional cognitive schema in delusional disorder. This safety context displays a procedure to cope with the delusions and to learn to take early measures, so that relapse can be avoided.

Recovery from delusional disorder means that the person copes effectively with the delusions and has improved the cognitive functions and the comorbid disorders, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person copes with the majority of delusions effectively at a cognitive and behavioral level. The person shows some difficulties in coping with one delusion. Additionally, the person shows long-term grief as a consequence of this chronic disorder. The person is functional in the daily routine, but needs more psychotherapy to cope with the psychotic elements and grief.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be carried out in the future (Fig. 20.1).

Delusional disorder is a chronic mental health disorder. People are regularly exhausted from the strength of the delusions. All the above interventions contribute to coping with the delusions and suicidality, to gaining more control over delusions, to the improvement of cognitive functions, and to the acceptance of the disorder. A reintegration into society via long-term ambulant recovery-oriented therapy and rehabilitation presents the most important goal.

Interventions on many levels, such as individual and family, are necessary to help people who suffer, to cope with this disorder and to help their environment to accept a new reality, and to develop a new path of life together with the person who suffers. A new dimension of life should be activated.

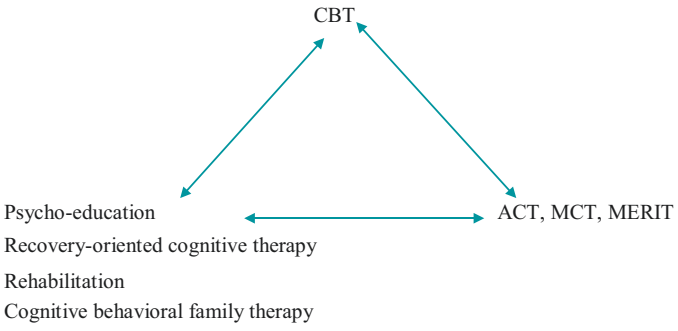

Fig. 20.1 The psychotherapy of delusional disorder

20.6 Conclusions

Delusional disorder is a chronic psychotic disorder, which is associated with high emotional burden for the individuals who suffer from it. Evidence-based treatments in the context of CBT and rehabilitation are available for this disorder and should be combined with each other in the future.

20.7 Revision Questions

1. How do you define delusional disorder?
2. What is the difference between schizophrenia and delusional disorder?
3. Which comorbid disorders arise in delusional disorder?
4. What is the case formulation of this disorder?
5. Which evidence-based treatments in the context of CBT are available?
6. Describe the recovery process of this disorder.
7. What should be done in the future of the psychotherapy of delusional disorder?

The author offers every year a seminar about the evidence-based treatments of CBT and its further development and of rehabilitation for psychotic disorders for clinical psychologists, psychiatrists, and cognitive behavioral psychotherapists. For more information, please see https://www.linkedin.com/in/stavroula-rakitzi-0b512b45/ and http://orcid.org/0000-0002-5231-6619 or email srakitzi@gmail.com.

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Part IX

Personality Disorders

Personality Disorders

21

21.1 Introduction

Personality disorders present a chronic mental health disorder, which has a negative impact on the interpersonal context and the quality of life of people in the long term. A personality disorder presents a pattern of behavior which begins early in life—in adolescence or early adulthood—is stable, and leads to stress and deterioration of functional outcomes in various areas of life.

Cluster A contains paranoid, schizoid, and schizotypal personality disorder with eccentric behavior in the foreground. Cluster B contains antisocial, borderline, histrionic, and narcissistic personality disorder with dramatic and impulsive behavior in the foreground. Finally, cluster C includes avoidant, dependent, and obsessive-compulsive personality disorder characterized by anxiety and fear.

This chapter will present the clinical characteristics of the personality disorders as well as the evidence-based interventions for them.

21.2 The Clinical Features of the Disorders

21.2.1 Diagnostic Procedure

Paranoid personality disorder is characterized by a general lack of trust and suspiciousness towards other people and the belief that other people are able to harm him/her, which began early in life. A differential diagnosis should be made from other mental disorders with psychotic features; from other medical problems, which change the personality; from substance use disorders; and from other personality disorders.

