Psychotherapy in Contemporary Psychiatry: an essential treatment

Prof Anthony W Bateman
Hon Professor in Psychotherapy University of Copenhagen

Psykoterapeutisk Center Stolpegård March 2014
Psychiatry is Psychotherapy

- Neurobiology, psychology, social cognition and relationships interweave to disrupt mental processing
- Mental Disorders require complex treatment to optimize outcome
- The person of the treater is essential
- Psychiatry is a relational enterprise
Psychiatry and Psychotherapy: an illusory division

- Psychiatry
  - Biological
  - Psychological
  - Social
  - Cultural
- Symptoms, syndromes, Diagnosis
- Mental Illness
- Medication

- Psychotherapy
  - Talking – indiv, group, family
  - Relationships
  - Emotions
  - Cognitions
- Psychological processes
  - Less diagnostic and more dimensional
The Nature of Attachment: Challenges the myth that biology separates psychiatry and psychotherapy.
The mesocorticolimbic dopaminergic reward circuit in addiction process
1. Medial prefrontal cortex

- Mentalising proper
  - Implicit ability to infer mental states such as beliefs, feelings and desires

Fletcher et al., 1995; Gallagher et al., 2000; Gilbert et al., 2006 (meta-analysis)
The social brain

2. pSTS/TPJ

- Prediction
  - Biological motion, eye gaze
- Perspective-taking
  - Different physical points of view

Pelphrey et al., 2004a,b; Kawawaki et al., 2006 (review); Mitchell 2007
The social brain

3. Amygdala
   - Attaching reward values to stimuli
     - ‘Approach’ vs. ‘avoid’
   - Facial expressions

The social brain

4. Temporal poles

- Social scripts, complex event knowledge

Funnell, 2001; Damasio et al., 2004; Moll et al., 2001, 2002, 2005 (review)
Shared neural circuits for mentalizing about the self and others (Lombardo et al., 2009; J. Cog. Neurosc.)

- Self mental state
- Other mental state
- Overlapping for Self and Other
<table>
<thead>
<tr>
<th>Study</th>
<th>Diagnosis</th>
<th>No. of patients</th>
<th>Imaging method</th>
<th>Treatment</th>
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<tbody>
<tr>
<td>Baxter⁶</td>
<td>OCD</td>
<td>18</td>
<td>FDG-PET</td>
<td>BT vs fluoxetine</td>
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<td>Martin⁴</td>
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<td>IPT vs venlafaxine</td>
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<td>Furmark¹¹</td>
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<td>¹⁵O-PET</td>
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<td>Paquette¹²</td>
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<td>fMRI</td>
<td>CBT</td>
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<td>Goldapple⁶</td>
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<tr>
<td>Praško⁹</td>
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<td>fMRI</td>
<td>CBT vs fluvoxamine</td>
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<td>Sakai²⁰</td>
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<td>CBT</td>
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<td>fMRI</td>
<td>DBT</td>
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<td>Schnell¹⁵</td>
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<td>DBT</td>
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<td>Laj¹⁶</td>
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<td>SPECT</td>
<td>PDT</td>
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<td>Felmingham¹⁴</td>
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<td>19</td>
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<td>PDT vs waiting list</td>
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<td>Apostolova³¹</td>
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<td>Karlsson¹⁷</td>
<td>MDD</td>
<td>9</td>
<td>WAY-PET</td>
<td>Short-term PDT vs fluoxetine</td>
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</tbody>
</table>

