An extract from

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MYTEN OM BIVIRKNINGSFRI TERAPI

(Harmful Help – Myths About Therapy Without Side Effects)

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INTRODUCTION

Psychological treatment and conversation therapy are meant to reduce human suffering. An individual seeks help for their problems, and a professional therapist listens to what is said, what they can bear to hear and then they provide advice or suggestions on how to think, feel or act differently. Professional therapists like this are caregivers and healthcare providers who have trained to *help* people. It may seem paradoxical to claim that psychological treatment of this kind – provided with the best of intentions – should have negative effects. How can interventions directed at healing *increase* the patient's suffering? How can something that is designed to help end up causing harm?[1]

In this book, we examine situations, places, therapists or moments where treatment works *against* its purpose - namely, cases where it would actually have been better to do nothing at all.

At the same time, it is important to remember that the question is not whether therapy *works* – we already know that it does, even if it is difficult to know with a degree of certainty *why* this is. Sometimes it is sufficient for a person to be seen, accommodated and understood by a warm and empathetic therapist. In other cases, a good method or technique will be appropriate to a specific type of problem. For example, subjecting yourself to something you fear alongside a therapist – known as exposure – is an effective method to treat anxiety. But it can also be the case that some people experience positive changes during the period of therapy without the therapy itself or the therapist being the cause of this. Time really does heal some wounds – not to mention the significant impact of a new job, a new environment or a new love interest on getting out of depression or a tough life situation. Causal relationships in therapy are complicated. Many of the causes often work together simultaneously without it necessarily being possible to identify which ones have the greatest impact.

This is also true when therapy doesn't work – and when therapy causes harm. Methods, therapists and therapeutic settings can have a negative impact – either individually or in parallel. When we are describing *how* psychological treatment can work against its purpose, these varied and complex reasons will make it challenging – but not impossible – to understand *why* this happens. However, we must first recognise that conversations *can* cause harm, and that – as we shall see – this does not go without saying.

6.

We Have To Do *Something*

Psychologist Priscilla Dass-Brailsford was one of the first therapists to arrive in New York City after 9/11. She was responsible for providing the *Critical Incident Stress Debriefing* programme for a major finance company that had been based in the World Trade Center. Many of the employees had lost their colleagues or had barely survived the flames and collapsing buildings. Priscilla enabled people to process what they had seen, heard and felt. It was one part of overall response that followed the attacks. In New York, witnesses and relatives were flooded with thousands of helpful therapists. The firefighters received free psychoanalysis, and were warned not to grieve on their own. Survivors and witnesses were asked how they were and what had been worst about their experiences. They were supported to manage their own stress. A well-oiled support machine was in full swing in New York. The traditional helpers from the police and hospitals received much praise in aftermath of 9/11. The efforts of talk therapists received less attention.

After accidents and disasters like 9/11, survivors, loved ones and witnesses often feel a need to talk about what has happened. Debriefing has formed an important part of the crisis psychology toolbox for several decades. It takes place in groups immediately after the event, during which participants discuss negative emotions and review the events in detail. Part of the idea is to prevent the development of post-traumatic stress disorder (PTSD). Stress disorders like this result in people suffering from dramatic and repetitive repeat experiences through flashbacks featuring sounds, smells and images in their mind's eye. People are on their guard – worried and anxious. They avoid anything that might remind them of the trauma. This condition can be debilitating, just as it was for the soldiers for whom the diagnosis was originally intended. It has later been understood

that trauma from abuse or accidents can result in similar torment to that suffered by war veterans.

Debriefing has also been common in Norway. The Red Cross recommends it as part of its established procedures for its Search and Rescue Corps. Psychological debriefing was used after the terrorist attacks at Utøya and in Oslo on 22 July 2011. In an interview with the *Aftenposten* newspaper, a Norwegian soldier described how this method took place following battles in Afghanistan:[2]

> All notebooks and journals are put away. Each man recounts his experience of the incident to the best of his ability. This deals with emotions relating to almost being killed or wounded, frustration over things that did not work, the experience of killing or maiming someone, issues around civilians caught in the crossfire, general fears and coping. Many things are experienced equally, but some are also experienced differently.