Schizoid personality disorder is characterized through isolation from others, lack of interpersonal relationships, and a restricted expression of emotions in the

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context of social relationships. A differential diagnosis should be made from other mental health disorders with psychotic features, from autism spectrum disorder, from medical problems leading to a personality change, from substance use disorders, and from other personality disorders. *Schizotypal personality disorder* is characterized by interpersonal deficits, isolation from others, eccentricity, and magical and paranoid thinking. A differential diagnosis should be made from other mental disorders with psychotic symptoms, from neurodevelopmental disorders, from medical conditions leading to personality change, from substance use disorders, and from other personality disorders. *Antisocial personality disorder* is characterized by a lack of respect towards the rights of other people and a lack of following social norms, through impulsivity and aggression. A differential diagnosis should be made from schizophrenia and bipolar disorder, from substance use disorders, from other personality disorders, and from criminal behavior without a personality disorder. *Borderline personality disorder* is characterized by instability and impulsivity in relationships, self-image, and emotions. They also show repeated suicidal behavior, identity disturbance, and chronic feelings of emptiness. A differential diagnosis should be made from depressive and bipolar disorder, from other personality disorders, from medical problems which lead to a personality change, from substance use disorders, and, finally, from identity problems [1].

Histrionic personality disorder is characterized by attention and emotionality seeking. They want to be the center of the attention; they show sexually seductive or provocative behavior in interpersonal relationships and dramatized expression of emotion. A differential diagnosis should be made from other personality disorders, from medical problems which lead to personality changes, and from substance use disorders. *Narcissistic personality disorder* is characterized by a grandiosity and lack of empathy. They show fantasies of success and power, they believe that they are special, they need admiration, they manipulate other people in order to achieve their goals, and they are arrogant. A differential diagnosis should be made from other personality disorders, mania or hypomania, and substance use disorders. *Avoidant personality disorder* is characterized through hypersensitivity towards criticism and negative evaluation and avoiding interpersonal relationships due to a fear of rejection. A differential diagnosis should be made from anxiety disorders, other personality disorders, substance use disorders, and medical problems, which lead to personality changes. *Dependent personality disorder* is characterized through needy behavior and fear of separation. They show decreased autonomy in taking a decision and increased dependency on relationships. A differential diagnosis should be made from other medical and mental disorders, other personality disorders, and substance use disorders.

Obsessive-compulsive personality disorder is characterized by perfectionism and control. They focus on details, rules, and organization; they work many hours and show stubbornness. A differential diagnosis should be made from obsessive-compulsive disorder, hoarding disorder, other personality disorders, substance use disorders, and medical problems, which lead to personality change [1].

The structured clinical interview for the DSM-5 Alternative Model for Personality Disorders Module I could be used as a psychometric interview for the evaluation of personality disorders [2].

21.2.2 Epidemiology

The prevalence of *paranoid personality disorder* is 2.3% and 4.4%; of *schizoid personality disorder* 4.9% and 3.1%; of *schizotypal personality disorder* 0–1.9% in clinical populations and 3.9% in the general population; of *antisocial personality disorder* 0.2–3.3%; of *borderline personality disorder* is 6% in primary care settings, 10% in outpatients with mental health problems, and 20% in inpatients in psychiatric departments; of *histrionic personality disorder* 1.84%; of *narcissistic personality disorder* is 0–6.2%; of *avoidant personality disorder* 2.4%; of *dependent personality disorder* 0.49%; and of *obsessive-compulsive personality disorder* 2.1–7.9% [1].