OCD, obsessive-compulsive disorder; FDG-PET, [18F]-fluorodeoxyglucose positron emission tomography; BT, behavior therapy; CBT, cognitive-behavioral therapy; MDD, major depressive disorder; HMPAO-SPECT, ⁹⁹mTc–hexamethylpropyleneamine oxime single photon emission CT; IPT, interpersonal psychotherapy; ⁹¹O-PET, oxygen-15 positron emission tomography; Xe-CT, xenon-enhanced CT; BT, behavioral therapy; fMRI, functional MRI; PD, panic disorder; DBT, dialectic behavior therapy; BPD, borderline personality disorder; SPECT, single photon emission CT; PDT, psychodynamic psychotherapy; PTSD, posttraumatic stress disorder; WAY-PET, positron emission tomography using [carbonyl-11C] WAY-100635.
Effects of dialectic-behavioral-therapy on the neural correlates of affective hyperarousal in borderline personality disorder


Fig. 3  Differences of BOLD responses to a priori categorized high arousal negative stimuli between BPD-patients and controls before (t 2) and after (t 5) DBT-treatment assessed by two sample t-tests (p = 0.005, k = 20, uncorrected). Anterior Cingulate, temporal and posterior cingulate, and left insula
Effects of dialectic-behavioral-therapy on the neural correlates of affective hyperarousal in borderline personality disorder

Knut Schnell, Sabine C. Herpertz  

Decreased modulation of regional activation through stimulus-related arousal in five sequential sessions before, during and after DBT treatment assessed by repeated measures ANOVA. Left: all patients (n = 6, p = 0.001, k = 10, uncorrected). R...

Responders Left Amygdala and hippocampi
Baron-Cohen’s (2005) model of the social brain

The Emotion Detector
- Left inferior frontal gyrus
- Mirror neurons

The Intention Detector
- Right medial prefrontal cortex
- Inferior frontal cortex
- Bilateral anterior cingulate
- Superior temporal gyrus

Eye Direction Detector
- Posterior superior temporal sulcus

Shared Attention Mechanism
- Bilateral anterior cingulate
- Medial prefrontal cortex
- Body of caudate nucleus

The Empathising System
- Fusiform gyrus
- Amygdala
- Orbio-frontal cortex

Theory of Mind Mechanism
- Medial prefrontal cortex
- Superior temporal gyrus
- Temporo-parietal junction

EMOTION UNDERSTANDING ↔ BELIEF-DESIRE REASONING
Functions of attachment

- Physical survival
  - **Protection of life**, then of brain development

- Emotional survival
  - **Feeling loveable**, interesting → turn to world
  - **Stress regulation**, being able to tolerate self and others

- Cognitive survival
  - **Capacities** – attention/focus, social skills and trust, curiosity: exploration and engagement with learning
What does research show us about the importance of this early relationship?

- Regulation of the brain system – emotion regulation
- Sense of security – distress will be met by comforting
- Faster development of cognitive capacities
- Sense of identity – a firmer sense of knowing oneself
Ainsworth’s Attachment Classification

- **Secure**
  - explores readily
  - anxious with stranger
  - seeks contact on reunion
  - readily comforted

- **Insecure avoidant or resistant**
  - less anxious about separation
  - no proximity-seeking on reunion
  - impoverished exploration
  - or distressed but not comforted by reunion
Extended Attachment Classification

- **Disorganized-disoriented** infants
  - freezing, hand clapping, wish to escape
- Arousal of attachment system
  - attachment figure is simultaneously haven of safety and source of stress
- Associated with
  - severe neglect
  - physical abuse
  - sexual abuse
Attachment Disorganisation in Maltreatment

Adverse Emotional Experience

The ‘hyperactivation’ of the attachment system
Disorganized Attachment and Institutionalization

Attachment and cognitive functioning: the development of competence in logical reasoning

Source: Jacobson et al
Secure Relationships Calm Children’s Stress Hormone Response

Sensitive Care Calms Children’s Stress Hormone Response in Parent’s Absence

Delayed Intervention Harms Development
Bucharest Early Intervention Program

IQ/DQ (Mean)

Tested at 3 1/2 Years Old
Tested at 4 1/2 Years Old

"normal" range

Age of placement in foster care (months)

Source: Nelson et al. (2007)
Science, 318, 1937
Instability Disrupts the Stress Response System — But Relationships Reverse the Effect

Psychoneuroendocrinology, 32, 892
How Attachment Links to Affect Regulation

The forming of an attachment bond

Down Regulation of Emotions

BONDING

EPISTEMIC

TRUST
Disordered Attachment in BPD
The two-dimensional space defined by attachment anxiety and avoidance, showing Bartholomew’s 4 categories.