Following 9/11, Patricia Watson – a researcher based at the National Center for PTSD in the USA – began searching for documentation on the effects of debriefing. Her conclusion was striking: it is an unnecessary treatment that produces no clearly positive health benefits, and it may additionally be harmful. Watson believes that debriefing is too short-lived to allow emotional processing, and asserts that the method may increase both tension and anxiety in individuals. 'Not only does it provide inadequate help, but the method also has great potential to cause harm,' she says.

Remember – the whole idea is to prevent PTSD. However, fewer than 20% of people actually develop post-traumatic stress following traumatic events. The typical response following trauma – or, more appropriately, potentially traumatising events – is for people to adapt and demonstrate resilience. This adaptability and resilience has been referred to as being part of the psychological immune system. If people have forgotten potentially traumatic events, it is likely to be a sign that this system is working well. As a result, crisis interventions are unnecessary for many people – and for those who do succumb to the disorder, debriefing is hardly a good solution. Patricia Watson highlights that people who are provided with this type of treatment will have a higher threshold for seeking out others and receiving more efficient treatments at a later date. She is well-supported in other scholarship, which finds that patients deteriorate over time when debriefing is used.[3] There are no good indications that psychological debriefing or similar short-term

measures aimed at everyone who experiences an incident reduce the symptoms of post-traumatic stress. A number of bodies no longer advise the use of debriefing, including the American Psychological Association.[4]

In the late 1980s, Professor Atle Dyregrov – probably Norway's most famous crisis psychologist – encouraged meetings directly after crisis situations with emphasis on impressions and reactions of participants, and where it was necessary to discuss anger, fear and anxiety, as well as feelings of self-loathing and helplessness. 'It may feel painful and worse during the meeting than it did beforehand, but experience shows that this will help in the long-term,' Dyregrov wrote at the time. Dyregrov warned that if too much time passes without doing anything, symptoms could become entrenched and more difficult to process, and encouraged the use of sounds, images or video from the event if so much time had passed that people had forgotten what had happened. We can recognise this from the Betania case and the studies examining repressed memories: it has to hurt before things can get better, and it is important to talk about what has happened.

It looks like Dyregrov has come to change his views on this. 'Conversation in the aftermath of crisis situations is not and should not be a deep dive into emotions,' he wrote in 2016, while also emphasising that any such review *should absolutely not* be carried out on the same day as the incident itself. Nowadays, Dyregrov describes his approach as being one of experience-based debriefing meetings, and he asserts that the knowledge base for these meetings is different. He is among a group of crisis experts who have become focused on marketing the debriefing concept with new, different content that does not involve any apparent risk. The difference lies in the fact that the debriefing occurs some days after the event rather than within twenty-four hours, and that it lasts for several hours. On YouTube, Dyregrov explains that it is preferable to hold unloading conversations – not a debriefing – before those affected go home after any such incident. Nevertheless, the Norwegian Directorate of Health describes debriefing and unloading conversations as being one and the same method in their summary of the health measures implemented in the aftermath of the July 22nd attacks. It is difficult to understand that the principle of rapid aid following trauma has been radically changed. The impression that *we have to talk about it* lives on.

As the author of books and articles about *Critical Incident Stress Debriefing* in particular, in addition to having run the Centre for Crisis Psychology at the University of Bergen for

many years, it is hardly strange that Dyregrov refuses to throw the debriefing approach onto the fire. He poses the following rhetorical question:

> Should we not allow the helpers who encountered survivors and anxious relatives at Utøya to have the chance to sit down after the fact and reflect on and talk about their experiences? Should we deprive the helpers of the opportunity to review their experiences together with others they worked alongside so that they can build coherence and structure into their experiences? Should we say "sorry, it's not good to talk about this" and deny them recognition from others in the group for what they did and the efforts they put in? Is it okay to deny them confirmation for their own responses and to allow them to give and receive advice to and from colleagues and professionals on how they should handle the tough situation they dealt with?