21.2.3 Comorbidity

Comorbid disorders and problems with *paranoid personality disorder* are brief psychotic episodes, interpersonal problems in intimate relationships, major depressive episodes, agoraphobia, obsessive-compulsive disorders, and substance abuse and other personality disorders, such as schizotypal, schizoid, narcissistic, avoidant, and borderline. Comorbid disorders and problems with *schizoid personality disorder* are brief psychotic episodes, major depressive disorder, lack of social skills and interpersonal relationships, occupational dysfunction, when interpersonal relationships play an important role, and other personality disorders, such as schizotypal, paranoid, and avoidant. Comorbid disorders and problems with *schizotypal personality disorder* are anxiety, depression, major depressive episodes, other personality disorders, and brief psychotic episodes. Some brief psychotic episodes may meet the criteria for schizophrenia, schizophreniform disorder, and delusional disorder. Comorbid disorders and problems of *antisocial personality disorder* are anxiety and depressive disorders, impulse control disorders, somatic symptom disorder, other personality disorders, unstable interpersonal relationships as a partner and a parent, and traumatic experiences in childhood, such as child abuse and unstable parenting. Comorbid disorders and problems of *borderline personality disorder* are depressive and bipolar disorders, substance use disorders, eating disorders, post-traumatic stress disorder, attention-deficit/hyperactivity disorder and other personality disorders, and psychotic symptoms during stress, job loss, not completed education, divorce or separation, and history of abuse, neglect, and early parental loss [1].

Comorbid disorders and problems of *histrionic personality disorder* are suicide, when they do not gain attention, somatic symptom disorder, conversion disorder, major depressive disorder, and other personality disorders. They cannot feel

intimate in sexual relationships, they seek immediate success, and they are bored with a stable routine. Comorbid disorders and problems of *narcissistic personality disorder* are persistent depressive disorder (dysthymia), major depressive disorder, hypomanic phases, anorexia nervosa and substance use disorders, and other personality disorders, and they react with high vulnerability in self-esteem towards critics. Comorbid disorders and problems of *avoidant personality disorder* are anxiety, depressive and bipolar disorders, and other personality disorders. They are very isolated and this could lead to occupational dysfunction. Comorbid disorders and problems of *dependent personality disorder* are anxiety, depressive and adjustment disorders, other personality disorders, chronic physical illness, and separation anxiety disorder in childhood. They react very negatively to criticism as proof of their inadequateness. Comorbid disorders and problems of *obsessive-compulsive personality disorder* are anxiety, depressive and bipolar disorders, and eating disorders. They may be furious as a consequence of losing control in a situation and need more time to make a decision [1].

21.2.4 Etiological Psychological Models

The cognitive model of Beck presents a very captivating model. Personality disorders are the result of an interaction between genes and the environment. Strategies and behaviors are the consequence of the activation of cognitive schemas and beliefs, which are the result of the abovementioned interaction. Beliefs and behaviors are expressed in all social contexts, are not flexible, and are resistant to change. Every personality disorder has a different cognitive profile regarding self and others, along with a specific behavior [3].

21.3 Case Formulation

The above cognitive models serve as a case formulation in therapy.

The main questions in the case formulation are the following: Is there any biological vulnerability? Is there any vulnerable and traumatic experience from the past which enhances the vulnerability in the present? Which trigger in the present activates cognitive and emotional vulnerability? What are the consequences of this activation at emotional, cognitive, and behavioral levels?

21.4 Interventions

CBT presents an effective as well as an efficacious intervention for personality disorders and their comorbid disorders. It is crucial to understand, according to the case formulation, the process of this disorder. Behavioral and cognitive interventions should be chosen. CBT focuses on specific therapeutic goals regarding the personality disorder itself and the comorbid disorders. Comorbid disorders, such as

anxiety and depression, should be treated as a first priority, in order to open the way for the psychotherapy of the personality disorder.

Pharmacotherapy should be combined with CBT.

The therapeutic relationship with a chronic mental health disorder, such as personality disorders, means that the psychotherapists are available in the context of long-term therapeutic goals and interventions, that a case formulation will explain this process, and that psychotherapists try in every session to enhance motivation for change and restart in life. The positive therapeutic relationship and alliance presents the appropriate conditions to implement the behavioral and cognitive interventions. A person with personality disorder needs transparency and safety in the therapeutic process, so that dysfunctional cognitions and emotions can be expressed and dysfunctional and dangerous behaviors can be treated. These elements will be expressed very intensively in the therapeutic relationship, which should be a new restart for a life free from hopelessness and weakness and with reattribution of the cognitive schemata of the personality disorder as well as with more optimism and quality of life in the long term.