- **High avoidance**
  - -ve view of other
  - Fearful avoidant

- **Low avoidance**
  - +ve view of other
  - Dismissing avoidant

- **Low anxiety**
  - +ve view of self
  - Secure

- **High anxiety**
  - -ve view of self
  - Preoccupied
## Assurances Game Payoff Matrix

<table>
<thead>
<tr>
<th>Partner</th>
<th>Participant</th>
<th>Strategy A (cooperate)</th>
<th>Strategy B (defect)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy A (cooperate)</td>
<td>You get $6</td>
<td>You get $4</td>
<td>You get $0</td>
</tr>
<tr>
<td></td>
<td>Your partner gets $6</td>
<td>Your partner gets $0</td>
<td></td>
</tr>
<tr>
<td>Strategy B (defect)</td>
<td>You get $0</td>
<td>You get $2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Your partner gets $4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Kollock, 1998; Kelley et al., 2003)
Response to partner’s hypothetical cooperation in Assurances Game

Group x Oxytocin: F(1, 23) = 4.82, p < .05 (Bartz et al)
Actual cooperative behavior for all (BPD and control) participants as a function of OXT or placebo, and individual differences in attachment anxiety and attachment avoidance.

From: Oxytocin and Reduction of Social Threat Hypersensitivity in Women With Borderline Personality Disorder


Figure Legend:

Latency of Fixation Changes Targeting the Other Major Facial Feature After Stimulus Offset in Patients With Borderline Personality Disorder and Healthy Control Subjects in the Oxytocin and Placebo Conditions as a Function of Facial Expression (Angry, Fearful, Happy).

* p<0.05. ** p<0.01.

Error bars indicate standard error of the mean.
Oxytocin and performance on Mind in the Eves test (Domes et al., 2008)
EEG study of the responses of maltreated and non-maltreated children to viewing an angry face (Cicchetti & Curtis, 2005 Dev. & Psychopath.)

Maltreated group

Comparison group
How Attachment Links to Affect Regulation

The forming of an attachment bond

Down Regulation of Emotions

BONDING

BONDING
The Impact of Therapists on Treatment Outcome
Estimating Variability in Outcomes Attributable to Therapists: A Naturalistic Study of Outcomes in Managed Care.


Outcomes (residualized gain scores) of 15 therapists for patients with concurrent medication (meds) and no medication (nomeds).
Variance due to therapists in practice

Wampold & Brown, JCCP, 2005

- 581 Therapists, 6146 heterogeneous patients
- Diagnosis, degree, experience: 0% variance
- Medication: 1% (but also dependent on psychotherapist)
- Provider: 5%
- Top quartile produced twice the effect of the lowest quartile in subsequent year
BDI residual gain score as a function of type of treatment (PLA-CM v. IMI-CM) for each psychiatrist (1–9). Note that lower scores indicate better outcomes; negative residualized gain scores indicate better than average outcomes.
Variance due to Tx and Therapists in NIMH study of Depression (CBT & IPT)

Kim et al., 2006, Psychother Res, 16:161

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>0%</td>
<td>5% to 11%</td>
</tr>
<tr>
<td>HRSD</td>
<td>0%</td>
<td>1% to 12%</td>
</tr>
<tr>
<td>HSCL-90</td>
<td>0%</td>
<td>3% to 10%</td>
</tr>
<tr>
<td>GAS</td>
<td>0%</td>
<td>8% to 12%</td>
</tr>
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</table>
Impact of individual therapists in routine practice
Okiishi et al. 2006 (J Clin Psychol 62:9, 1157)

- 6,499 patients seen by 71 therapists
- therapists had to see at least 15 clients
  - on average saw 92
- number of sessions: range 1-203; mean 8.7
- therapists saw equivalent range of clients in terms of disturbance & presentation
- HLM used to compare ‘trajectories’ (recovery curves) of patients using OQ45
Clients of some therapists improve faster or slower than others.