Dyregrov believes we have to do *something*, and refers to what people want. This is the explanation also offered by helpers who offered debriefing following 9/11 who – despite known controversies – still gave people this type of treatment. Three professionals at the New York State Psychiatric Institute [5] say there was significant pressure to offer something, and that they were convinced it was necessary *to do something*. They explain there was extensive demand for such services, and many participants felt they had been helped. The problem is that what most people want and crave is not necessarily appropriate. Depressed people think they *have* to ruminate on everything, and people with compulsions think they *have* to wash or check things. They don't have to. In fact, what they are doing can help to feed rather than solve the problem.

Sometimes, it is not appropriate to rely on patients' satisfaction with a treatment as its very basis – instead, one must professionally assess the ability of the measure in question to make an actual difference.

Proponents of debriefing, grief therapy and similar interventions argue that these measures are useful because people avoid developing trauma or chronic grief after undergoing such treatment. However, they forget along the way to check for negative effects and evaluate the potential cost of such treatment. It is generally problematic to provide preventative health measures to groups who have not been found to have a condition that necessitates any treatment. [6] Key guidelines recommend that one first identify a need in those who have been subjected to trauma and accidents, and then initiate measures to address at-risk groups. Not only does this have a better effect, it is

also a more sensible use of the limited resources available in the health budget.[7] The challenge for clinicians is to not always have to *do something*.

A Little Therapy Can't Be That Dangerous

Patients who suffer migraines may notice something brewing hours or days before an attack. They become sleepy, irritable or have cravings for particular foods. These are not symptoms of migraine – but are something known as prodromes. Prodromes are precursors indicating the onset of something. We also find prodromes of this kind in the case of mental disorders. Learning to recognise prodromes can be important for patients – for instance, in the case of bipolar disorder.[8] The earlier you identify a negative development, the easier it is to do something to halt continued deterioration. A feeling of incipient mania or depression can be a hint to seek out support, start taking medication, take time off from work or adjust sleeping patterns and activity levels. The knowledge and skills to identify and manage prodromes help patients reduce the length and frequency of manic periods. Today, much of the treatment for bipolar disorder focuses on identifying prodromes such as social withdrawal or other changes to sleep patterns. If the patient spots the symptoms earlier, it is easier to start medical treatment, arrange for a scheduled admission to a healthcare institution, start electroconvulsive therapy or seek out help by other means.

Giving patients information of this kind is known as psychoeducation, and today it represents an important element of many forms of treatment. Education also involves raising and socialising people in a certain type of environment. In psychoeducation, this environment is the knowledge and insight that exists in relation to psychology and mental health. This upbringing occurs when the patient has learned what their therapists believe is important for them to know. The idea of patients acquiring professional knowledge is a relatively new one, and until recently it would have been unthinkable to share professional input and assessments with patients. Nowadays, it causes a stir if professionals know something important about a patient and their suffering that remains unsaid. Teaching knowledge about mental health can be both democratising and a power equaliser.

Psychoeducation has many applications. For example, increasing motivation for further treatment, preventing mental ailments from developing into something more serious, and

actually treating those who have a mental illness. Many people who suffer from mental illness and symptoms are afraid of being sectioned or 'going crazy'. People become anxious about anxiety. They can become terrified that their heart is about give out when it is pounding away in the middle of a panic attack. Some are also afraid of bothering others with their depression. Being afraid of one's own thoughts and feelings becomes a form of double suffering. It thereby becomes more important for someone to tell you that anxiety is not dangerous and that hearing voices does not mean you are mad. It is quite natural for painful emotions to ebb and flow. The knowledge the therapist possesses about suffering can help the patient to understand. Providing the patient with both the knowledge of suffering and disseminating a treatment model is a natural part of any active and effective therapy.

The German Professor Michael Linden, who warned us against discomfort in exposure therapy, has conducted a study on the impact of issuing patients with psychoeducational brochures on topics such as anxiety, depression and how feelings and thoughts affect bodily pain.[9] A group of patients were handed these brochures and assigned appointments to receive treatment using behavioural therapy, while second group were only assigned an appointment. Unsurprisingly, the group issued with brochures had greater knowledge of mental health upon completion of their treatment. Perhaps more surprising was that the group issued with brochures described themselves as having less self-confidence, less autonomy and less satisfaction with themselves compared to the other group. More of them were quite simply dissatisfied with their course of therapy. But why? Michael Linden speculates that the brochures gave the patients theoretical information, but provided them with very little in the way of skills to translate this information into actual changes. Better health information is not necessarily equal to better health behaviour, according to Linden.