The above therapeutic context is also safe for treating suicidal thoughts, which can arise from personality disorders. People with personality disorders who express suicidal thoughts or want to die by suicide are characterized by hopelessness, weakness, lack of problem-solving ability, lack of cognitive flexibility, and lack of control over their life. They feel very isolated from others. Therapy should give them the opportunity to talk about suicidal thoughts or thoughts about dying by suicide without stigma. Suicidality is the first priority in therapy. Collaboration with important individuals of the people with suicidal thoughts and plans is crucial for coping effectively with suicidality or preventing suicide.

Therapists should accept the psychopathology of each of the personality disorders without judging the phenomena as well as the consequences of them. Psychotherapists should train those people step by step to be goal-oriented and problem-focused in the daily routine, to learn to step back and rethink or restructure a difficult situation, avoiding dysfunctional and self-destructive behaviors. This procedure leads to a new relationship with yourself and others. Structured, goal-oriented with quality of life daily routine, enhanced motivation and cognitive flexibility should be the main principles of psychotherapy as a new model for life for a person with personality disorders. A new beginning in life is possible.

CBT presents an evidence-based treatment for personality disorders [4, 5].

A psycho-education in personality disorder via the case formulation [3] contributes to a reduction of relapses and to a better recovery in the long term.

Cognitive interventions lead to the identification of cognitive distortions and to the cognitive restructuring of thoughts, beliefs, and schema [3]. Cognitive interventions can also restructure the beliefs and schema because of possible comorbid disorders.

Assertiveness training enhances people with personality disorders to improve communication and assertiveness skills, such as anger expression, setting limits towards other individuals and situations, building relationships with other people, and being generally effective in interpersonal context [6].

Individuals with *paranoid personality disorder* don't trust other people, and they perceive themselves as vulnerable to mistreatment by others. They are always ready to cope with an attack from others and the affect is anger. People with *schizoid personality disorder* prefer isolation and autonomy, and they avoid intimacy. They perceive other people as controlled. The affects are sadness and anxiety. Individuals with *schizotypal personality disorder* perceive themselves as vulnerable, loner, and detached. They don't trust other people, and they are isolated. Sadness and anxiety are the main affects. Persons with *antisocial personality disorder* view themselves as autonomous, and they don't respect the limits of others. The affect is anger. People with *borderline personality disorder* see themselves as vulnerable to rejection, needy for emotional support, weak, out of control, and unlovable. They threaten when others reject them, and they deal with the tension between suicidality and self-destruction. Individuals with *histrionic personality disorder* evaluate themselves as impressive and try to seek attention. Others are good as long as they give their attention to them. They show dramatic behavior to gain attention. The affects are anxiety, anger, and sadness. Persons with *narcissistic personality disorder* see themselves as special and unique in comparison to others. They seek recognition from others. The main affect is anger [3].

Individuals with an *avoidant personality disorder* see themselves as incompetent and others as critical and uninterested. They avoid situations in which they are going to be evaluated. The main affects are dysphoria, sadness, and anxiety. Persons with a *dependent personality disorder* see themselves as needy, weak, and incompetent. Others are strong people who take care of them. They try to stay in dependent relationships and the main affect is anxiety. Individuals with *obsessive-compulsive disorder* see themselves as responsible for themselves and others. They are dependent on themselves to achieve a goal and they are perfectionists. Others are irresponsible and incompetent. The main affects are anger, depression, and disappointment [3].

Cognitive restructuring of the main schemata and beliefs; skills training; assertiveness training and problem-solving skills training; the reduction of impulsivity, isolation, and suicidality; and the increasing of autonomy, relaxation, and empathy present the main interventions for the above-described personality disorders [3].

Further studies regarding the efficacy of CBT in all personality disorders, but especially in paranoid, in schizoid, in schizotypal, in antisocial, in obsessive-compulsive personality, in histrionic, in narcissistic, and in dependent personality disorder, are necessary [5, 7–12].

