
UNIT 1 PSYCHOANALYSIS, PSYCHOANALYTIC/ PSYCHODYNAMIC THERAPY

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1.0 INTRODUCTION

To the majority of people, psychotherapy is synonymous with psychoanalysis. This may be because psychoanalysis is the most well known psychotherapy method practiced. In addition, the popular media such as television and movies continue to depict most psychiatrists and psychologists solely as practitioners of psychoanalysis. Most people are surprised to learn that psychoanalysis is only one of many therapeutic techniques currently used by clinicians. Also surprisingly, Sigmund Freud was not the first individual to apply principles of psychotherapy.

Historically psychoanalysis (of course developed by Freud) is one of the most influential methods of psychotherapy. The contributions of psychoanalysis to psychotherapeutic and counselling theories and practices are enormous. The main

ideas of psychoanalysis have been instrumental in the development of many therapeutic methods that followed. Concepts such as unconscious, transference, and dream analysis continue to play a very prominent role with many clinicians who do not consider themselves psychoanalysts.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Elucidate the theoretical principles of classical psychoanalytic or Freudian theory;
- Describe the different theoretical orientations under the broad umbrella of ‘psychoanalysis’; and
- Explain the treatment principles, standard methods, techniques, concepts and features of psychoanalytic/ psychodynamic therapy.

1.2 PSYCHOANALYSIS

Psychoanalysis (or Freudian psychology) is a body of ideas developed by Austrian neurologist Sigmund Freud and continued by others. It is primarily devoted to the study of human psychological functioning and behaviour, although it can also be applied to societies. Psychoanalysis has three main components:

- a method of investigation of the mind and the way one thinks;
- a systematised set of theories about human behaviour;
- a method of treatment of psychological or emotional illness.

Under the broad umbrella of psychoanalysis, there are at least 22 theoretical orientations regarding human mentation and development. The various approaches in treatment called “psychoanalysis” vary as much as the theories do. The term also refers to a method of studying child development.

1.2.1 Theoretical Models

The predominant psychoanalytic theories can be grouped into several theoretical “schools.” Although these theoretical “schools” differ, most of them continue to stress the strong influence of unconscious elements affecting people’s mental lives. There has also been considerable work done on consolidating elements of conflicting theory. As in all fields of healthcare, there are some persistent conflicts regarding specific causes of some syndromes, and disputes regarding the best treatment techniques. Some of the most influential theories are described below.

1.3 FREUDIAN PSYCHOANALYTICAL THEORY

Sigmund Freud is important as the first major theorist to write exclusively about non biological approaches to both understanding and treating some of mental illnesses. These illnesses, specifically what was then called hysteria, were considered medical in his time, but were reshaped through his theories.

Freud was awarded Hypnosis grant and after completing his hypnosis grant, he published his first book *The Interpretation of Dreams*, and although it originally sold only 600 copies, it has become one of the most respected and most

controversial books on personality theory. In this book, he described his views of the human psyche, introducing the concept of the unconscious to the medical world. In a world of biological theorists, this concept was not accepted by many of his colleagues.

1.3.1 Basic Human Drives

According to Sigmund Freud, there are only two basic drives that serve to motivate all thoughts, emotions, and behaviour. These two drives are (i) sex and (ii) aggression. Also called Eros and Thanatos, or life and death, respectively, they underlie every motivation that humans experience.

Freud's theory emphasised sex as a major driving force in human nature. While this seems overdone at times, sexual activity is a means to procreation, to bringing about life and therefore assuring the continuation of human bloodline. Even in other animals, sex is a primary force to assure the survival of the species.

Aggression, or the death instinct, on the other hand serves just the opposite goal. Aggression is a way to protect us from those attempting harm. The aggression drive is a means to allow us to survive while at the same time eliminating our enemies who may try to prevent us from doing so.

While it sounds very primitive, it must not be looked at merely as sexual activity and aggressive acts. These drives entail the whole survival instinct and could, perhaps, be combined into this one drive:

The drive to stay alive, procreate, and prevent others from stopping or reducing these needs.

Looking at the animal kingdom it is easy to see these forces driving most, if not all, of their behaviour.

Let us look at a few examples. Why would an adult decide to get a college degree? According to Freud, we are driven to improve ourselves so that we may be more attractive to the opposite sex and therefore attract a better mate. With a better mate, we are more likely to produce offspring and therefore continue our bloodline. Furthermore, a college degree is likely to bring a higher income, permitting advantages over others who may be seen as our adversaries.

1.3.2 Structural and Topographical Models of Personality

Sigmund Freud's Theory is quite complex and although his writings on psychosexual development set the groundwork for how our personalities developed, it was only one of five parts to his overall theory of personality. He also believed that different driving forces develop during these stages which play an important role in how we interact with the world.

Structural Model (id, ego, superego)

According to Freud, we are born with our Id. The Id is an important part of our personality because as newborns, it allows us to get our basic needs met. Freud believed that the Id is based on pleasure principle. In other words, the Id wants whatever feels good at the time, with no consideration for the reality of the situation. When a child is hungry, the Id wants food, and therefore the child cries. When the child needs to be changed, the child cries and the Id wants that the change is done immediately. When the child is uncomfortable, in pain, too

hot, too cold, or just wants attention, the Id speaks up until his or her needs are met. The Id does not care about reality, about the needs of anyone else, only its own satisfaction. If you think about it, babies are not real considerate of their parents' wishes. They have no care for time, whether their parents are sleeping, relaxing, eating dinner, or bathing. When the Id wants something, nothing else is important.

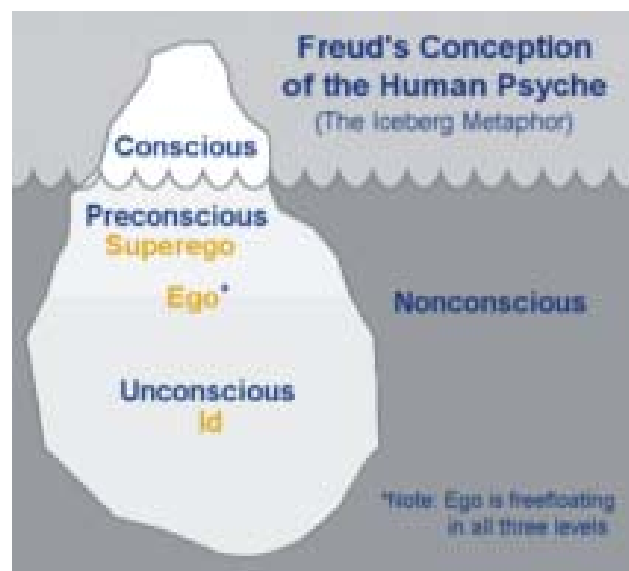
Within the next three years, as the child interacts more and more with the world, the second part of the personality begins to develop. Freud called this part as the Ego. The Ego is based on the reality principle. The ego understands that other people have needs and desires and that sometimes being impulsive or selfish can hurt us in the long run. It's the Ego's job to meet the needs of the id, while taking into consideration the reality of the situation.

By the age of five, or the end of the phallic stage of development, the Superego develops. The Superego is the moral part of the personality and develops in response to the moral and ethical restraints placed on the individual by the caregivers. Many equate the Superego with the conscience as it dictates our belief of right and wrong.

In a healthy person, according to Freud, the Ego is the strongest so that it can satisfy the needs of the id, not upset the Superego, and still take into consideration the reality of every situation. If the Id gets too strong, the impulses and self gratification take over the person's life. If the Superego becomes too strong, the person would be driven by rigid morals, would be judgmental and unbending in his or her interactions with the world.

Topographical Model

Freud believed that the majority of what individuals we experience in their lives, the underlying emotions, beliefs, feelings, and impulses are not available to them at a conscious level. He believed that most of what drives them is buried in their unconscious. For instance, in the case of Oedipus and Electra complex, the feelings and thoughts associated with the same sex parents were pushed into the unconscious, out of the awareness of the individual due to the extreme anxiety these thoughts and feelings caused. While buried there, however, they continue to impact us dramatically according to Freud.



The role of the unconscious is only one part of the model. Freud also believed that everything we are aware of is stored in our conscious. Our conscious makes up a very small part of who we are. In other words, at any given time, we are only aware of a very small part of what makes up our personality; most of what we are is buried and inaccessible.

The final part is the preconscious or subconscious. This is the part of us that we can access if prompted, but is not in our active conscious. It's right below the surface, but still buried somewhat unless we search for it. Information such as our telephone number, some childhood memories, or the name of your best childhood friend is stored in the preconscious. Because the unconscious is so large, and because we are only aware of the very small conscious at any given time, this theory has been likened to an iceberg, where the vast majority is buried beneath the water's surface. The water, by the way, would represent everything that we are not aware of, have not experienced, and that has not been integrated into our personalities, referred to as the nonconscious.

1.3.3 Stages of Psychosexual Development

Sigmund Freud (1856-1939) is probably the most well known theorist when it comes to the development of personality. *Freud's Stages of Psychosexual Development* are, like other stage theories, completed in a predetermined sequence and can result in either successful completion or a healthy personality or can result in failure, leading to an unhealthy personality. This theory is probably the most well known as well as the most controversial, as Freud believed that we develop through stages based upon a particular erogenous zone.

During each stage, an unsuccessful completion means that a child becomes fixated on that particular erogenous zone and either over- or under-indulges once he or she becomes an adult.

Oral Stage (Birth to 18 months): During the oral stage, the child is focused on oral pleasures (sucking). Too much or too little gratification can result in an Oral Fixation or Oral Personality which is evidenced by a preoccupation with oral activities. This type of personality may have a stronger tendency to smoke, drink alcohol, over eat, or bite his or her nails. Personality wise, these individuals may become overly dependent upon others, gullible, and perpetual followers. On the other hand, they may also fight these urges and develop pessimism and aggression toward others.

Anal Stage (18 months to three years): The child's focus of pleasure in this stage is on eliminating and retaining faeces. Through society's pressure, mainly via parents, the child has to learn to control anal stimulation. In terms of personality, after effects of an anal fixation during this stage can result in an obsession with cleanliness, perfection, and control (anal retentive). On the opposite end of the spectrum, they may become messy and disorganised (anal expulsive).

Phallic Stage (ages three to six): The pleasure zone switches to the genitals. Freud believed that during this stage boys develop unconscious sexual desires for their mother. Because of this, he becomes rivals with his father and sees him as competition for the mother's affection. During this time, boys also develop a fear that their father will punish them for these feelings, such as by castrating them. This group of feelings is known as Oedipus complex (after the Greek Mythology figure, who accidentally killed his father and married his mother).

Later it was added that girls go through a similar situation, developing unconscious sexual attraction to their father. Although Freud Strongly disagreed with this, it has been termed the Electra complex by more recent psychoanalysts.

