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Recent Trends in Clinical Psychological Intervention (Methods based on other than Behaviour Therapy)

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Santosh K Verma &, A Shekhar Rao, - *Division of Clinical Psychology, Department of Psychiatry, Post Graduate Institute of Medical Education & Research (PGIMER), Chandigarh - 160 012, India*

Abstract

Clinical psychologists use a number of techniques to alleviate human suffering in patients with psychological / behaviour disorders. These methods include use of behaviour therapy - in isolation or in combination with other methods in a particular case. In this paper, however, an attempt is made to cover methods other than behaviour therapy that clinical psychologists frequently employ, particularly in our country. These include, Vipassana, Transcendental Meditation, Family Therapy, Group Therapy, Crisis intervention, Projective Psychotherapy, Religious Psychotherapy, Leisure Time Activities, using parents / teachers as cotherapists, etc. Recent changes in overall approach as well as in specific techniques are highlighted wherever considered necessary.

Key words -
Psychotherapy,
Psychoanalysis,
Yoga therapy,
Recent trends,
Leisure,
Family therapy

Clinical psychology is an applied branch of psychology, where in one deals with understanding, evaluation, treatment and prevention of mental health problems in the individual. There are a number of methods available which clinical psychologists use, can use and / or must use to alleviate human suffering due to these problems. Some of these methods are relatively older, while others are of more recent origin. Even with the older techniques, the relative emphasis on different aspects of the methods have undergone some important changes. In this paper, therefore, an attempt is made to elucidate these methods with the exclusion of behaviour therapy techniques.

It is not implied, however, that only clinical psychologists have used these techniques or, can use them. Other helping professionals also, with good knowledge, adequate training and sufficient practice of these methods can and should use them. After all it is the specific trainings which separate different professionals from one another - and nobody is, in fact, born as one or the other professional. Secondly, there is no bar using more than one group of therapeutic interventions (e.g. a combination of therapies may be tried) by the clinical psychologists, with any particular patient. Thirdly, with the recent re-emphasis on team approach and division of labour, more than one group of professionals may be simultaneously / successively / jointly involved in treating a patient with mental health problem (s). Fourthly, it needs to be remembered that some amount of overlap in methods is possible, for all concepts, definitions and classifications are, in the final analysis, arbitrary, human-made and for our convenience only. Lastly, the relative importance given to certain

constituents (e.g. therapist-patient relation, relaxation, interpretation, explanation, emotional / social / family support, etc.) may be different or, may be interpreted differently in different groups of intervention techniques and / or by different clinical psychologists, using the same techniques also.

The first contact

The role and importance of the very first contact between the therapist and the patient needs no emphasis. It plays a significant part in any psychological intervention and perhaps a greater part in those methods based on the techniques other than behaviour therapy. Surprisingly, it is only vaguely hinted at, never given due attention and / or documented fully and properly. The patients may even drop out of treatment - because of careless, poor, unconvincing, non-assuring - even anxiety producing and highly unsatisfactory first contact. The patients and their relatives are also, more likely than not, to give different reasons for their dropping out of treatment, at different stages but consciously or unconsciously, this factor plays an important part in arriving at any such decision. The first contact needs to be given proper attention, be carefully planned and well executed. The skill to make full use of this opportunity to motivate the patient to take and continue with the psychological intervention, needs to be developed. After all any intervention does not start by saying "one, two, three".....and "start" and it starts. The patients need to be psychologically prepared for it at the very first contact-otherwise the patient, even if not dropping out of treatment - may be unnecessarily biased against a treatment modality yet to be introduced to him.

This, though over lapping with rapport building (on which there is some limited literature available), is not the same thing. The first contact may be satisfactory, even if no special effort at establishing good rapport, is made. Or, alternately, the first impression may be poor but is changed with patience and conscious effort, by the therapist. A desirable first contact may consist of the congenial overall atmosphere (in the waiting room, as well as the therapist's humane approach), the accepting tone, the warm look, the cordial talk with other patients, as well as the understanding shown by the therapist, in the presence of the patient, for a successful psychological intervention, it is as if the battle is already half won. A good beginning is made, which makes what follows a little less intolerable, if not more acceptable and pleasant - and may make all the difference between a sucessful and a not so successful psychological intervention.

Intervention based on providing necessary information

We all need basic information about something that worries us at any given time. It may be

(a) about some harmless thing like information about travel routes, regulations, visiting places, people, etc. or,

(b) about specific illness from which we or, our loved ones may be or, are in fact suffering, or

(c) about future course of treatment / facilities available / treatment cost / precautions required, etc. - the latter may be more anxiety producing.