It would appear that not all psychoeducation works in the same way. Patients with bipolar disorder responded differently to information about depressive prodromes than they did to information about manic prodromes. The patients who recognised depressive prodromes ended up taking more anti-depressants without this helping the duration, length or volume of depressive episodes they suffered from. The researchers emphasise, just like Linden, how important it is not only to be able to recognise symptoms, but that a patient must also have good skills in place to deal with them.

This is not a simple dilemma. Increased awareness of one's own ill health offers the opportunity to do something – but it can also cause concern around how to do this. It is similar to the dilemma long faced by doctors when informing patients about the possible side effects of treatment, and the challenge of how much risk-related information to include on packaging inserts for medication. Ironically, expectations of getting ill can make you ill. If you read the insert in the box of tablets offering pain relief for your headache, you will find out that headaches are a possible side effect. In theory, the active ingredient – for example, paracetamol – can do its job and your headache will disappear. But your own expectation that the headache will persist as a side effect means that you do not make any recovery. It is actually possible to induce negative expectation effects of this kind. In one study, participants experienced allergy symptoms after being given an injection they were told was allergenic, but which in reality was not.[10] These are all examples of the placebo effect's lesser known evil twin, nocebo.[11]

The nocebo effect has been well demonstrated in somatics, but has been little explored in mental health care – which is ironic given it is a psychological effect. Nevertheless, nocebo can be a term used to describe when treatments create problems that were not there initially. Like when the Betania patients began to remember new memories of abuse that had probably never taken place. False memories like this occur when therapists or others pose leading questions or make assumptions that there is something suppressed or hidden in the memory. This is similar to the objections to debriefing following accidents: the vast majority of people will manage just fine without treatment like this. The therapists, or the system that the therapists are part of, create expectations that 'something is wrong' and this infects people who could continue living quite happily and unknowingly, or at least spared of new problems.

Expectation effects like this are not solely the preserve of long-term or intensive courses of therapy. Even 'simple' and 'easy' initiatives such as psychoeducation can involve risk. A recent example is the interdisciplinary subject *livsmestring* ('life mastery') which is to be introduced into the curriculum taught in Norwegian primary schools. The goal is to prevent mental disorders through pupils learning about thoughts and feelings – effectively a type of psychoeducation. One of the first specific examples of how this manifested itself could be seen in a report from NRK in the spring of 2019. The story describes pupils practising pulling power poses – in this case a way of sitting (legs astride) or standing that promotes self-confidence and self-assurance.[12] There was a no-holds-

barred response from the professional sphere. Professor of Psychology Ole Jacob Madsen wrote that he was concerned that life mastery could become 'yet another source of setbacks for those who are less talented'.[13] Psychologists Joar Øveraas Halvorsen and Jan-Ole Hesselberg referred to the knowledge basis for power poses as pseudoscience and emphasised the importance of life mastery in schools being knowledge-based.[14]

Life mastery in schools and psychoeducation are similar to each other in that they are about *sharing information* about mental health and suffering, but also because they are well-meaning initiatives that affect many people. Neither of them is therapy in its typical shape and form, but both often involve therapists and share a knowledge basis with therapy. It is typical for well-meaning measures such as this to be introduced long before they have been adequately tested. Suddenly, events happen so quickly that there is no time to wait for an evaluation of whether the initiative has the desired effect, no time to examine whether it is more expensive than other interventions, and no time to check whether it is actually better than doing nothing at all. The spending of large sums of money on undocumented approaches is typical. For instance, research examining public awareness campaigns is discouraging – often they have no effect, and a Norwegian survey of public awareness campaign research determined that they can actually sometimes have a negative impact.[15] Instead of scientific documentation of a positive effect and the absence of negative effects, they are based on whether people like what is being proposed. For example, the debriefing programmes were evaluated from an early stage on the basis of user satisfaction, rather than how much or how little they prevented PTSD. When actual evaluations of these programmes' effects and efficacy began to be carried out, the negative results emerged. The same happened in the case of Betania Malvik, as well as in programmes like Scared Straight and DARE. One can't help but wonder whether the teaching of life mastery in schools will be highlighted as a success because pupils, teachers and parents *like* it.