According to Freud, out of fear of castration and due to the strong competition of their father, boys eventually decide to identify with him rather than fight him. By identifying with his father, the boy develops masculine characteristics and identifies himself as a male, and represses his sexual feelings toward his mother. A fixation at this stage could result in sexual deviancies (both overindulging and avoidance) and weak or confused sexual identity according to psychoanalysts.

Latency Stage (age six to puberty): It's during this stage that sexual urges remain repressed and children interact and play mostly with same sex peers.

Genital Stage (puberty on): The final stage of psychosexual development begins at the start of puberty when sexual urges are once again awakened. Through the lessons learned during the previous stages, adolescents direct their sexual urges onto opposite sex peers; with the primary focus of pleasure are the genitals.

1.3.4 Ego Defense Mechanisms

We stated earlier that the Ego's job was to satisfy the Id's impulses, not offend the moralistic character of the Superego, while still taking into consideration the reality of the situation. We also stated that this was not an easy job. Think of the Id as the 'devil on your shoulder' and the Superego as the 'angel of your shoulder.' We don't want either one to get too strong so we talk to both of them, hear their perspective and then make a decision. This decision is the Ego talking, the one looking for that healthy balance.

Before we can talk more about this, we need to understand what drives the Id, Ego, and Superego. According to Freud, we only have two drives; sex and aggression. In other words, everything we do is motivated by one of these two drives. Sex, also called Eros or the Life force, represents our drive to live, prosper, and produce offspring. Aggression, also called Thanatos or our Death force, represents our need to stay alive and stave off threats to our existence, our power, and our prosperity.

Now the Ego has a difficult time satisfying both the id and the superego, but it doesn't have to do so without help. The ego has some tools it can use in its job as the mediator; tools that help defend the ego. These are called Ego Defense Mechanisms or Defences. When the ego has a difficult time making both the Id and the Superego happy, it will employ one or more of these defenses mentioned in the table given below.

Table: 1.4: Defense Mechanisms

Defense	Description	Example
Denial	arguing against an anxiety provoking stimuli by stating it doesn't exist	denying that your physician's diagnosis of cancer is correct and seeking a second opinion
Displacement	taking out impulses on a less threatening target	slamming a door instead of hitting as person, yelling at your spouse after an argument with your boss

Intellectualisation	avoiding unacceptable emotions by focusing on the intellectual aspects	focusing on the details of a funeral as opposed to the sadness and grief
Projection	placing unacceptable impulses in yourself onto someone else	when losing an argument, you state “You’re just Stupid;” homophobia
Rationalisation	supplying a logical or rational reason as opposed to the real reason	stating that you were fired because you didn’t kiss up the the boss, when the real reason was your poor performance
Reaction Formation	taking the opposite belief because the true belief causes anxiety	having a bias against a particular race or culture and then embracing that race or culture to the extreme
Regression	returning to a previous stage of development	sitting in a corner and crying after hearing bad news; throwing a temper tantrum when you don’t get your way
Repression	pulling into the unconscious	forgetting sexual abuse from your childhood due to the trauma and anxiety
Sublimation	acting out unacceptable impulses in a socially acceptable way	sublimating your aggressive impulses toward a career as a boxer; becoming a surgeon because of your desire to cut; lifting weights to release ‘pent up’ energy
Suppression	pushing into the unconscious	trying to forget something that causes you anxiety

Ego defenses are not necessarily unhealthy as you can see by the examples above. In face, the lack of these defenses or the inability to use them effectively can often lead to problems in life. However, we sometimes employ the defenses at the wrong time or overuse them, which can be equally destructive.

1.3.5 Limitations

Some of the limitations typically raised in response to Freudian theory are:

Freud’s hypotheses are neither verifiable nor falsifiable. It is not clear what would count as evidence sufficient to confirm or refute theoretical claims.

The theory is based on an inadequate conceptualisation of the experience of women.

The theory overemphasises the role of sexuality in human psychological development and experience.

1.4 OBJECT RELATIONS THEORY

1.4.1 Symbiosis and Separation/Individuation

Another adaptation of psychoanalytic theory known as “object relations theory” starts from the assumption that the psychological life of the human being is created in and through relations with other human beings. Thus, the object

relations theorist distinguishes between the *physical* and the *psychological* birth of the individual. While the physical birth is a process that occurs over a specific and easily observable period of time, the psychological birth is typically extended over the first three years of life and can occur only in and through social relations. During this time, certain “innate potentials and character traits” (the ability to walk and talk) are allowed to develop in the presence of “good object relations”. The quality of these relations affects the quality of one’s linguistic and motor skills.

The first three years of life are characterised by

- a) the establishment of a close (symbiotic) relationship to the primary caretaker (which is generally the mother), and
- b) the subsequent dissolution of that relationship through separation (differentiating oneself from the caretaker) and individuation (establishing one’s own skills and personality traits).

A central element in this emerging “core identity” is one’s gender, which tends to be determined within the first one and a half to two years. Unlike Freudian theory, in object relations theory this gendering of the subject has little to do with the child’s own awareness of sexuality and reproduction. It does, however, involve the internalisation of any inequities in the value assigned to one’s gender, as well as the associated imbalance in power.

This psychological development of the child is part of a reciprocal process of adjustment between child and caretaker — both must learn to be responsive to the needs and interests of the other. During the symbiotic stage (one to six or seven months) the infant has little if any sense of distinction between self and other, and is extremely sensitive to the moods and feelings of the caretaker. In order for this phase to be adequate (i.e. “good enough”), the mother must be emotionally available to the child in a consistent, reasonably conflict-free way. She should be able to enjoy the sensual and emotional closeness of the relationship without losing her own sense of separateness. She should be concerned for the child’s well being without developing a narcissistic overinvestment in the child as a mere extension of her own self. Her infantile wishes for a symbiotic relationship should have been adequately gratified in childhood. If this was not the case, resentment and hostility may be aroused in her by the infant’s needs. The mother requires adequate support, both emotional and material, during this period from adults who are able both to nurture her and reinforce her own sense of autonomy.

The process of separation begins at around the sixth month and continues through the second year. During this time, the child experiences both pleasure and frustration as motor skills develop along with the corresponding awareness of one’s limitations. The child explores and continually develops its separateness, then returns to the mother for ‘emotional refueling’. The potential presence of the relationship between child and mother allows the child to leave it.

Gradually the relationship is internalised and becomes part of the child’s internal psychic reality. Both members of the dyad must learn to let go of the early bond without rejecting the other. The ambivalence present throughout this process gradually intensifies. The child both wants to return to the symbiotic state and

fears being engulfed by it. In 'good enough' social relations a resolution is achieved in which both members of the dyad come to accept their bond (mutuality) and their separateness. This is the basis of a truly reciprocal relationship with others.

1.4.2 Self Identity and Gender Identity

The process of becoming a "gendered subject" adds further complications to the child's development during this period. Since its initial identity is fused with that of the primary caretaker, and since that role is generally filled by the mother, it follows that initially the child's *gender* is the same as the mother's. Thus, boys and girls are originally "feminine". To become "masculine", the boy must repress much of his early, symbiotic experience. (Girls are less likely to repress infantile experience).

By the age of five, the boy will have repressed most of the feminine components of his nature along with his earliest memories. He will deal with the ambivalence of the separation/individuation period by means of denial of having been identified with the mother, by projection of blame onto women as the source of the problem, and by domination.

These defenses become part of ordinary male behaviour toward adult women and to anything which seems similar to them or under their (potential) control such as the body, feelings, and nature. The ability to control (and to be in control) becomes both a need and a symbol of masculinity. Relations are turned into contest for power. Aggression is mobilised to distance oneself from the object and then to overpower it. The girl, on the other hand, seeks relationships, even at the expense of her own autonomy. The two genders thus come to complement each other in a rather grotesque symmetry.

As we can see, there are two important aspects of child development:

- self-identity and
- gender-Identity.

In the traditional context of the nuclear family, we must also be able to account for the contribution of the father to the separation/individuation process. Since the child must move away from the mother in order to achieve autonomy, the father offers an alternative with which to identify. This is less problematic for the boy since the father also facilitates gender identification. Thus, the boy tends to develop strong self identity but weak gender identity. Since the girl does not experience the same kind of gender transformation, but at the same time cannot identify as closely with the father, she will tend to form a weak self identity, but a strong and less problematic gender identity.

1.4.3 Reproduction of Social Patterns

Finally, it must be remembered that the key insight contained in object relations theory is that the human subject is largely the product of the interaction that it, as a developing person, has with its caretakers. And since those caretakers are themselves socially determined persons, they will pass on to the child their own personal tendencies and social experiences with respect to race, class and gender. In this way, social relations are constitutive of "human nature".

1.5 SELF PSYCHOLOGY

Self psychology emphasises the development of a stable and integrated sense of self through empathic contacts with other humans, primary significant others conceived of as “self objects”. Self objects meet the developing self’s needs for mirroring, idealisation, and twinship, and thereby strengthen the developing self.

The process of treatment proceeds through “transmuting internalisations” in which the patient gradually internalises the self object functions provided by the therapist. Self psychology was proposed originally by Heinz Kohut, and has been further developed by Arnold Goldberg, Frank Lachmann, Paul and Anna Ornstein, Marian Tolpin, and others.

1.6 ATTACHMENT THEORY

John Bowlby was responsible for the development of attachment theory, largely in opposition to the existing psychoanalytic theories of his day. Nevertheless, in recent years attachment theory has started to become integrated with the pluralistic edifice of psychoanalysis.

Bowlby (1988) repeatedly emphasised the child’s real experience and the importance of the external world in the child’s healthy development. Borrowing from ethology, attachment behaviours were viewed by Bowlby as not reducible to another drive. In contrast to object relations thinking, the motivation of the child is not object seeking. Rather, the goal of the child is to achieve a psycho physiological state related to being in close proximity with the mother or caretaker.

Holmes (2001) suggested that the same is true of adults, who, when stressed or threatened, may, if insecurely attached, resort to ‘pathological secure base phenomena’, such as substance abuse, deliberate self-harm, or binge eating. These behaviours may re-create a shortcut to the physiological state of the secure base without its relational or psychological components.

The work of Ainsworth et al. (1978) was critically important in refining the attachment concept by studying the infant’s response to what was called the Strange Situation. In this 20 minute laboratory test, a child is exposed to brief separations from the child’s mother. The reaction to these separations led to a classification of children as securely attached, anxious-avoidantly attached, anxious-ambivalent or resistant in the attachment style, or disorganised/disoriented.