Needless to say having the information helps while not having it creates uncertainty, anxiety, worry, stress, at times fears and apprehensions particularly in those already predisposed.

Besides the information and guidance manuals for different disorders like schizophrenia, epilepsy, mental retardation, stammering, depression, etc., - some even separately for psychologists, teachers, parents, physicians, health workers, etc. - specific manuals have also been developed for the purpose of using the available community resources (like parents, teachers, community health workers and interested laymen / self help groups alcoholic annonymous, etc.) are also made available [1]. Recently Mental Health Division of World Health Organisation, Geneva has brought out a number of Behaviour Science Learning Modules like "Communicating bad news". "Preparation for invasive procedures". "Introducing parents to their abnormal babies". Promoting non-pharmacologic interventions to treat elevated blood pressure". "Psychological intervention for patients with chronic back pain". "Self-management of recurrent headache", "Improving adherence behaviour with treatment regimes", etc. providing useful guidelines for handling such problems.

The questions again may be asked :-

a) What information is necessary ? (Right to have full information versus possible harmful effects from any such information e.g. terminal illness, still birth, death, accident, etc.).
b) What information may be withheld ? (Patient not yet ready for it ?).
c) When it should be given ? (Immediately versus preparing the patient beforehand).
d) By whom it should be given ? (Doctor / Psychiatrist / Psychologist / Social Worker / Family).
e) To whom it should be given / (Patient Family / Friend / Court).
f) To whom it should not be given / (for divorce cases / employers).
g) In what doses it should given / (all at once versus slowly in easily digestible forms).

There are no easy answers to them.

Views might differ among the mental health experts (clinical psychologists) as well as among family members / legal experts etc. In a particular case. A clinical psychologist often has to take a decision soon and act accordingly, in the best interest of his patient (s), with all good intentions.

Experience shows that at times mere giving of informations may not be sufficiently helpful. Discussion with the family, other such sufferers, sharing their experiences is often helpful if conducted under the guidance of a trained clinical psychologist [2]. Shailaja [2], for example found group discussion following the providing of information quite helpful in reducing menstrual distress in pubertal girls.

Psychoanalysis and short term dynamic psychotherapies

There are very few, if any, clinical psychologists in India who are using purely Freudian psychoanalysis - saturated and unadulterated - without some modifications. While some clinical psychologists are almost allergic to it - many go for short-term, focussed, dynamic psychotherapy or, an eclectic therapy with different degrees of utilization of dynamic principles as advocated by Freud, Post Freudians, Neo-Freudians, with additions / modifications of their own. Shorter, briefer and focussed models are there, more so in actual practice although published material is limited - almost negligible, in this area and any hard data on it is really hard to get now-a-days [3].

Cultural influences: Conventional Western-model psychotherapy is based on a number of premises, regarding its rationale and techniques, the universality of which is being questioned and challenged with greater emphasis on a flexible approach taking into account the socio-cultural reality. Some of these cultural variables have been identified as : Dependence, Attachment, Autonomy, Social distance,

Concept of Sin, Belief in karma, Dharma, Reincarnation, Guru-chela relationship. Detached observation, Prayers, Recitation of Gurbani, etc. Indian introspectionists have produced a rich harvest of profound psychological insights which need to be incorporated into psychotherapy with our patients. e.g. "Nirvana" (burning out of passions, mental impurities), "Moksha" (freedom from conditioning constraints of all types), "Sahaja" (one's nature born with oneself), "Yoga". "Meditation", Samadhi", "Atman", "Maya", etc. Use of Indian myths, legends, fairy tales and folk practices have been discussed and used in their eclectic approach [3]. Guru-Chela (Teacher-taught) relationship has been postulated by Dhairyam, further elaborated by Neki and Varma [4]. It culcates a close relationship, a sense of belonging, identification and involvement as well as pins down responsibility on the Guru (teacher) for the success of training. Combining the Eastern and Western psychotherapy in his own way, Dosajh [5], has reported good results with his eclectic approach emphasizing the importance of establishing good rapport with the patient, using psychoanalysis with the help of projective tests and in depth interviews, followed by psychosynthesis using various methods of yoga, analysis, and even shock therapy, drug therapy, group therapy, occupational therapy, recreational therapy, music therapy, biblio therapy, environmental manipulation, etc. with the help of experts in each area (e.g. psychiatrist for E.C.T. and drug therapy). Shilpa et al [6]. have reported good results with psychosocial treatment (occupational therapy) combined with drug in drug addicts. Eastern techniques such as Agnihotra have been found to be effective in maintaining abstinence in alcohol dependence [7], and in heroin addiction [8]. Transcendental Mediation has been reported useful in reducing anxiety [9].