Simple questions can be the antitoxin against this naivety. Has the programme or initiative in question been evaluated for negative or unwanted effects? Does it do a better job than other types of programmes, or is it an improvement compared to doing nothing at all?[16] Answering such questions requires more than mere satisfaction surveys.

There are two important messages to take away so far: doing a little something does not necessarily mean that it is harmless, and just because we like something does not mean that it yields good results. One example of something that is cited as an effective and

low-cost initiative are courses in depression management (known as KiD courses in Norway). These are offered by most Norwegian municipalities and are aimed at people with mild to moderate depression. The courses have become wildly popular. Their content is based on cognitive theory and emphasises that the patient has to learn about the relationship between thoughts, feelings and behaviour – with a focus on the here and now rather than what happened in their childhood. Course leaders set specific tasks and usually set homework too, meaning that participants are able to follow up on the themes raised between lessons. The training course spans the equivalent of a week, resulting in very cheap therapy. The course content is professionally uncontroversial, and the course itself is very cheap to deliver.

At the same time, depression is one of the most debilitating and costly disorders in society. The waiting lists for treatment are so long, and people's problems so manifold, that it is necessary to think differently. For politicians involved in formulating health policy, courses in depression management are win-win. But for 'Maria', a KiD course of this kind formed an example of how their simplicity fares poorly in encounters with more complex conditions.

'Maria' had waited a long time before seeing her GP about her depression, and following conversations with a psychiatric nurse that had done little to help she was enrolled on a KiD course. Maria was positive about the course – she knew it was high time she did something. The first hurdle was attendance. The course started early in the morning, and Maria was struggling to sleep. She was a single parent who was low on funds. At the KiD, she was tasked with setting up hobbies that she liked doing. This proved difficult for Maria, who was neither particularly interested in hobbies nor had the finances to keep doing them. She found she received little in the way of understanding about this. Instead, she describes how she experienced the course as practical problems being reduced down to something that was in her head. 'I believe that people often have real, specific problems that need to be addressed in therapy,' Maria says after the fact.

Maria found that she was not taken especially seriously. One specific challenge with depression is that all problems seem bigger than they would be otherwise. Trivialising these problems will rarely work. 'Maybe cheap simple solutions aren't the solution to complex situations in life and mental illness,' suggests Stian Solem, a psychologist and Associate Professor at NTNU. Solem warns against the KiD courses as a quick fix for depression. He wonders whether they are *too simple*, and believes that the effects of the

courses are measured using overly narrow parameters. Just one questionnaire, the *Beck Depression Inventory*, is used to evaluate whether participants have got better or worse. While the evaluation of these courses is on the thin side, key individuals in both in Norway and internationally have an interest in turning out positive results. Course developers and researchers earn money from the sale of course materials used by course participants. The founders of the method are involved in almost all research studies that take place. Solem's urge for caution is difficult to hear amidst the cacophony of everyone else supporting these courses.

Straightforward low-threshold initiatives like this often have research references to therapy methods and therapy theory that the measures are 'built on', but there is rarely any research showing that the specific initiative actually works. This is similar to self-help literature. Despite there being thousands of self-help books, there are only a handful of studies that have evaluated whether the books themselves actually have any impact. One book, or one proposition, is not evidence-based simply because the therapy it is based upon is. On the contrary, we know from psychotherapy research that interventions do not necessarily work even if they are based on other interventions that have worked. Therapy is not necessarily improved by combining things that have worked individually. Self-help books that are 'based on' therapy that is known to work still lack a crucial ingredient: the therapist. This constitutes a rather significant difference. Nevertheless, perhaps it is too much to expect a book to have a documentable impact? Perhaps it is too much to expect the school system to have research-based references prior to introducing a new subject? At the same time, you might ask what the point is in a self-help book or a low-threshold initiative if it is not possible to document whether it actually helps.

You might think that psychological knowledge is a good thing when it is shared by talented writers with impeccable academic qualifications and good intentions. But we have seen that good intentions are rarely good enough in themselves, and low thresholds, small numbers and satisfied participants are no guarantee of a good outcome or the absence of harm.