Although there is not a one-to-one correlation necessarily between the categories of child attachment and those of adults, attachment theorists have found it clinically useful to think of adult individuals in four somewhat analogous categories of attachment:

- secure/autonomous individuals who value attachment relationships;
- insecure/dismissing individuals who deny, devalue, idealise, or denigrate both current and past attachments;
- Preoccupied adults who are overwhelmed or confused by current and past attachment relationships; and

- Disorganised or unresolved individuals who have often suffered neglect or trauma.

Compared with other psychoanalytic schools of thought, there is much more rigorous empirical research behind attachment theory. Some of this research demonstrates that expectant parents' mental models of attachment predict subsequent patterns of attachment between mother and infant.

A key concept in attachment theory is mentalisation, the capacity to understand that one's own behaviour and that of others is motivated by internal states, such as thoughts and feelings.

In addition, part of mentalisation is an understanding that one's perceptions of others are representations rather than the way reality actually is. The mother's or caregiver's capacity to observe the infant's intentional state and internal world appears to influence the development of secure attachment in the child. The child's secure attachment to the caregiver is highly influential in the child's development of the capacity to mentalise.

1.7 LACANIAN PSYCHOANALYSIS

Lacanian psychoanalysis, which integrates psychoanalysis with semiotics and Hegelian philosophy, is especially popular in France and parts of Latin America. Lacanian psychoanalysis is a departure from the traditional British and American psychoanalysis, which is predominantly Ego psychology. Jacques Lacan frequently used the phrase "retourner à Freud" ("return to Freud") in his seminars and writings, as he claimed that his theories were an extension of Freud's own, contrary to those of Anna Freud, the Ego Psychology, Object relations and "self" theories and also claims the necessity of reading Freud's complete works, not only a part of them. Lacan's concepts concern the "mirror image", the "Real", the "Imaginary" and the "Symbolic", and the claim that "the unconscious is structured as a language".

Though a major influence on psychoanalysis in France and parts of Latin America, Lacan and his ideas have had little to no impact on psychoanalysis or psychotherapy in the English speaking world, where his ideas are most widely used to analyse texts in literary theory. Due to his unorthodox methods and theories, Lacan was expelled by the International Psychoanalytic Association, and many of Lacan's psychoanalytic concepts have been described as nonsensical, inconsistent or pseudoscientific.

1.8 POSTMODERN SCHOOLS

In recent years a number of theoretical models that emphasise the two person nature of psychoanalytic treatment have emerged. These various approaches, with labels such as intersubjectivity, relational theory, constructivism, or interpersonal psychoanalysis, all endorse scepticism about any fundamental truth residing in the patient or in the analyst. The truth is co-constructed in the interaction between therapist and patient. They are all postmodernists in outlook in that they doubt the existence of an objective reality.

Renik (1993), for example, stresses the irreducible subjectivity of the analyst in the way that the analyst approaches listening and formulating interventions. The treatment situation is intersubjective in that the psychoanalytic therapist can never fully transcend his or her own unconscious motivations for attempting to help the patient. In a similar vein, the postmodernist perspective recognises that the appearance of the patient's pathology is heavily influenced by the culture, gender, and personal biases of the therapist. The constructivist point of view stresses that we should be hesitant about regarding the patient's transference as a 'distortion' in that it may be a plausible construct based on the patient's recognition of real aspects of the analyst's behaviour.

Self Assessment Questions 1

1) What are the main components of psychoanalysis?

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2) Write about the two basic drives that motivates us according to Freud?

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3) Name the psychosexual stages of development according to Freud's theory?

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4) What are defense mechanisms?

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5) Write about the different categories of adult attachment?

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1.9 PSYCHOANALYTIC/PSYCHODYNAMIC THERAPY

The terms psychodynamic and psychoanalytic are often used interchangeably. However, within the psychodynamic and psychoanalytic terms, psychoanalysis is the term used when referring to a psychological treatment where the therapist, called a psychoanalyst or analyst, adheres to standard techniques focused on *interpretation* leading to insight in the context of the transference. In psychoanalysis the patient usually attends treatment three to five times weekly for 45- to 50-minute sessions. Treatment usually involves the patient lying on a couch and the analyst sitting behind the patient while the patient free associates i.e., says whatever comes to mind. Psychodynamic psychotherapy is characterised by the same basic techniques as psychoanalysis but tends to be briefer and less intensive than psychoanalysis.

Although any given session of psychodynamic psychotherapy may be indistinguishable from a psychoanalytic session, in psychodynamic psychotherapy the therapist is more likely to be actively engaged with the patient, to resonate emotionally with the patient's affect states, and rely more on the interpersonal relationship between client and therapist than in psychoanalysis.

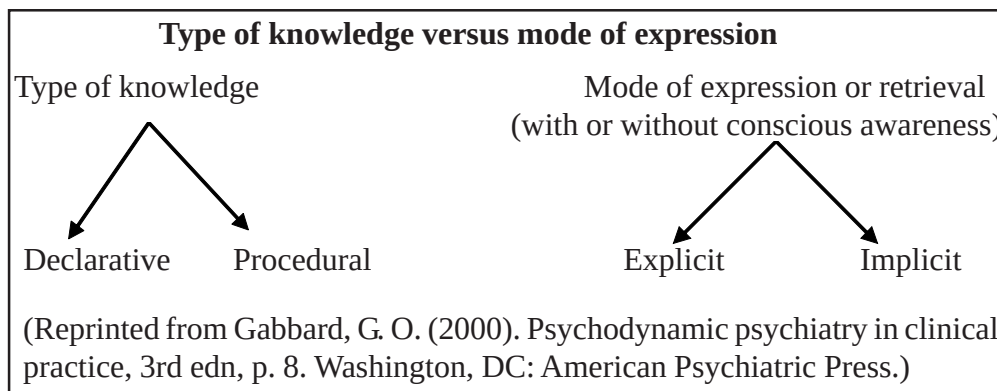
1.9.1 Basic Tenets and Concepts of Psychoanalytic Therapy

A number of basic tenets and concepts are central to psychodynamic psychotherapy. These include the following:

The Unconscious

Freud's premise that much of mental life is unconscious has been extensively validated by research in the field of experimental psychology. However, psychoanalytic psychotherapists are more likely to refer to unconscious representations or unconscious mental functioning rather than the unconscious. The notion of 'the unconscious' as a storage place or reservoir is no longer in keeping with contemporary neuroscience research.

We now recognise that memories are stored differently, depending on the type of knowledge being stored. Declarative memory involves facts and episodes of one's life, while procedural memory involves skills or procedures. Defense mechanisms, for example, are automatic unconscious procedures that regulate affect states. Memories of difficult times in one's life are aspects of declarative knowledge that may be conscious and easily recalled or may be repressed and therefore unconscious. Declarative knowledge is knowledge 'of', whereas procedural knowledge is knowledge 'how'. The table below presents the type of knowledge and mode of expression



In current thinking that integrates psychodynamic and neuroscience data, both procedural and declarative memories can be viewed as either conscious or unconscious. A distinction between explicit and implicit memory relates to whether knowledge is expressed and/or retrieved with or without conscious awareness. Hence the explicit versus implicit distinction can be understood as equivalent to conscious versus unconscious.

Within this model defense mechanisms are primarily in the domain of implicit procedural memory. Suppression, though, one of the few conscious defense mechanisms, lies in the realm of explicit procedural memory because it involves the conscious banishment of certain thoughts and/or feelings from one's mind.

Implicit declarative knowledge involves repressed ideas and repressed memories of events in one's life and knowledge that involves various kinds of expectations about how others will react in response to what one does. This latter category may be retrievable if one shifts one's attention to it, a category Freud called preconscious. Explicit declarative knowledge consists of facts and events that are fully conscious.

Unconscious aspects of mental functioning may reveal themselves as slips of the tongue, forgetting, or substituting names or words. Nonverbal behaviour is also a reflection of unconscious and internalised modes of relating to others. In other words, how the patient relates to the therapist may say a great deal about unconscious representations of self and other within the patient.

The Developmental Perspective

All psychoanalytic thinking is based on a developmental model of behaviour. A fundamental assumption is that childhood events shape the adult person. The repetitive patterns of problematic interactions with others stem from intrapsychic issues that are internalised during childhood. In contemporary thinking about the interface between genetics and environment, we know that the genetically based temperament of the child shapes much of the interaction with the parents. In other words, characteristics that are genetically determined evoke specific parental responses, which in turn shape the child's personality. Psychoanalytic therapists do not blame parents for their patient's difficulties. They see the patient's difficulties as a complex interaction between the child's characteristics, the parents' characteristics, and the 'fit' between them.

Subjectivity

Subjectivity is a psychodynamic perspective that emphasises the importance of *individual or personal meaning* of events. Psychodynamic clinicians are interested in the patient's phenomenological experience, that is how the patient experiences himself, important others, the world in general, etc.

In this way, psychodynamic clinicians are focused on what those from the cognitive-behavioural therapy tradition call schemas or schemata. The difference, however, is that in a psychodynamic model, these schemas are seen as having explicit, conscious, and implicit unconscious aspects, and the implicit parts can be simply out of awareness or kept out of awareness for defensive purposes. The psychoanalytic model posits that individuals may use one set of representations to defend against other intolerable representations. There is greater attention to the emotional aspects of these schemas or representations and to the structural

aspects of representation, that is, the degree of differentiation and hierarchical integration of representations. Evidence from developmental, clinical, and neuroscience provide validation for these basic premises.

Transference

Patients unconsciously relate to the psychotherapist as though the therapist is someone from their past. Although Freud regarded transference as a simple displacement of a past relationship into the present, we now recognise that the therapist's actual characteristics and behaviour continuously contribute to the nature of transference. The physical characteristics, way of relating to the patient, gender, and age of the therapist all influence the patient's perception of the therapist. These features trigger neural networks within the patient that contain representations of past figures and revise these 'ghosts' from the past in the present. In addition to the repetitive dimension of transference, the patient also may harbour a longing for a healing or corrective experience to compensate for the problems that occurred in childhood relationships. Hence a longing for a different kind of relationship may be inherent in transference.

Resistance

Patients still resist psychotherapy as they did in Freud's day. One of the great discoveries of Freud was that patients may be ambivalent about getting better and unconsciously (or consciously) oppose attempts to help them. Resistance may manifest itself as silence in therapy sessions, as avoidance of difficult topics, or as the forgetting of sessions. In essence, resistance can be viewed as any way that patients defend themselves against changing in the service of preserving their illness as it is. Resistance is no longer viewed as an obstacle to be removed by the therapist. Rather, it is viewed as a revelation about how the patient's past influences current behaviour in the relationship with the therapist.

If, for example, a male patient experiences his male therapist as critical, he may be reluctant to say much. This reticence may reveal a great deal about his relationship with his father and with other male authority figures. Helping the patient to understand resistance is a central feature of psychodynamic therapy.