Religious psychotherapy: Finding western psychotherapy based on Freudian psychoanalytical concepts as untenable in non-western cultures, many have turned to what could be termed as "Religious psychotherapy" [10]. In this practical and useful alternative to traditional psychoanalytical therapy, use is made of religious concepts deeply engrained in one's culture to help the patients get over their problems. The methods can be many and varied. For example, "Karma" is a Hindu philosophical viewpoint, the essence of which is that work should be done for the sake of doing as a duty and not for result(s) which may be effected by the large number of uncontrolled factors - as described in "Gita" - an ancient Hindu document and a "master-piece in psychotherapy [11]. A Guru-Chela model is more acceptable and effective to many Indian patients although the role of a Guru is more difficult than that of a western psychotherapist. The message of Gita was delivered in the battlefield of Mahabharat by Lord Krishna (a master healer and true Guru) to Arjun (symbolically the patient) to "arise" meaning arousal from 3 states of activity - from ignorance to knowledge, from apathy to positive feeling and from inertia to purposeful activity (representing the cognitive, affective and conative aspects of the mind). Work (duty) is yoga (worship) which needs to be carried out for its own sake.

Similarly the religious concepts of death, rebirth / reincarnation / avtar, nirvana, moksha etc., are utilized to foster a death acceptance view in terminally ill patients and the bereaved families. Catholic charismatic healings have been reported. Praying, recitation form religious books (Gita, Koran, Bible, Ramayana, etc) have been found useful to bring peace and solace to many.

Sometimes doubts have been expressed about the possible harmful effects of religious psychotherapy in cases with psychosis, mental retardation and personality disorders [10].

Yoga techniques: Yoga is a system by which a person can enhance his physical and mental abilities so that he can develop a deeper insight into the meaning of existence. It was mainly meant for spiritual

aspirants but recently yoga has been recognized world wide as a treatment procedure. The first written treatise on Yoga dates back to 5 BC and Patanjali Yoga Sutra has eight steps :
(1) Yama (Rules for morality such as non-stealing, non converting, truthfulness, non-violence) :
(2) Niyama (Rules of Self-discipline such as purity, austerity, study of scriptures, continence);
(3) Asana (Postural patterns);
(4) Pranayam (Regulated breathing);
(5) Pratyahar (Withdrawal of senses from external objects);
(6) Dharana (Effortful concentration);
(7) Dhyana (Spontaneous concentration);
(8) Samadhi (State of super consciousness in which there is oneness with object of concentration).

The first two steps guide passions and emotions and keep man in harmony with others in society: the third keeps body healthy and strong; the fourth stills the restless minds; - all these are "outer" quests of yoga, while the last four constitute the "inner" yoga which keeps man in harmony with himself and his creator.

The methods of yoga, however, are not standardized and the practices of different yoga centres are not uniform. Different approaches are based on personal experiences of yoga teachers. "Yoga packages" have been developed and found useful in different studies and groups which include patients with naso-branchial allergy, psychoneuroses, psychogenic headache, diabetes, depression, drug addicts, hypertensives, etc. as well as normals [6], [12], [13], [14]. As opposed to drug these yoga packages are inexpensive, easily accessible, devoid of side effects and useful in preventive and promotive roles.

Vipassana: Vipassana mediation is a scientific technique of self-observation, a system of self-transformation by self-exploration, a healing by observation of an participation in the Universal laws of nature. Also known as Awareness, Mindfulness Mediation, Insight, etc. Vipassana is an ancient Indian meditation technique rediscovered by Gautama the Buddha about 2500 years ago. It is Pali term which means "insight" - seeing things as they really are and requires residential course under a ;qualified teacher. To begin with, one has to take a vow of observing certain rules of moral conduct (SILA) - e.g. abstention from killing any sentinent being, stealing, sexual misconduct, telling lies, and taking intoxicant. This first step itself is likely to bring about positive changes in one's life style. It is followed by Anapana (awareness of respiration). The individual observes the natural flow of incoming and outgoing breath, just breath. Then the mind gets concentrated on the neutral activity and the person assumes greater control over his mind. It promotes the awareness of present moment and equanimous observation, since the act of breathing is free from any craving, or aversion. The third step is Panya, i.e. purification of mind through enhanced awareness. The individual engages himself in choiceless and effortless observation of body sensations and tries to develop an attitude of non-judgement and non-reaction. This is supposed to have corrective influence on psychic disturbances (anger, fear, insecurity, passion, sadness). People from different backgounds-psychiatric patients, prisoners, normals - all have found it of practical, useful value in their lives. Improvements - both in negative mental health (reduction of anxiety, depression, helplessness, etc.) as well as in positive mental health (well - being, hope etc.) have been reported [15]. It has been found effective in the management of headache, chronic pain, bronchial asthma, hypertension, peptic ulcer, psoriasis, etc. [16], [17]. In fact it is a way and means to self-actualization / self-realization.