Therapeutic Culture

Will everyone benefit from learning about thoughts, feelings or themselves? Is it really the case that *a little therapy* also means that it is virtually harmless? Several Norwegian psychologists, including some from our interview study, say they cannot imagine patients who would have been better off without therapy. Some even assert that it would be unethical to discourage therapy while we do not know who benefits from it. Such arguments fuel the myth that therapy is free from side effects.

Life mastery in school, psychoeducation, debriefing after accidents and depression management courses can be deployed quickly and to cover many people. The idea behind this is a little for the many is better than a lot for the few. When short and simple for the many looks like it is working as a result of high levels of satisfaction, it is even harder to contemplate negative effects. The challenge being that of course negative effects can occur outside long-term psychoanalytic treatment – they can occur in short, effective and even generally helpful forms of therapy. Instead, the question ought to be whether it is unethical to recommend therapy while we do not know who may deteriorate as a direct result.

Professor of Psychology, Ole Jacob Madsen, compares therapists with the advertising industry on the basis of their willingness to offer comfort and relief.[17] The self-improvement industry, the therapy industry and the care industry are all other names that have been used to describe the emergence of psychology into society. Madsen argues that psychology presents itself as a scarce resource that you cannot get enough of, and that an increasing number of people see all problems in light of psychology – meaning that psychology automatically becomes a positive contributor to society. Therapy is portrayed as an integral benefit that as many people as possible should have access to. He points out that this is a poor starting point for ethical and critical thinking.

Therapists are experts in finding deviations and are able to observe symptoms of mental illness among survivors and relatives following disasters like 9/11, which can then be treated using therapy and medication. The problem is when they observe quite ordinary reactions and interpret these using their therapeutic belief system. Additionally, the nation's therapists can help you make anything mediocre even better: improve your relationship, launch your career or 'get to know yourself'. This combination of creating a

need for help and an exaggerated belief in one's own ability to help can cultivate psychologization.

The psychologist or psychiatrist can also contribute to the psychologization process themselves although in the context of health care, this is known as normalising. For example, helping people to understand that thoughts and feelings are not in themselves dangerous will only be positive. This is normalising information. Likewise when seeking to reduce and resolve concerns that one might be going mad or otherwise be abnormal. But is it necessary or normal for such support to be provided by authorised healthcare professionals? It is somewhat paradoxical that people qualified to *heal the sick* are also simultaneously tasked with disseminating the message that it is quite normal to think painful thoughts and have difficult feelings. There is something about the *format* of the help provided that can contribute negatively – regardless of the actual contents of that help. One can always argue that it is good to talk about difficult things, but you don't need to talk to a professional. Access to professional assistance may instead lead to you *not* speaking to friends or family about these very things. An important relational function is thereby outsourced from informal to formal networks. This strengthens a therapeutic culture.

This therapeutic culture does not appear to naturally self-correcting. There are quite simply very few brake mechanisms in place, and society seems to accept all these therapists as a natural matter of course. The experts themselves can hardly slow down this trend. Allen Frances, Professor emeritus, psychiatrist and head of development for the American DSM 4 diagnosis system, once said that he had never once met an expert who was *not* focused on expanding their own field of expertise. Experts in schizophrenia want more research funding, more treatment sites and more therapists in their field. Experts in eating disorders want the same thing for their field. Those who have developed new treatment methods want to expand popularity of the method at the expense of other, competing methods. The tale about letting the fox guard the chickens springs to mind: a field of mental health experts sets out the parameters of what constitutes healthy and sick, before then standing by to deliver services that will make people healthy again. If this was a planned business model it would be almost brilliant. Even more ingenious would be if it were hidden behind genuinely-held, well-meaning intentions. The positive arguments are manifold: therapists are conscientious and have

good intentions; therapy is short-term; and there are people out there who have experienced difficulties and need help. We have to do something!

So what are the alternatives to not keeping it short or simple when encountering psychological problems that people or society expect to be fixed? One option is to do nothing at all. According to Allen Frances, this has multiple benefits:[18] Firstly, you avoid providing harmful treatment, you save time, effort and money, you can delay therapy until a more suitable time, ensuring that previous treatment can continue to work, giving the patient the perception he or she can live without therapy and avoid giving the impression that there is effective therapy when this is not the case in reality.