Countertransference

Freud wrote very little about countertransference. He originally defined it as the analyst's transference to the patient. He generally regarded it as interference in the analyst that paralleled transference in the patient. In other words, the analyst would unconsciously view the patient as someone from the past and therefore have difficulty treating the patient.

Countertransference is now regarded as an enormously valuable therapeutic tool in psychoanalytic therapy. It is a joint creation that stems in part from the therapist's past but also in part from the patient's internal world. In other words, patients induce certain feelings in the therapist that provide the therapist with a glimpse of the patient's internal world and what sort of feelings are evoked in other relationships outside of therapy.

Psychic determinism

The principle of psychic determinism asserts that our internal experience, our behaviours, our choice of romantic partners, our career decisions, and even our

hobbies are shaped by unconscious forces that are beyond our awareness. The psychodynamic therapist approaches a patient with the understanding that any symptom or problem may serve multiple functions. A variety of conflicts from different developmental levels all may converge to form the end result of a behaviour or symptom. A psychoanalytic therapist recognises that many of the reasons for the patient's difficulties lie outside the patient's awareness, and both therapist and patient must be willing to explore a variety of converging causes.

Although other concepts have been stressed within psychoanalysis at various times, such as the Oedipus complex or psychosexual stages, it should be noted that these concepts are not as central or crucial to the psychoanalytic and psychodynamic models as the other tenets we have identified.

1.9.2 Components of Psychoanalytic and Psychodynamic Psychotherapy

The aim of psychodynamic psychotherapy is to make what is unconscious conscious in an effort to better understand a person's motivations and thus respond to them in reality more honestly. Three essential features of the psychoanalytic method are interpretation, including

- i) clarification and confrontation,
- ii) analysis of the transference, and
- iii) technical neutrality.

These three aspects are dealt with in detail below:

- i) **Clarification, Confrontation and Interpretation:** The three main techniques used in psychodynamic psychotherapy are clarification, confrontation, and interpretation.

Clarifications simply are requests for more information or further elaborations in order to better understand the patient's subjective experience. Beginning therapists and those with only a cursory understanding of psychodynamic psychotherapy, often neglect this technique and move prematurely to interpretation. Even if a therapist could determine the appropriate interpretation without clarifying, it would be difficult for the patient to integrate it without first properly clarifying.

Clarifying and confronting a patient's experience are preparatory steps for interpretation. The therapist should clarify thoroughly until both the therapist and the patient have a clear understanding of any areas of vagueness. It is important to recognise vague communications, which is not easily done, because therapists prematurely foreclose clarification by inserting their own preconceptions when patients are vague or unclear.

For example, if a patient says he feels depressed, the therapist should clarify what the patient means by the term. A standard technique is to start with short open ended questions and become more specific as needed. For example, a therapist might simply respond by saying "Can you say more about that?"

A recommended device for determining if clarification is required is to ask oneself whether a patient's presentation could be veridically described to a

supervisor or consulting colleague. Frequently, a patient will become puzzled by contradictions in his or her thinking or experience during the clarification process.

Confrontations sound harsher than they are because they actually involve tactfully pointing out discrepancies or incongruities in the patient's narrative or the patient's verbal and nonverbal behaviour (affect or actual behaviour). It is difficult to successfully confront a patient without thoroughly clarifying because the patient may not be aware of what the therapist is observing. (Conversely, without clarifying, the therapist may incorrectly confront the patient regarding material that would otherwise be clear.)

The therapist uses the clarified material or information that is contradictory for further exploration and understanding. This is done in an effort to better understand conflicting mental states or representation of experience that implicitly address the patient's defensive operations.

Interpretations focus on the unconscious meaning of what has been clarified and confronted.

Interpretations can be made regarding experience in the therapy or about the relationship between the patient and the therapist (interpretations of the "here and now") or about relationships outside the therapy, either with important others or other people in the patient's life.

Interpretations about relationships outside of therapy are referred to as extra transference interpretations. Interpretations made about early experiences with caregivers are called genetic interpretations. In any regard, it is important that interpretations be timely, clear, and tactful and made in a collaborative manner only after clarifying the patient's experience and pointing out gaps and inconsistencies. The interpretation is not offered until the patient is just about ready to discover it by him or herself. Interpretation is offered as a hypothesis in the context of a collaborative endeavour and not as a pronouncement from an all knowing authority as is frequently portrayed in movies, the media, and poorly trained individuals.

- ii) **Technical neutrality:** The psychodynamic psychotherapist uses the techniques of clarification, confrontation, and interpretation in the context of technical neutrality. Technical neutrality, or therapeutic neutrality, is an often misinterpreted construct whereby the psychodynamic therapist mistakenly believes that he or she needs to adopt a stone-face or blank screen, say very little, refuse to self-disclose, or provide advice, support, or reassurance. The therapist is seen as nonactive, passive, maybe even bland, monotonous, or indifferent and at worst cold and lacking in concern. This is not what technical neutrality is supposed to be.

Technical neutrality is a therapeutic strategy in which the therapist avoids communicating any judgment about the patient's conflicts while they are being discussed (i.e., remains equidistant from all sides of the patient's conflicts). Typically, therapists refrain from providing advice, praise, or reproof of the patient, and they restrain their own needs for a particular type of relationship (to be liked, valued, idealised, or the centre of attention).

Technical neutrality fosters warmth and genuine human concern. A nonjudgmental, noncritical stance provides the patient with a sense of safety that allows the exploration of previously avoided memories, thoughts, and feelings. Adopting this position encourages the patient to become more fully aware of his or her mental life and can be validating to the patient.

Connecting with the entirety of the patient's internal experience is experienced as empathic. This strategy also helps the therapist avoid enactments and collusions with the patient.

Finally, it is important to note that technical neutrality is modified to the extent required to maintain the structure of the treatment.

Two other secondary strategies are worth noting. In recent years, self-disclosure by the therapist in a limited way has become a common intervention. Judicious self-disclosure may promote increased reflective function by helping the patients see that their representation of the therapist is different from the way the therapist actually feels.

- iii) **Self-disclosures:** Another aspect is self disclosure of here and now countertransference feelings which may also help patients understand the impact they have on others. In addition, an affirmation process goes on in most dynamic therapies where patients feel that their point of view is valued and validated.

This empathically validating function of the therapist may serve to mitigate longstanding feelings of being disbelieved or dismissed by earlier figures in one's life.

1.9.3 Distinctive Features of Psychodynamic Technique

The features listed below concern process and technique of psychodynamic therapy.

- i) **Focus on affect and expression of emotion:** Psychodynamic therapy encourages exploration and discussion of the full range of a patient's emotions. The therapist helps the patient describe and put words to feelings, including contradictory feelings, feelings that are troubling or threatening, and feelings that the patient may not initially be able to recognise or acknowledge. There is also recognition that intellectual insight is not the same as emotional insight, which resonates at a deep level and leads to change (this is one reason why many intelligent and psychologically minded people can explain the reasons for their difficulties, yet their understanding does not help them overcome those difficulties).
- ii) **Exploration of attempts to avoid distressing thoughts and feelings:** People do a great many things, knowingly and unknowingly, to avoid aspects of experience that are troubling. This avoidance (in theoretical terms, defense and resistance) may take coarse forms, such as missing sessions, arriving late, or being evasive. It may take subtle forms that are difficult to recognise in ordinary social discourse, such as subtle shifts of topic when certain ideas arise, focusing on incidental aspects of an experience rather than on what is psychologically meaningful, attending to facts and events to the exclusion

of affect, focusing on external circumstances rather than one's own role in shaping events, and so on. Psychodynamic therapists actively focus on and explore avoidances.

- iii) **Identification of recurring themes and patterns:** Psychodynamic therapists work to identify and explore recurring themes and patterns in patients' thoughts, feelings, self-concept, relationships, and life experiences. In some cases, a patient may be acutely aware of recurring patterns that are painful or self-defeating but feel unable to escape them (e.g., a man who repeatedly finds himself drawn to romantic partners who are emotionally unavailable; a woman who regularly sabotages herself when success is at hand). In other cases, the patient may be unaware of the patterns until the therapist helps him or her recognise and understand them.
- iv) **Discussion of past experience (developmental focus):** Related to the identification of recurring themes and patterns is the recognition that past experience, especially early experiences of attachment figures, affects our relation to, and experience of, the present. Psychodynamic therapists explore early experiences, the relation between past and present, and the ways in which the past tends to "live on" in the present. The focus is not on the past for its own sake, but rather on how the past sheds light on current psychological difficulties. The goal is to help patients free themselves from the bonds of past experience in order to live more fully in the present.
- v) **Focus on interpersonal relations:** Psychodynamic therapy places heavy emphasis on patients' relationships and interpersonal experience (in theoretical terms, object relations and attachment). Both adaptive and nonadaptive aspects of personality and self-concept are forged in the context of attachment relationships, and psychological difficulties often arise when problematic interpersonal patterns interfere with a person's ability to meet emotional needs.
- vi) **Focus on the therapy relationship:** The relationship between therapist and patient is itself an important interpersonal relationship, one that can become deeply meaningful and emotionally charged. To the extent that there are repetitive themes in a person's relationships and manner of interacting, these themes tend to emerge in some form in the therapy relationship. For example, a person prone to distrust others may view the therapist with suspicion; a person who fears disapproval, rejection, or abandonment may fear rejection by the therapist, whether knowingly or unknowingly; a person who struggles with anger and hostility may struggle with anger toward the therapist; and so on (these are relatively crude examples; the repetition of interpersonal themes in the therapy relationship is often more complex and subtle than these examples suggest). The recurrence of interpersonal themes in the therapy relationship (in theoretical terms, transference and countertransference) provides a unique opportunity to explore and rework them in vivo. The goal is greater flexibility in interpersonal relationships and an enhanced capacity to meet interpersonal needs.
- vii) **Exploration of fantasy life:** In contrast to other therapies in which the therapist may actively structure sessions or follow a predetermined agenda, psychodynamic therapy encourages patients to speak freely about whatever

is on their minds. When patients do this (and most patients require considerable help from the therapist before they can truly speak freely), their thoughts naturally range over many areas of mental life, including desires, fears, fantasies, dreams, and daydreams (which in many cases the patient has not previously attempted to put into words). All of this material is a rich source of information about how the person views self and others, interprets and makes sense of experience, avoids aspects of experience, or interferes with a potential capacity to find greater enjoyment and meaning in life.