Graph showing the relationship between session number and score on OQ 45.
Odds of a clinical episode in MBT by therapist
Slope of Improvement Across Therapists Unaffected by:

- therapist experience
- gender
- type of training
  - counselling psychology, clinical psychology, social work, marital/family therapist
- orientation
  - CBT, humanistic, psychodynamic
## Outcomes for Best and Worst Performing Therapists

<table>
<thead>
<tr>
<th></th>
<th>recovered</th>
<th>improved</th>
<th>deteriorated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>top 10% therapists</strong></td>
<td>22.4%</td>
<td>21.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td><strong>bottom 10% therapists</strong></td>
<td>10.6%</td>
<td>17.4%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>
Incidence of Harmful Effects

- estimates are that 5-10% of therapy clients deteriorate
  - across all orientations, client groups, modalities
  - in RCTs of ‘empirically supported treatments’

- rates higher than in control groups
  - e.g. NIMH reanalysis (Ogles et al. 1995)
  - 13/162 (8%) deteriorated, all in active treatments

- in Lambert’s work therapists tend to be poor at:
  - predicting who will do badly
  - recognising failing therapies
Reducing the Harmful Effects of Psychotherapy: The work of Lambert (2009)

- Across studies the rate of observed deterioration in psychotherapy was 10-25% with young people.
- Some therapists have rates of deterioration of around 50% and their treatment is NEVER associated with recovery.
- Introduction of outcome tracking (session by session monitoring)
  - Early warning when patient goes off trajectory
- Therapists randomized to feedback vs no-feedback
  - Deterioration reduced by 50%
  - Recovery improves by 50%
  - Average therapy is shorter
  - Patients who show early negative response receive longer and more effective treatment
Most therapists see themselves as better than average:

Dew & Riemer (2003, 16th Annual Research Conference, University of South Florida)

- 143 counselors asked to grade their job performance on scale from A+ to F
  - 66% rate themselves as A or better
  - none rated themselves as below average

Outcomes informed care may be a critical way of linking the EBP approach and practice based evidence
Therapist predicted treatment success compared to actual treatment outcomes after psychotherapy

Area all psychotherapies the same?
What happens when you ask a room of psychotherapists whose approach is the most effective?

What can be done to end this unseemly behaviour?
The Efficacy of Cognitive-Behavioral Therapy and Psychodynamic Therapy in the Outpatient Treatment of Major Depression: A Randomized Clinical Trial

CONSORT Diagram of Participants in a Study of the Efficacy of Psychodynamic Therapy Relative to Cognitive-Behavioral Therapy

CBT=cognitive-behavioral therapy; HAM-D=Hamilton Depression Rating Scale; MINI-Plus=Mini-International Neuropsychiatric Interview–Plus.
CBT vs. Psychodynamic Psychotherapy for Major Depression (N=341)

- **CBT**
  - 16 individual sessions
  - Manualised (Molenaar et al., 2009)
  - N= 164

- **Psychodynamic Therapy**
  - 16 individual sessions
  - Manualised (de Jonhge, 2005)
  - N=177

![Graph showing Observer-Rated HAM-D Scores During Treatment](image1)

![Graph showing Patient-Rated IDS-SR Scores During Treatment](image2)
Outpatients with anorexia nervosa (ANTOP) study Lancet, 2013

242 randomly allocated to treatment groups

PDT
N=80
80 assigned to receive focal psychodynamic therapy
53 completed treatment