The duration of CBT for personality disorders is over 50 sessions. It depends on the chronicity of the disorder and its comorbidity disorders and should be implemented in the long term.

It will be useful to evaluate whether this person suffers from grief as a cause of the personality disorder and to integrate that into the therapy process.

Relapse prevention is a part of CBT and presents a strategy which decreases the possibility of a relapse. Relapse prevention means that the person should take

measures when problems arise. That means the person alone should implement cognitive and behavioral interventions, in order to deal with possible dysfunctions. Alternatively, the person should ask for a follow-up psychotherapeutic session.

A combination of individual and group CBT could enhance the recovery process of people with personality disorders.

Trauma contributes to the development of a personality disorder [13]. Therefore, a resolution of a trauma can contribute to a better restructuring of the cognitive beliefs and schemata of the personality disorder.

When psychological trauma exists, trauma-focused interventions should be preferred, and they are safe for personality disorders [14].

Individuals with personality disorders show dysfunction in interpersonal relationships. Cognitive behavioral couple therapy [15] after individual therapy can enhance the recovery process.

Recovery-oriented therapy presents a new and a very promising evidence-based treatment for chronic mental health disorders, which enhances resilience and positive beliefs regarding progress in life [16]. It could also be implemented in treatment-resistant comorbid disorders of personality disorders in the future.

The alliance-focused training can help cognitive behavioral therapists build a better relationship with individuals with personality disorders. The dependence of the individuals who participate on psychotherapy was decreased, and their expressiveness was increased [17].

DBT is efficacious for borderline personality disorder [18]. MC Therapy [19], MBCT [20], and ACT [21] present efficacious treatments for comorbid disorders of personality disorders.

21.5 Discussion

Personality disorder presents a chronic mental health disorder, which has a negative impact on the quality of life of people.

An effective cooperation between psychiatrists and cognitive behavioral psychotherapists presents an important circumstance, which enhances the effectiveness of the interventions.

An appropriate diagnostic procedure along with a differential diagnosis will lead to the current diagnosis of this disorder. Comorbid disorders should be treated properly in cooperation with other health and mental health experts.

The priorities in the psychotherapy of personality disorders present a crucial issue. Psychotherapy of comorbidity disorders and suicidality is the first priority. The next step should be the psychotherapy of existing psychological trauma, which contributes to a personality disorder, and lastly, psychotherapy must focus on the dysfunctional cognitive schema and behaviors which are related to the personality disorder (Fig. 21.1).

The cognitive model of Beck for personality disorders presents an evidence-based etiological model, and it serves as a case formulation.

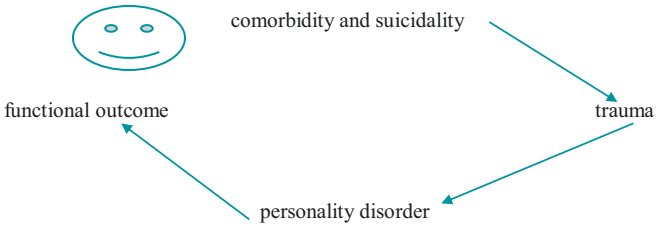

Fig. 21.1 The priorities in the psychotherapy of personality disorders

Psycho-education, CBT for personality disorders, recovery-oriented cognitive therapy, DBT, MC Therapy, MBCT, and ACT present evidence-based psychotherapies for personality disorders and their comorbidity. The alliance-focused training improves the skills of the therapists regarding a better therapeutic relationship with people with personality disorders. Further studies regarding the efficacy of CBT, of recovery-oriented cognitive therapy, and of DBT for personality disorders and their comorbidity are essential.

The psychotherapy of trauma via exposure to trauma and cognitive interventions in persons with personality disorders presents a safe strategy and could enhance the reattribution of cognitive beliefs which are related with personality disorders.

Persons with personality disorders can be hospitalized, sometimes not voluntarily. This kind of hospitalization is associated with transport to the hospital from the police. The above experience is very traumatic but sometimes necessary to avoid a suicidal attempt and reactivates the psychological trauma from the past.