The last sentence hints at a larger goal that is implicit in all of the others: The goals of psychodynamic therapy include, but extend beyond, symptom remission. Successful treatment should not only relieve symptoms (i.e., get rid of something) but also foster the positive presence of psychological capacities and resources. Depending on the person and the circumstances, these might include the capacity to have more fulfilling relationships, make more effective use of one's talents and abilities, maintain a realistically based sense of self-esteem, tolerate a wider range of affect, have more satisfying sexual experiences, understand self and others in more nuanced and sophisticated ways, and face life's challenges with greater freedom and flexibility. Such ends are pursued through a process of self-reflection, self-exploration, and self-discovery that takes place in the context of a safe and deeply authentic relationship between therapist and patient.

Self Assessment Questions 2

1) What is psychic determinism?

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2) What is clarification?

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3) Explain the method of Interpretation?

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4) What is technical neutrality?

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5) Explain the strategy of self-disclosure?

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1.10 LET US SUM UP

As a system of thought and a technique for dealing with mental illness, psychoanalysis has been developing and changing over the years. What seemed at first a monolithic theory is now being examined critically from many different points of view. Technical innovations and reformulations of theoretical concepts are appearing in ever-increasing numbers. Freud's theory is deterministic; that is he assumes that all behaviour has a specific cause and that cause can be found in the psyche. Nothing we do is accidental but is governed by the innate drives of our unconscious. Freud described two basic drives: Eros and Thanatos (love and death in Greek). Eros, a positive creating force, is the life instinct and includes self-preservation and therefore the need for food, water, and shelter. Thanatos refers to the drive that provokes us to aggressive behaviour including self-destructive acts.

Freud's model of the mind has three elements, which his translators have called by the Latin words, the id, the ego and the super-ego. Defence mechanisms play an important role in normal development and we all use them. Freud described five stages of development: oral, anal, phallic, latency and genital. These stages are referred to as 'psychosexual' because they relate to the mental aspects of sexual phenomena. Psychodynamic psychotherapy is probably the most widely practiced and most well-known form of therapy. Based on psychoanalysis, its unique features include an emphasis on unconscious mental life, systematic attention to transference themes and developmental issues, the exploration of countertransference as an important therapeutic tool, and the working through of resistance, defense, and conflict. The psychodynamic approaches are sometimes called the 'uncovering' therapies. They all aim to help the client take the lid off that seething cauldron and bring the contents of the unconscious into conscious awareness. The idea is that if we know what it is that frightens or upsets us and can understand the underlying conflicts, we can then change our behaviour. By making links between the past and the present, clients can be helped to combine the previously unknown parts of themselves into their present and future selves, thus becoming more integrated individuals.

1.11 UNIT END QUESTIONS

- 1) Describe in depth the Freud's theory of personality?
- 2) Discuss the core ideas of object relations theory?
- 3) Explain in detail the treatment principles and concepts of psychodynamic therapy?
- 4) Write about the techniques used in psychoanalytic/ psychodynamic therapy?
- 5) What are the distinctive features of psychodynamic therapy?

1.12 SUGGESTED READINGS

Bateman, A. and Holmes, J. (1995). *Introduction to Psychoanalysis: Contemporary Theory and Practice*. London: Routledge.

Brenner, C. (1973). *An Elementary Textbook of Psychoanalysis*. New York: International Universities Press.

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Ursano, Robert J., Sonnenberg, Stephen M., Lazar, Susan G. (2004). *Concise Guide to Psychodynamic Psychotherapy*. London: American Psychiatric Publishing, Inc.

1.13 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

- 1) Psychoanalysis is a method of investigation of the mind and the way one thinks, a systematised set of theories about human behaviour and a method of treatment of psychological or emotional illness.
- 2) Freud described two basic drives: Eros and Thanatos (love and death in Greek). Eros, a positive creating force, is the life instinct and includes self-preservation and therefore the need for food, water, and shelter. It also includes the preservation of the species, making sexuality a powerful force. Thanatos refers to the drive that provokes us to aggressive behaviour including self-destructive acts.
- 3) Freud described five stages of development: oral, anal, phallic, latency and genital. These stages are referred to as 'psychosexual' because they relate to the mental aspects of sexual phenomena. Passing through each stage successfully (meaning with few tensions or conflicts remaining) requires an adequate amount of gratification—not too much and not too little.
- 4) To enable us to lead comfortable lives free from feelings of anxiety resulting from the conflict between its three masters, the ego employs a variety of defence mechanisms to ward off the forbidden impulses of the id. They are means by which people push threatening thoughts or feelings from awareness.

- 5) There are four categories of attachment they are: secure/autonomous individuals who value attachment relationships; insecure/dismissing individuals who deny, devalue, idealise, or denigrate both current and past attachments; preoccupied adults who are overwhelmed or confused by current and past attachment relationships; and disorganised or unresolved individuals who have often suffered neglect or trauma.

Self Assessment Questions 2

- 1) It is the idea that nothing in the mind happens by chance; that all mental and physical behaviour is determined by prior psychological causes.
- 2) It is a request for more information or further elaboration in order to better understand the patient's subjective experience.
- 3) Interpretation is a focus on the unconscious meaning of what has been clarified and confronted, regarding experience in therapy, the relationship between the patient and therapist, or about relationships outside of therapy
- 4) Technical neutrality is a therapeutic strategy in which the therapist avoids communicating any judgment about the patient's conflicts while they are being discussed.
- 5) Self-disclosure may be defined as the revelation of personal rather than professional information about the therapist to the client only in the context that it should help the client in self exploration.

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UNIT 2 INSIGHT PSYCHOTHERAPY, INTERPERSONAL PSYCHOTHERAPY

Structure

- 2.0 Introduction
- 2.1 Objectives
- 2.2 Insight Psychotherapy
 - 2.2.1 Psychoanalysis
 - 2.2.2 Analytical Psychology
 - 2.2.3 Existential Therapy
 - 2.2.4 Person-Centered Therapy
 - 2.2.5 Evaluation of Insight Therapies
 - 2.2.6 Behaviour Therapies
 - 2.2.7 Gestalt Therapy
- 2.3 Interpersonal Psychotherapy (IPT)
 - 2.3.1 Characteristics of Interpersonal Psychotherapy
 - 2.3.2 Techniques of Interpersonal Therapy
- 2.4 Let Us Sum UP
- 2.5 Unit End Questions
- 2.6 Suggested Readings

2.0 INTRODUCTION

Psychotherapies aim at changing the maladaptive behaviours and decreasing the sense of personal distress and helping the client to adapt better to his environment. At other times, inadequate marital, occupational and social adjustment also requires that major changes be made in an individual's personal environment. There are different types of therapies available today and therapists are becoming more and more concerned with finding the most appropriate form of therapy for an individual. In this unit we will discuss two such therapies: Insight psychotherapy and Interpersonal therapy. We would be discussing in detail the concept of insight therapy and the different types of therapies which fall under this therapy. In the second half of the unit we would be discussing the characteristics and techniques of interpersonal psychotherapy.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the concept of insight psychotherapy;
- Describe the different types of insight therapies and their techniques;
- Describe the characteristics of interpersonal psychotherapy; and
- Understand the techniques used in interpersonal psychotherapy.

2.2 INSIGHT PSYCHOTHERAPY

Insight therapy is the umbrella term used to describe a group of different therapy techniques that have some similar characteristics in theory and thought. Insight therapy assumes that a person's behaviour, thoughts, and emotions become disordered because the individual does not understand what motivates him, especially when a conflict develops between the person's needs and his drives. The theory of insight therapy, therefore, is that a greater awareness of motivation will result in an increase in control and an improvement in thought, emotion, and behaviour.

The goal of this therapy is to help an individual discover the reasons and motivation for his behaviour, feelings, and thinking. The different types of insight therapies are described below.

2.2.1 Psychoanalysis

The Father of Psychoanalysis, Sigmund Freud (1856–1939) laid the groundwork for many forms of mental health therapies with his introduction of psychoanalysis and the psychoanalytic or psychodynamic paradigm, which states that psychopathology (the study of the nature and development of mental disorders) is a result of “unconscious conflicts” within a person.

Freud believed that personal development is based on inborn, and particularly sexual, drives that exist in everyone. He also believed that the mind, which he renamed the psyche, is divided into three parts, viz., the Id, The Ego and the Super ego. Functioning together as a whole, these three parts represent specific energies in a person.

The Id: Present at birth, the Id is a part of the mind and is also in charge of all the energy needed to “run” the psyche. It comprises the basic biological urges for food, water, elimination, warmth, affection, and sex. (Originally trained as a neurologist, Freud believed that the source of all of the Id's energy is biological.) Later, as a child develops, the energy from the psyche, or the libido, is converted into unconscious psychic energy. The Id works on immediate gratification and operates on what Freud called the pleasure principle. The pleasure principle is a primary process, and the Id strives to rid the psyche of developing tension by utilising the pleasure principle, which is the tendency to avoid or reduce pain and obtain pleasure. A classic example is that of an infant who, when hungry, works under the pleasure principle to overcome his discomfort when he reaches for his mother's breast.

The Ego: A primarily conscious part of the psyche, the ego develops during the second half of an infant's first year, and deals with reality and the conscious situations surrounding an individual. Through planning and decision making, which is also called secondary process thinking, the ego learns that operating on the id level is generally not very effective in the long term. The ego, then, operates through realistic thinking, or on the reality principle. The ego gets its energy from the id, which it is also in charge of directing.

The Superego: The superego, which develops throughout childhood, operates more or less as a person's conscience. According to Freud, the superego is that

part of the mind that houses the rules of the society in which one lives (the conscience), a person's goals, and how one wants to behave (called the ego-ideal). While the Id and Ego are considered characteristics of the individual, the Superego is based more on outside influences, such as family and society. For example, as children grow up, they will learn what actions and behaviours are or are not acceptable and from this new knowledge, they learn how to act to win the praise or affection of a parent.

Freud believed that the Superego develops from the Ego much as the Ego develops from the Id. Both the Id's instincts and many Superego activities are unknown to the mind, while the Ego is always conscious of all the psyche's activities. These three parts of the psyche work together in a relationship called psychodynamics.

Psychoanalytic theory and psychoanalysis are based on Freud's second theory of neurotic anxiety, which is the reaction of the Ego when a previously repressed Id impulse pushes to express itself. The unconscious part of the Ego, for example, encounters a situation that reminds it of a repressed childhood conflict, often related to a sexual or aggressive impulse, and is overcome by an overwhelming feeling of tension. Psychoanalytic therapy tries to remove the earlier repression and helps the patient resolve the childhood conflict through the use of adult reality. The childhood repression had prevented the Ego from growing; as the conflict is faced and resolved, the Ego can reenter a healthy growth pattern.

Free Association: Raising repressed conflicts occurs through different psychoanalytic techniques, one of which is called free association. In free association, the patient reclines on a couch, facing away from the analyst. The analyst sits near the patient's head and will often take notes during a session. The patient is then free to talk without censoring of any kind. Eventually defenses held by the patient should lessen, and a bond of trust between analyst and patient is established.