When one accepts that psychological treatment has a cost-benefit component, and that treatment can not only have a lack of impact but can also cause harm, it consequently becomes relevant for us to find realistic confines for when we should not offer this type of help. Frances summarises it like this: first we have to avoid doing harm, then we must identify the patients we can neither help nor harm, and finally allow those patients who are recovering by themselves to do just that – without our assistance.

[1] Strupp, H.H., Hadley, S.W. & Gomes-Schwartz, B. (1977). *Psychotherapy for Better or Worse: The Problem of Negative Effects*.

[2] Taken from https://www.aftenposten.no/norge/i/rAEJ0/Slik-foregar-en-emosjonell-debriefing

[3] On Psychological Science, L.-S. (2007). 'Psychological treatments that cause harm.' *Perspectives on Psychological Science*.

[4] Tuckey, M.R. & Scott, J.E. (2014). 'Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial.' Anxiety, Stress & Coping, 27(1), 38–54.

[5] Herman, R., Kaplan, M. & LeMelle, S. (2002). 'Psychoeducational Debriefings After the September 11 Disaster.' *Psychiatric Services*, *53*(4), 479–479. doi:10. 1176/appi.ps.53.4.479

[6] Taken from https://katarsisuib.no/hjelper-flor-vs-dyregrov-debatten-videre/

[7] The Directorate of Health (2016). 'Mestring, samhørighet og håp. Veileder for psykososiale tiltak ved kriser, ulykker og katastrofer.' [Mastery, togetherness and hope. Guidelines for psychosocial measures following crises, accidents and disasters].

[8] Perry, A., Tarrier, N., Morriss, R., McCarthy, E. & Limb, K. (1999). 'Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment.' *BMJ*, *318* (7177), 149–153. doi:10.1136/bmj.318.7177.149

[9] Linden, M. & Wasilewski, J. (2019). 'Better patient knowledge and worse treatment outcome after written patient information in inpatient cognitive behaviour therapy as compared to non-informed patients.' *Cognitive Psychology*, *0*(0). doi:10.1080/23 311 908.2019.1612825

[10] Jewett, DL, Fein, G, & of, G.-M. (1990). 'A double-blind study of symptom provocation to determine food sensitivity.' *New England Journal of* ... doi:10. 1056/NEJM199 008 163 230 701

[11] Wells, R. & Kaptchuk, T. (2012). 'To Tell the Truth, the Whole Truth, May Do Patients Harm: The Problem of the Nocebo Effect for Informed Consent.' *The American Journal of Bioethics*, *12*(3), 22–29. doi:10.1080/15 265 161. 2011.652798 Cohen, S. (2014). 'The Nocebo Effect of Informed Consent.' *Bioethics*, *28*(3), 147–154. doi:10.1111/j.1467–8519.2012.01983.x

[12] Taken from https://www.nrk.no/buskerud/slik-skal-ungdommen-laere-a-mestre-hverdagen-1.14520405

[13] Taken from https://www.nrk.no/ytring/er-det-slik-vi-skal-ruste-de-unge-forlivet_-1.14531539

[14] Taken from https://www.aftenposten.no/meninger/debatt/i/VbgvJ4/Gir-pseudovitenskap-pa-timeplanen-bedre-livsmestring–Halvorsen-og-Hesselberg

[15] Ekle, V. (2009). Effekt av holdningskampanjer på atferd: En metaanalyse av massemediebaserte holdningskampanjer i Norge [The Effect of Behavioural Campaigns on Behaviour: a Meta-analysis of Mass Media-based Attitude Campaigns in Norway] (Master's dissertation) University of Oslo.

[16] Lilienfeld, S.O., Fowler, K.A., Lohr, J.M. & Lynn, S.J. (2005). 'Pseudoscience, nonscience, and nonsense in clinical psychology: Dangers and remedies.' *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm*, 187–218.

[17] Madsen, O.J. (2010). *Den terapeutiske kultur*. Oslo: Universitetsforlaget

[18] Frances, A & of Psychiatry, C.-J. (1981). 'No treatment as the prescription of choice.' *Archives of General Psychiatry*. doi:10.1001/archpsyc.1980. 01780300054006