3 months after treatment start
71 assessed
9 lost to follow-up
End of treatment
63 assessed
17 lost to follow-up
3-month follow-up
57 assessed
23 lost to follow-up
12-month follow-up
58 assessed
22 lost to follow-up
Lost 28%
80 analysed for primary outcome

CBT
N=80
80 assigned to receive enhanced cognitive behaviour therapy
65 completed treatment

3 months after treatment start
74 assessed
6 lost to follow-up
End of treatment
72 assessed
8 lost to follow-up
3-month follow-up
66 assessed
14 lost to follow-up
12-month follow-up
65 assessed
15 lost to follow-up
Lost 18%
80 analysed for primary outcome

TAU
N=82
82 assigned to receive optimised treatment as usual

3 months after treatment start
66 assessed
16 lost to follow-up
End of treatment
53 assessed
29 lost to follow-up
3-month follow-up
48 assessed
34 lost to follow-up
12-month follow-up
46 assessed
36 lost to follow-up
Lost 44%
82 analysed for primary outcome
Outpatients with anorexia nervosa (ANTOP) study Lancet, 2013
“Common factors” research in psychotherapy

- Traditional common factors
- Common principles
- Cross modality predictors
The Paradigmatic Common Factor

- **Centrality of the therapeutic relationship**
  - establishment of a **strong working alliance**,
    - My therapist and I have *figured out a good way to work* on my sad or angry emotions.
    - My therapist and I *work well together* on things that bother or upset me
  - therapist capacity for **understanding**
    - My therapist really *understands* what bothers or upsets me
    - I *feel uncomfortable* talking about my thoughts and feelings with my therapist
  - feeling supported and **cared about**
    - I don’t *get much support* from my therapist (reversed)
    - I feel like my therapist is *on my side* and tries to help me
  - **agreement** between patient and therapist on **treatment goals**.
    - I *use my time* with my therapist to make changes in my thoughts and behavior
    - I would rather *not work* on my problems or issues with my therapist
The working alliance controversy
Castonguay et al. (1996)
Depressed patients treated with CBT

- took measures of:
  - level of alliance
  - therapist focus on distorted thinking

- alliance significantly associated with outcome
- greater focus on distorted thinking associated with poorer outcomes
- effect disappears if alliance levels controlled for

- implies technique needs to be practised mindful of the interpersonal context
A sample of 646 patients (76% women, 24% men) in primary care psychotherapy Administered the Working Alliance Inventory and CORE session by session,

<table>
<thead>
<tr>
<th>Fixed effects</th>
<th>b</th>
<th>95% CI</th>
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<tbody>
<tr>
<td>CORE-OM lag1 → CORE-OM</td>
<td>-0.06*</td>
<td>[−0.09, −0.02]</td>
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<tr>
<td>WAI-S lag1 → CORE-OM</td>
<td>-0.30**</td>
<td>[−0.52, −0.08]</td>
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<td>WAI-S lag1 → WAI-S</td>
<td>-0.15***</td>
<td>[−0.19, −0.12]</td>
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<tr>
<td>CORE-OM → WAI-S</td>
<td>-0.03***</td>
<td>[−0.03, −0.02]</td>
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Reciprocal Influence of Alliance to the Group and Outcome in Day Treatment for Eating Disorders


<table>
<thead>
<tr>
<th>Model</th>
<th>Alliance</th>
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<td>Baseline ($\gamma = 0$)</td>
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<tr>
<td>Model 1 (alliance $\rightarrow$ restrict $\gamma =$ free)</td>
<td>$-0.22 (0.08)$</td>
</tr>
<tr>
<td>Model 2 (restrict $\rightarrow$ alliance $\gamma =$ free)</td>
<td>$-0.18 (0.09)$</td>
</tr>
<tr>
<td>Final model ($\gamma =$ free)</td>
<td>$-0.23 (0.05)$</td>
</tr>
</tbody>
</table>

**SO WHY DOES IMPROVED ALLIANCE IN SESSION$_{t-1}$ LEAD TO IMPROVEMENT IN SESSION$_t$?**
Understanding benefit from working alliance