Dream Analysis: Another analytic technique often used in psychoanalysis is dream analysis. This technique follows the Freudian theory that ego defenses are relaxed during sleep, which allows repressed material to enter the sleeper's consciousness. Since these repressed thoughts are so threatening they cannot be experienced in their actual form; the thoughts are disguised in dreams. The dreams, then, become symbolic and significant to the patient's psychoanalytic work.

Transference: Yet another ingredient in psychoanalysis is transference, a patient's response to the analyst which is not in keeping with the analyst-patient relationship but seems, instead, to resemble ways of behaving toward significant people in the patient's past. For example, as a result of feeling neglected as children, patients may feel that they must impress the analyst in order to keep the analyst present. Through observation of these transferred attitudes, the analyst gains insight into the childhood origin of repressed conflicts. The analyst might find that patients who were often home alone as children due to the hardworking but unaware parents could only gain the parental attention they craved when they acted in extreme ways.

Analysis of defense: One focus of psychoanalysis is the analysis of defenses. This can provide the analyst with a clearer picture of some of the patient's conflict. The therapist studies the patient's defense mechanisms, which are the ego's

unconscious way of warding off a confrontation with anxiety. An example of a defense mechanism would occur when a person who does not want to discuss the death of a close friend or relative during her session might experience a memory lapse when the topic is introduced and she is forced to discuss it. The analyst tries to interpret this patient's behaviour, pointing out its defensive nature in order to stimulate the patient to realise that she is avoiding the topic.

Psychoanalytic sessions between patients and their analysts may occur as frequently as five times a week. This frequency is necessary at the beginning of the relationship in order to establish trust between patient and analyst and therefore bring the patient to a level of comfort where repressed conflicts can be uncovered and discussed.

2.2.2 Analytical Psychology

Carl Gustav Jung (1887–1961) was one of the close associates of Sigmund Freud who decided to branch out on his own. He defined analytical psychology, which is a mixture of Freudian and humanistic psychology. Jung believed that the role of the unconscious was very important in human behaviour. In addition to our unconscious, Jung said there is a collective unconscious as well, which acts as a storage area for all the experiences that all people have had over the centuries. He also stated that the collective unconscious contains positive and creative forces rather than sexual and aggressive ones, as Freud argued. Carl Jung believed that all persons have masculine and feminine traits that can be blended within a person and opined that the spiritual and religious needs of humans are just as important as the libidinal, or physical, sexual needs.

Analytical psychology organises personality types into groups such as the “extroverted,” or acting out, and “introverted,” or turning oneself inward. These are Jungian terms used to describe personality traits. Developing a purpose, decision making, and setting goals are other components of Jung's theory. While Freud believed that a person's current and future behaviour is based on experiences of the past, Jungian theorists often focus on dreams, fantasies, and other things that come from or involve the unconscious.

Jungian therapy, therefore focuses on an analysis of the patient's unconscious processes so that the patient can ultimately integrate them into conscious thought and deal with them. Much of the Jungian technique is based on bringing the unconscious into the conscious.

In explaining personality, Jung said that there are three levels of consciousness, viz.,

- i) the conscious,
- ii) the personal unconscious, and
- iii) the collective unconscious.

The conscious is the only level of which a person is directly aware. This awareness begins right at birth and continues throughout a person's life. At one point, the conscious experiences a stage called individuation, in which the person strives to be different from others and assert himself as an individual. The goal of individuation is to know oneself wholly and completely. This is accomplished, in part, by bringing unconscious material to the conscious.

The personal unconscious is the landing area of the brain for the thoughts, feelings, experiences, and perceptions that are not picked up by the ego. Repressed personal conflicts or unresolved issues are also stored here. Jung integrated this concept into his psychoanalytic theory. According to Jung, the thoughts, memories and other material in the personal unconscious are associated with each other and form an involuntary theme. Jung assigned the term “complex” to describe this theme. These complexes can have an extreme emotional effect on a person.

The idea of the collective unconscious is one that separates Jung’s theory of psychotherapy from other theories. Jung said that the collective unconscious is made up of the following:

- i) images and ideas that are independent of the material in one’s personal consciousness
- ii) instincts, or strong motivations that are present from birth, and
- iii) archetypes, which are universally known images or symbols that predispose an individual to have a specific feeling or thought about that image.

Archetypes will often show themselves in the form of archetypal images, such as the archetype of death or the archetype of the old woman. Death’s definition is pretty clear (death equals death) and the archetype of the old woman is often used as a representation of wisdom and age.

Jung believed that to fully understand people, one has to appreciate a person’s dreams and not just his or her past experiences. Through analytical psychology, the therapist and patient work together to uncover both parts of the person and address conflicts existing in that person.

2.2.3 Existential Therapy

Another insight therapy is the existential therapy. This is based on the philosophical theory of existentialism, which emphasises the importance of existence, including one’s responsibility for one’s own psychological existence.

One important component of this theory is dealing with life themes instead of techniques. More than other therapies, existential therapy looks at a patient’s self awareness and his ability to look beyond the immediate problems and events in his or her life and focus instead on problems of human existence.

The first existential therapists were trained in Freud’s theories of psychoanalysis, but they disagreed with Freud’s stress on the importance of biological drives and unconscious processes in the psyche. Instead, these therapists saw their patients as they were in reality, not as subjects based on theory.

The concepts of existential therapy developed out of the writings of European philosophers, such as Soren Kierkegaard, Friedrich Nietzsche, Karl Jaspers, philosopher and theologian Martin Heidegger, and the writer and philosopher Jean Paul Sartre.

With existential therapy, the focus is not on technique but on existential themes and how they apply to the patient. Through a positive, constructive therapeutic relationship between therapist and patient, existential therapy uncovers common themes occurring in the patient’s life. Patients discover that they are not living

their lives to the full potential and learn what they must do to realise their full capacity.

The existential therapist must be fully aware of patients and their needs in order to help them attain that position of living to the full of their existence. As patients become more aware of themselves and the results of their actions, they take more responsibility for life and become more “active.”

2.2.4 Person Centered Therapy

Once called nondirective therapy, then client centered therapy, person centered therapy was developed by American psychologist Carl Rogers. Drawing from years of in depth clinical research, Rogers’s therapy is based on four stages: the developmental stage, the nondirective stage, the client centered stage, and the person centered stage.

Person centered therapy looks at assumptions made about human nature and how people can try to understand these assumptions. Like other humanistic therapists, Rogers believed that people should be responsible for themselves, even when they are troubled. Person-centered therapy takes a positive view of patients, believing that they tend to move toward being fully functioning instead of wallowing in their problems.

Carl Rogers’ Humanist perspective replaced Freud’s personality structure with the self concept. This theory developed unique techniques which run parallel with Freud’s therapeutic structure. In psychoanalysis, the dynamic was between the patient and the therapist, which implied an embedded power difference between the two participants. In humanism, the patient is in charge of his own therapy, which is why they are called clients. The therapist and client have equal power here. Rogers, like Freud, treated patients with somatoform and anxiety disorders. The person centered therapy believed that anxiety results from incongruence (disparity between one’s self concept and one’s experienced reality). According to this theory, defensive mechanisms exacerbate incongruence. The goal of client centered therapy (CCT) , once again, is to reorganise personality.

The most important thing to CCT is the therapeutic climate, that is a warm, supportive, accepting climate is essential, which allows client to accept personal shortcomings.

The components of the ideal therapeutic climate include the following:

- i) Genuineness from the therapist
- ii) Unconditional positive regard for the client
- iii) Empathy for the client

The Therapeutic Process: In CCT, the therapist clarifies rather than interprets the client’s experience, which forces clients to develop their own solutions. Emotion focused couples therapy (where couples simply reiterate how they are feeling to one another) works in a similar way.

Cognitive therapies: Aaron Beck (1970s-1980s) put forward this therapy and stated that cognitive psychology tries to look at how people process information. Beck treated patients with major depression and from Beck’s perspective, depression is caused by negative thoughts and maladaptive beliefs (depressed

patients see setbacks as due to personal inadequacies, they tend to focus on negative events, they are pessimistic about future projections, and they have negative conclusions about their own self worth). The goal of cognitive insight therapy is to reorganise the way patients think: therapists try to promote realistic evaluations of reality in their patients. Unlike psychoanalysis or client centered therapy (which can take years), cognitive therapies only take 4-20 sessions. However, these therapies may only treat the symptoms of depression, rather than the causes (which makes it less effective).

Group therapy: Any one of these aforementioned types of therapies can be conducted in a group (4-15 clients). Group therapy originally came into use because there was a high demand for clinicians following world war 2. There were few mental health professionals, and lots of people who needed help, so group therapy was used to increase efficiency.

Some of the benefits of group therapy include the following:

- less expensive,
- improves social skills, and
- increases social networks (everyone in a group therapy sessions share a similar problem)
- participants also act as therapists to one another (they describe problems and previous coping strategies, and provide social support).

At the same time, the professional therapist leads the discussion, chooses which individuals are included or removed from the group, and sets goals or assigns “homework” to patients.

2.2.5 Evaluation of Insight Therapies

Hans Eysenck (1952) published an article claiming there was no evidence that insight therapies actually helped people. Two thirds of clients who entered insight therapies improved their conditions and two thirds of untreated neurotics improved, despite not utilising insight therapy (spontaneous remission).

Subsequent studies using control groups, however, indicated that the therapeutic effect is durable and superior to the placebo effect (there is a placebo effect in insight therapy, but therapy works beyond that).

2.2.6 Behaviour Therapies

Here, therapists apply learning principles in order to modify problematic behaviour (this limits the scope of what behavioural therapies can treat, as problems without major behavioural components cannot be remedied within this model)

Behaviourists are unconcerned with the psychological roots of disorders (the mind is a black box)

In insight therapies, symptoms reflect underlying problems: in behaviour therapies, the symptoms are the problems.

There are three important assumptions in behavioural therapies:

- 1) The problematic behaviour is a product of learning (remember little Albert with his conditioned fear of rats: that was a learned phobia)

- 2) Learning behaviour can be unlearned (remember little Peter whose fear of white rabbits was vanquished with the use of milk and cookies as a reinforce.
- 3) Problematic learned behaviour can be extinguished over time.

The following are the Behavioural Therapeutic Approaches:

- Systematic Desensitisation
- Aversion Therapy
- Social Skills Training
- Systemic Desensitisation.

This is used to treat phobias and other anxiety disorders with counter conditioning. Here, anxiety responses are seen as acquired through classical conditioning. The goal is to replace anxious responses with relaxation (replace phobic response with relaxation).