Homeostasis Reality Therapy (HRT): HRT is a new school of psychotherapy rooted in Indian psychology and culture [18]. According to this theory 59% intensity of dominant positive emotions

(courage, gain, reality and justice) and 50% intensity of dominant negative emotions (fear, loss anger and guilt) are essential for the survival and self-actualization. The reason for all the stress induced disorders (like tension, headache, essential hypertension, low back pain, etc.) are according to this theory, caused by disequilibrium between two group of emotions of the individual. The disequilibrium is experienced as problems and by way of problem diffusion technique, it is possible to restore an equilibrium or homeostasis by re-experiencing these events in present time while modulating alpha waves in the brain. The individual is thus freed of his problems.

Projective Psychotherapy: Although known to be in use in earlier days also, the newer projective techniques, particularly the Somatic Inkblot Series (Booklet, Card, Video forms) are increasingly being used as a powerful media to take the person back in time, creating hypnotic like effect, helping the person in catharsis, using responses through content analysis and psychoanalytic interpretations, thus proving them to be an effective therapeutic tool to release somatised grief [19], unprocessed unconscious material in transexuals [20], in depression and panic attacks [21], in coronary cases [22], etc.

Creataive use of leisure: Intelligent and creative use of leisure has been variously described and recommended as a "human right", "mother of philosophy", "best of all possession", "supremely desirable object of all sane and good men", "the final test of civilization", "the best product of civilization", etc. [23], [24]. A man is known by the company he keeps, the books he reads, the occupation he selects, the habits / hobbies he develops - as well as the way he spends his leisure time. Recreation is one form of such activities. We often hear of "laughing meditation", and its effects on mental health. Also though less known, is the "pleasure neurotic" - the one who is lost if he has no work to do. There is a deep fear of relaxation / leisure that he must remain in harness as long as possible - a kind of "work-addict". We infact all need some leisure to do things we want to do, to enjoy pleasures of life. It is good for our mental health. Even the handicapped persons have a lot to benefit from leisure activities, be it those with serious physical illness, addicts, delinquents, criminals, mal-adjusted, old or mentally handicapped [24].

Family therapy: Family therapy was started in the 1950's at Amitsar, India - at about the same time that it was initiated in the west [25]. Later it was taken up at Vellore and Bangalore. The experience shows that involvement of families cuts down hospital stays, increases acceptance of the patients and enhances family copings. It has been found effective in the management of patients with schizophrenia, with alcohol and drug addiction, those with marital and sexual problems, with mentally retarded children and to a lesser extent with personality and conduct disorders. Often it is combined with individual psychotherapy and drug therapy. However, it has not made much progress : most of the studies used inadequate methodologies, mainly conducted in urban or semi-urban population and often without any controls: using either no tools or very inadequate ones: hardly any research has made efforts to define the concepts: and most of the studies have used very rudimentary method for statistical analysis [25]. All this is inspite of the fact that the need and importance of involvement of family members is well recognised and accepted by the practising clinical psychologists in the treatment of persons with mental disorders, in different settings like child guidance clinics, welfare agencies, hospitals, family courts and private practice [26].

Crisis intervention: In order to help the subjects to cope with the psychological distress, mainly of sudden origin, a brief psychotherapy such as "crisis intervention" have been used effectively. Crisis may be due to a loss (e.g. of vision, of hearing, death, financial loss, serious illness, accident, still

birth, a major surgery, etc.) which may be real or imagined. The minimum therapeutic goal of crisis intervention is psychological resolution of the individual's immediate crisis and restoration of at least the level of functioning that existed before the crisis period. It has been effectively used to reduce death anxiety, depression, enhance sense of well-being in head and neck cancer patients [27], menstrual distress in adolescent girls [2], sudden loss of vision (T.B. Singh, NIVH, Dehradun, personal communication), etc....

Other methods: These include use of hypnotherapy in cases of psychogenic impotence [28], sex counselling in cases of masturbatory guilt [29], after care programs (including alcoholic anonymous) following detoxification [30], etc.

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