It is also crucial to implement all the abovementioned interventions, in order to follow an ambulant treatment in the long term and to avoid no voluntary hospitalizations.

Relapse prevention serves as a protective mechanism towards mental health.

The above procedure proves the democratic nature of CBT in personality disorders. People understand from the first session what is going on and how the therapy proceeds.

They understand that the only way to relieve from the personality disorder and its consequences as well as suicidality is to reattribute the dysfunctional beliefs and schema in relation to personality disorders.

The therapeutic relationship and alliance is the appropriate context for transparency and safety and for decreasing the dysfunctional cognitive schema in personality disorders.

Recovery in personality disorders means that the person has reattributed the cognitive schema related to personality disorders and has improved the comorbid disorders and its functional outcome, which should be registered as well in the psychometric tests. The individual is functional (recovery as an outcome).

Recovery as a process presents the subjective evaluation of the psychotherapy in this disorder. For example, the person has reattributed the majority of the cognitive schemata effectively at a cognitive and behavioral level. The person shows some

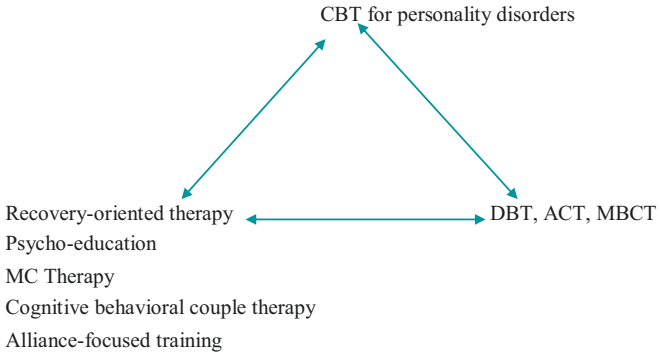

Fig. 21.2 The psychotherapy of personality disorders

difficulties in coping with one of the cognitive schema. Additionally, the person shows a long-term grief as a consequence of this chronic personality disorder. The person is functional in the daily routine, but needs more psychotherapy to change the cognitive schema and to cope with the grief.

A combination of the interventions, as described above, serves as a recovery model for this disorder. Research studies regarding the efficacy of this combination should be carried out in the future (Fig. 21.2).

Personality disorder presents a chronic mental health disorder. All the above interventions contribute to coping with the cognitive schema and dysfunctional behaviors, to gaining more control in the life, and to the acceptance of the disorder. A reintegration into society via long-term ambulant recovery-oriented therapy presents the most important goal.

Personality disorders, such as borderline, antisocial, and narcissistic personality disorder, are often confronted with legal problems due to criminal behavior, which means that they can be dangerous towards themselves and other people. The sooner psychotherapy begins, the better it is for the person who suffers and for society. A new reintegration into society with decreased criminal behavior presents a crucial therapeutic goal.

Interventions on many levels, such as person and couples, are necessary to help people who suffer, to cope with this disorder, and to help their environment to accept a new reality and to develop a new path of life together with the person who suffers. A new dimension of life should be activated.

21.6 Conclusions

Personality disorders display a chronic mental health disorder, which is associated with high emotional burden and problems in functional outcome for the individuals who suffer from it. Evidence-based treatments in the context of CBT are available for this disorder and should be combined with each other in the future.

21.7 Revision Questions

1. How do you define personality disorder?
2. Describe the main characteristics of cluster A (paranoid, schizoid, schizotypal), cluster B (antisocial, borderline, histrionic, narcissistic), and cluster C (avoidant, dependent, obsessive-compulsive).
3. Describe the differential diagnosis of each of the personality disorders.
4. Which comorbid disorders arise in each personality disorder?
5. What is the general case formulation of a personality disorder? How can the cognitive model of Beck explain the personality disorders?
6. Which evidence-based treatments in the context of CBT are available?
7. Describe the recovery process for a personality disorder.
8. What should be done in the future regarding psychotherapy of personality disorders?

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