The technique follows a four step process and this is given below:

- 1) Create an anxiety hierarchy (the patient must think of different situations involving the phobic object, and then rank them from most terrifying to least terrifying).
 - 2) The therapist trains the individual in how to induce deep muscle relaxation so that they can create relaxation for themselves at will.
 - 3) The patient must then imagine each item on their anxiety hierarchy, and use their relaxation training to calm themselves down until they no longer feel anxious thinking about the situations at each step (the idea is to work through them progressively).
 - 4) The final step is to confront the real stimulus in a similar fashion.
- Aversion Therapy

Aversive stimuli are paired with a stimulus that elicits an undesirable response (counter-conditioning). The therapist associates the negative stimulus with the stimulus he wants the patient to avoid (ie: shocks with pictures of young children to “cure” pedophiles).

This is often used with drug and alcohol abuse. For example, nausea from a taken drug causes people to develop taste aversion to alcohol.

The above is a treatment of last resort. It is very unpleasant. It is usually used in conjunction with other therapies.

Person centered therapy is based more on a way of being rather than a therapy technique. In this therapy, therapists create a comfortable, non judgmental environment by demonstrating congruence (genuineness), empathy, and unconditional positive regard toward their patients while using a non directive approach. This aids patients in finding their own solutions to their problems. Rogerian therapists follow the nondirective approach. Although they may want to aid the patient in making decisions that may prove difficult for the patient to realise alone, the therapist cannot provide the answers because a patient must come to conclusions alone. The therapist does not ask questions in a person centered therapy session, as they may hamper the patient's personal growth, the goal of this therapy.

If the patient is able to perceive these conditions offered by the therapist, then the therapeutic change in the patient will take place and personal growth and higher consciousness can be reached.

2.2.7 Gestalt Therapy

Gestalt therapy emphasises current day life in the wholeness of the personality. Most people have conflicting feelings, if this is a problem for a person, this method of psychotherapy tries to help balance these conflictions. By doing this, the psychologist tries to help the patient function better in everyday life.

If a person's beliefs are in constant confliction, then the persons can find themselves overwhelmed and confused and will often tend to seek out the negative, which is only harmful and damaging to a person's well-being. Gestalt psychology developed from the work of Frederick S. Perls, who felt that a focus on perception, and on the development of the whole individual, were important. This was attained by increasing the patient's awareness of unacknowledged feelings and becoming aware of parts of the patient's personality that had been previously denied.

Gestalt therapy has both humanistic and existential aspects; Perls's contemporaries primarily rejected it because Perls disagreed with some of the basic concepts of psychoanalytic theory, such as the importance of the libido and its various transformations in the development of neurosis (mental disorders). Originally developed in the 1940s, the overall concepts of the Gestalt theory state that people are basically good and that this goodness should be allowed to show itself; also, psychological problems originate in frustrations and denials of this innate goodness.

Gestalt therapists focus on the creative aspects of people, instead of their problematic parts. There is a focus on the patient in the therapy room, in the present, instead of a launching into the past; what is most important for the patient is what is happening in that room at that time. If the past enters a session and creates problems for the Gestalt patient, it is brought into the present and discussed. The question of "why" is discouraged in Gestalt therapy, because trying to find causes in the past is considered an attempt to escape the responsibility for decisions made in the present. The therapist plays a role, too: Patients are sometimes coerced (forced) or even bullied into an awareness of every minute detail of the present situation.

Perls believed that awareness acted as a curative, so it is an integral part of this therapy process. He created quite a few techniques for patients, but one well-known practice is the empty chair technique, where a patient projects and then faces those projections. When a patient projects, the ego rejects characteristics or thoughts that are unacceptable or difficult to focus on consciously. For example, a patient may have unresolved feelings about a parent's early death. The patient in Gestalt therapy will sit facing an empty chair and pretend that he is facing the dead parent. The patient can then consciously face, and eventually overcome, the unresolved feelings or conflicts toward that parent.

The goal of Gestalt therapy is to help patients understand and accept their needs and fears as well as increase awareness of how they keep themselves from reaching their goals and taking care of their needs. Also, the Gestalt therapist strives to

help the patient encounter the world in a nonjudgmental way. Concentration on the “here and now” and on the patient as responsible for his or her actions and behaviour is an end result.

2.3 INTERPERSONAL PSYCHOTHERAPY (IPT)

Interpersonal Psychotherapy (IPT) is one of the short term therapies that have been proven to be effective for the treatment of depression. Short term usually involves up to 20 sessions (usually weekly meetings, 1 hour per session) and maintains a focus on 1-2 key issues that seem to be most closely related to the depression.

Although depression may not be caused by interpersonal events, it usually has an interpersonal component, that is, it affects relationships and roles in those relationships. IPT was developed to address these interpersonal issues. The precise focus of the therapy targets interpersonal events (such as interpersonal disputes / conflicts, interpersonal role transitions, complicated grief that goes beyond the normal bereavement period) that seem to be most important in the onset and / or maintenance of the depression. The first 1-3 session of IPT are devoted to assessment and identification of the specific interpersonal issue(s) that will be the focus of the remainder of the therapy.

IPT may not be effective in all cases, however, several years of careful study has shown that IPT is equally as effective in the short term treatment of depression as anti-depressant medication therapy. IPT can also work well in conjunction with medications. The decision to use IPT and medications for depression is based on a number of factors such as the severity of the depression, past treatment history, and patient preferences. An IPT clinician (such as a psychologist, psychiatrist or social worker) should present treatment options during the assessment phase and discuss the rationale for IPT.

Since depression is a recurrent illness, it is recommended that successful short term treatment be combined with ongoing, maintenance therapy. Maintenance IPT (IPT-M) can be administered once per month following termination of the short term phase. Preliminary results from ongoing studies suggest that IPT-M may prolong time to recurrence of depression (Frank et al., 1990).

This form of therapy was originally developed in the USA by Gerald Klerman and Myrna Weissman for the acute treatment of outpatients with non-psychotic depression. It has also been used in the maintenance treatment of depression and in the treatment of a number of specific populations of depressed people—adolescents, older people, HIV positive patients and people with dysthymia, bipolar disorder and bulimia nervosa.

2.3.1 Characteristics of Interpersonal Psychotherapy

The principal assumption of IPT is that a person's moods, and events in his or her interpersonal world, are interdependent. Interpersonal events, both adverse and favourable, can lead to depressive symptoms, and depression may, in turn, impair a person's interpersonal functioning. By actively intervening to improve a person's interpersonal functioning, his or her mood will also improve. The focus of treatment is on interpersonal problems in one of four areas: grief, role disputes, role transitions or interpersonal deficits.

The therapy is time limited. In the original descriptions by Klerman and Weissman, it is spread over 12 to 16 weekly sessions each of 50 minutes duration. In this form, it is probably not suitable for use in general practice. However, a shorter version comprising six half hour sessions, that is Interpersonal Counselling (IPC) has been shown to be effective in primary care populations.

Although IPT shares many characteristics with other forms of psychotherapy, it is distinguished from these in a number of ways. Its unique feature is the interpersonal focus and, specifically, the focus on one of the four problem areas. Moreover, the focus is on here and now functioning. While information about past relationships, including childhood relationships is sought, this information is only used to cast light on current interpersonal functioning. Unlike dynamic and supportive therapies, it is time limited, a characteristic it shares with CBT and behavioural therapies. As in CBT, the therapist discusses cognitive distortions that may be contributing to interpersonal difficulties. However, unlike CBT, the therapist does not specifically seek out maladaptive patterns of thinking, nor does he or she set specific homework tasks. While dynamic psychotherapy may attempt to change a person's personality, IPT does not set this as a goal. IPT, nevertheless, recognises the influence of personality on the outcome of treatment, on the patient/therapist relationship and on interpersonal functioning.

2.3.2 Techniques of IP Therapy

Klerman and Weissman describe the following techniques as applicable (though not unique) to IPT.

Directive and non-directive exploration: At the beginning of sessions, non directive techniques are used to gather information. Ask open ended questions and use verbal and non verbal communication to encourage the person to continue what he or she is saying. Therapist may repeat what the person has just said or refer back to something said earlier. Later in the session, he/she may need to use more directive techniques. For example, therapist might use closed questions to clarify the details of an interpersonal dispute.

Clarification: Therapist might ask a man to repeat what he just said, or paraphrase his statement and check if that is what he meant. Therapist may wish to clarify how a person felt—‘You felt very frustrated?’ Point out the logical consequences of what the person has said. He might draw attention to apparent contradictions to clarify what the person means or feels—‘It is interesting that in the last session you said you had never enjoyed his company, but today you say you did have a good time together last weekend.’ Cognitive techniques are used to identify and challenge irrational automatic thoughts and underlying assumptions.

Encourage the expression of affect: Some patients will benefit from being encouraged to acknowledge and experience negative affects such as guilt, shame or anger, especially in grief work. Promote a detailed discussion of the relationship in question. Ask directly how the person feels. Remind him or her that certain negative feelings are normal, that is ‘Anybody would feel angry if they were treated like that’.

People are sometimes afraid to acknowledge unwanted feelings and impulses for fear that they might act upon them. Reassure them about the difference between feeling and acting.

Other patients may need to be taught more effective ways of controlling their moods and impulses. It is sometimes best for the person to avoid situations that arouse painful affect. Conflict is often more effectively resolved after both parties first take some time to calm down and get their feelings under control. Help the person to identify the thoughts that accompany a negative affect. Then use structured problem solving to deal with the underlying stressors. Help patients to identify and question irrational thoughts they have when they feel anxious or depressed.

Communication analysis: The goal is to identify communication failures and to learn new and more effective skills. Sometimes, conflicts arise simply through a lack of communication. Identify and modify the following unhelpful communication styles: using ambiguous non-verbal communications, such as sulking, remaining silent or self-harming; assuming that others know how one thinks or feels without being told; not checking the veracity of one's assumptions ('He thinks I'm a fool'); or being unable to assert oneself or criticise another person because of exaggerated fears of the consequences.

The therapeutic relationship: The way that people communicate with the therapist can be taken as a model of how they relate to others in their lives. It is useful to reflect on this interaction, especially when treating people with interpersonal deficits who have few other significant relationships. Therapists sometimes ask patients to tell them if they do something that upsets them. They then have the opportunity to rehearse being more assertive and therapists have the opportunity to correct faulty assumptions that they make.

Behaviour change techniques: Structured problem solving is used to help the person find workable solutions to their problems. At times, it may be appropriate to give the person advice. Education plays an important part in IPT. It includes explaining the symptoms and treatment of depression, the relationship of events in the person's interpersonal life to the depressive symptoms, and the process of IPT. In role-play, a (female) patient is asked to speak to the therapist as she would to the other person. This will clarify her feelings about the person, demonstrate the effectiveness of her communications and provide her with an opportunity to rehearse new ways of communicating.