- Is it to do with learning about oneself?
  - Most unlikely because improvement occurs between end of session and beginning of next session

- So what is it about working alliance that actually improves the patient?
  - a bizarre delayed reverse causality?
  - attachment mediated – but through what process?
  - opening up a social learning process that benefits the patient between sessions
Natural Pedagogy theory
(Csibra & Gergely, 2006; 2009, 2012)

- A human-specific, cue-driven social cognitive adaptation of mutual design dedicated to ensure efficient **transfer of relevant cultural knowledge**

- Humans are predisposed to ‘teach’ and ‘learn’ new and relevant cultural information from each other

- Human **communication** is specifically adapted to allow the transmission of
  
  a) cognitively **opaque** cultural knowledge
  
  b) kind-**generalizable** generic knowledge
  
  c) **shared** cultural knowledge
Definition of Ostensive Stimuli
(Sperber & Wilson, 1995)

- The signals whereby an agent makes manifest to an addressee her communicative intention: to manifest some new relevant information for the addressee (i.e. her informative intention).

- Infants display species-specific sensitivity to, and preference for, some non-verbal ostensive behavioral signals (see Csibra, 2010, Csibra & Gergely, 2009 for reviews)

- Examples of ostensive communication cues
  - eye-contact
  - turn-taking contingent reactivity
  - special tone (‘motherese’)

(Sperber & Wilson, 1995)
The Pedagogical Stance is triggered by Ostensive-Communicative cues

- Ostensive cues have in common
  - Infant recognized as a self
  - Paid special attention to (noticed as an agent)

- Ostensive cues function:
  - to signal that the other has a Communicative Intention addressed to the infant/child
  - to Manifest New and Relevant information about a referent
Ostensive cues ➔ referential expectation in infant

- 6-month-olds followed an agent’s gaze-shift to one of two objects but only when it had been preceded by either eye contact or infant-directed speech (ostensive signals) addressed to the infant (Senju and Csibra, 2008).

- An automated eye-tracker based study used an infant-induced contingent reactivity paradigm to demonstrate that 8-month-olds gaze follow an unfamiliar object’s bodily orientation response towards one of two targets, but only when the object had been reacting contingently before (producing self-propelled body movements such as tilting) to being looked at by the infant (Deligianni et al., 2011).
Epistemic trust and secure attachment

- **Secure attachment** is created by a system that also induces a sense of **epistemic trust** that the information relayed by the teacher may be trusted (i.e. learnt from)

- **Evidence**
  - Cognitive **advantage** of secure attachment
  - **Contingent** responsiveness to the infant’s own (at first, automatic) expressive displays in secure attachment
  - During **“mirroring” interactions**, the other will “mark” her referential emotion displays in a ‘manifestative’ manner to instruct the infant
How Attachment Links to Affect Regulation

Down Regulation of Emotions

BONDING

EPISTEMIC

TRUST

The forming of an attachment bond
Implications: The nature of psychotherapy

- Mentalizing may be key to psychotherapy not because we need to learn about our minds to learn about those of others

- Mentalizing is a generic way of establishing epistemic trust
  - Our subjectivity being understood is necessary key to open up wish to learn about world including social world
  - Experience of feeling thought about makes us feel safe enough to think about social world
Implications: The nature of psychotherapy

- Pernicious aspect of trauma is the destruction of trust in social knowledge of all kinds.
- Epistemic mistrust follows maltreatment or abuse and therapists ignores this knowledge at their peril.
- Psychotherapy may be effective for two reasons:
  - Content
  - Source
- Therapy is not just about the what but the how of learning:
  - Opening the person’s mind via establishing contingencies so (s)he once again can trust the social world by changing expectations.
  - Not what is taught in therapy that teaches but evolutionary capacity for learning from other is rekindled.
Thank you.

For further info
anthony.bateman@ucl.ac.uk