Dealing with resistance in therapy: Patients may behave in ways that interfere with the process of therapy. They may, for example, arrive late, miss appointments, remain silent or persist in discussing irrelevant material. Do not ignore these behaviours, but rather discuss them openly and matter-of-factly. Sometimes, there will be a simple reason for the behaviour, unrelated to the process of therapy. For example, a person may consistently arrive late because the appointments are scheduled at an inconvenient time. However, in other cases, the behaviour may be a manifestation of the person acting out i.e., acting on an impulse to avoid a problem, rather than thinking about it and seeking a rational solution to it. In such cases, it is important to bring the behaviour to the person's attention and discuss it, seek to understand its meaning, and help him or her find more effective solutions to the underlying problems and more effective ways of communicating.

In IPT terms, resistance in therapy is an example of a role dispute in which the expectations of the patient and the therapist are at odds. Therapist discusses the behaviour and the way that it is interfering with therapy. For example, the person

who arrives late will not have sufficient time to deal adequately with the material to be covered each week. He helps the person recognise that these behaviours represent indirect and inefficient ways of communicating. By openly discussing these difficulties, the person is able to allay their fears about the direct discussion of problems and experience how much more effective direct communication is in solving problems. The way the problem is dealt with in therapy becomes a model for how the person can more effectively deal with problems outside therapy.

Behaviours that sabotage therapy often serve to avoid discussion of painful topics. Note the context in which the avoidance behaviours occur. For example, a person may always change the topic of discussion when a particularly painful issue is being discussed. The person may fear therapist's reaction to the problem. Therapists should try to engender a feeling of trust in the patient. Accept and normalise unwanted feelings. Patients may fear that if they articulate unacceptable impulses, they will lose control and act upon them. Emphasise the difference between feelings and impulses, which are not under the person's conscious control, and actions, which are.

In all forms of psychotherapy, it is important to monitor the transference and countertransference. Therapists should resist the temptation to advise dependent people on how they should solve their problems. Instead, they should use counselling and structured problem solving to help deal with their problems themselves. The differences between a therapeutic relationship and a friendship should be discussed. Therapists should also monitor their own feelings about patients: by acknowledging unacceptable impulses and they will be less likely to act out upon them.

Self Assessment Questions

1) What is insight therapy?

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2) Name the levels of consciousness as described by Jung?

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3) What are the conditions that must be met in person-centered therapy?

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4) What are the goals of Gestalt therapy?

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5) What are the main focus areas in interpersonal psychotherapy?

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6) What is communication analysis?

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2.4 LET US SUM UP

Insight therapy or insight orientated psychotherapy are general terms used to describe a group of therapies that assumes that a person's behaviour, thoughts, and emotions become disordered because they do not understand what motivates them. The theory of insight therapy, therefore, is that a greater awareness of motivation will result in an increase in control and an improvement in thought, emotion, and behaviour. The goal of these therapies is to help an individual discover the reasons and motivation for their behaviour, feelings, and thinking so that they may make appropriate changes and thus improve their mental health. These therapies are psychoanalysis, analytical psychology, existential therapy, person-centered therapy and gestalt therapy.

Interpersonal Psychotherapy (IPT) is a time limited psychotherapy that focuses on the interpersonal context and on building interpersonal skills. IPT is based on the belief that interpersonal factors may contribute heavily to psychological problems. It is commonly distinguished from other forms of therapy in its emphasis on interpersonal processes rather than intrapsychic processes. IPT aims to change the person's interpersonal behaviour by fostering adaptation to current interpersonal roles and situations.

2.5 UNIT END QUESTIONS

- 1) What is insight psychotherapy? Discuss the various therapies under insight psychotherapy?
- 2) What is interpersonal psychotherapy and its characteristics?
- 3) Describe the techniques of interpersonal psychotherapy?

2.6 SUGGESTED READINGS

Gabbard, Glen O. (2009). *Textbook of Psychotherapeutic Treatments*. London: American Psychiatric Publishing, Inc.

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Sommers-Flanagan, John., Sommers-Flanagan, Rita. (2004). *Counseling and Psychotherapy Theories in Context and Practice: Skills, Strategies, and Techniques*. New Jersey: John Wiley & Sons, Inc.



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UNIT 3 SHORT TERM PSYCHOTHERAPIES

Structure

- 3.0 Introduction
- 3.1 Objectives
- 3.2 Short Term Psychotherapy
- 3.3 Defining Features of Short Term Therapies
 - 3.3.1 Time Limits
 - 3.3.2 Therapy Focus
 - 3.3.3 Therapist Activity
 - 3.3.4 Range of Applicability
- 3.4 Overview of Brief Therapies
 - 3.4.1 Psychodynamic Approaches
 - 3.4.2 David Malan and the Triangle of Insight
 - 3.4.3 The Work of Habib Davanloo
 - 3.4.4 Anxiety-Provoking and Anxiety-Suppressive Therapies
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- 3.5 Relational Approaches
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 - 3.5.4 Cognitive Analytic Therapy (CAT)
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 - 3.6.2 The Work of Garfield
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 - 3.6.5 Motivational Interviewing
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 - 3.6.7 Crisis Intervention and Critical Incident Debriefing
- 3.7 Let Us Sum Up
- 3.8 Unit End Questions
- 3.9 Suggested Readings

3.0 INTRODUCTION

There have been major changes in the way different therapeutic paradigms approach treatment length. At one time, conventional wisdom suggested that psychodynamic therapy was invariably long-term and cognitive-behavioural therapies (CBT) were short term. This is no longer the case, with the development of a range of brief psychodynamic therapies and of longer-term behavioural and

cognitive therapies. The first half of this unit deals with the defining features of short term or brief therapy. The second half gives an overview of brief therapies along with research evidence on the length of therapy in relation to its effects and its suitability for a range of clients.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the defining features of short term or brief therapy;
- Discuss the different types of brief therapies under different approaches; and
- Evaluate these therapies in relation to their effects and suitability for a range of clients.

3.2 SHORT TERM PSYCHOTHERAPY

A major shift has occurred in the last 20 years from delivery of long-term psychotherapy to briefer, time limited approaches. There are many reasons for this, that is

- i) There have been immense pressures from healthcare industry for cost-effectiveness and cost containment;
- ii) Innovation and refinement of technique has resulted in more efficient therapy
- iii) Research trials expediently focus on shorter-term approaches, which then become influential.
- iv) The conventional psychoanalytic view that 'longer is better' has been increasingly challenged by the evidence; and
- v) Many therapists have espoused brief approaches because they see intrinsic merit and therapeutic potential in this way of working.

'Brief' is a relative term, and the time span of a brief or short term therapy can vary between one and about 25 sessions, from a single meeting to a year's work. There is a distinction between very brief therapy (one to five sessions, less than 2 months), brief therapy (six to 16 sessions, 2 to 6 months), and time limited therapy (17 to 30 sessions, 6 to 9 months), while recognising that such distinctions are inevitably arbitrary.

A common definition of short term or brief therapy is up to 25 sessions in duration. However, the majority of therapy delivered falls into this category, either because the therapy offered is short term by design, or because although the therapeutic modality is long term or open-ended, by the 25th session most patients have decided to leave.

It also used to be common wisdom that only highly selected client groups were capable of benefiting from brief work, and that these methods were unsuitable for people with more severe and complex mental health problems.

Now there are powerful arguments and well developed methods for offering shorter term interventions to people with higher levels of distress and impairment.

We have reached the stage in the history of psychotherapy where brief or time limited therapy is mainstream practice and it will continue to be the norm for psychotherapeutic work to be conducted briefly and to time limits.

3.3 DEFINING FEATURES OF SHORT TERM THERAPIES

Common features of brief therapies include working to a time limit, the therapeutic focus, and therapist activity. Taken together they imply a form of therapy that is perhaps better termed intensive rather than brief, compared with longer term methods that could be described as extensive.

3.3.1 Time Limits

Therapies that set a time limit manage the frustrations and disappointments that this can arouse, in both patients and therapists, in contrasting ways, either to facilitate them or to minimise them. Despite the polar differences between these views, there is little research evidence base for which of these two approaches leads to the best outcomes, for which clients.

The former approach sees the time limit itself as of immense therapeutic significance and potential. James Mann (1978) is the prime example and most eloquent advocate of this view. The time limit of therapy is seen as a profound metaphor for the finiteness of time itself for any individual. It evokes, he argues, the reality of loss and death, but, if faced and endured, is a powerful maturational experience.

Mann gives the time factor most attention, but a number of psychodynamic and relational therapies emphasise setting an exact, nonnegotiable time limit, to facilitate the experience of anxiety, disappointment, and anger. Expressing these warded off emotions, it is argued, within a facilitating therapeutic relationship, leads to their being safely experienced, assimilated, and mastered.

These therapies work on the assumption that what was perceived as catastrophic can be transformed into something both manageable and personally empowering. Other therapies take the opposite line, reducing the significance of the time limit, either by interpreting it very flexibly, by using follow-up appointments, or by making it clear further therapy will be available in the future 'as needed'.

For example, Budman and Gurman (1998) argue that there is little empirical evidence that emphasising termination in therapy leads to better outcomes, and assert that it is therapists rather than patients who have difficulty ending. They do not see therapy as a 'one-shot' operation, instead preferring to conceptualise the therapist as a 'psychological family doctor', available over the life span to respond to different needs in a developmental process. They also emphasise a team approach, with no one therapist being all things to all patients.

On the whole it is those therapies rooted in psychodynamic theories that emphasise the time limit and the therapeutic value of the fixed termination, and those rooted in pragmatic eclecticism, and the cognitive-behavioural approaches, which are less concerned with this.

The use of time in brief therapy goes beyond fixing the number of sessions or setting a time limit. It can include varying the length of sessions, the frequency of sessions, and the flexibility with which therapy is delivered. For example, Mann's rigid adherence to the 12-session limit does not preclude considerable flexibility in how they are delivered. Variations to weekly sessions are mentioned, including in one instance weekly 15-minute sessions for 48 weeks. The key issue is that there is no ambiguity or uncertainty about the pattern and duration of the sessions (Mann, 1978).

3.3.2 Therapy Focus

The therapeutic focus is the second broad factor shared by most, if not all, brief therapies. It can relate to manifest symptoms or a presenting problem. For example, cognitive therapy was originally a brief problem-focused therapy for depression. Most brief cognitive and behavioural therapies have a problem focus, such as panic, although longer-term cognitive therapy with a schema focus has also been developed.

The focus for interpersonal therapy (IPT) is developed in the early sessions, relating to one of four problem areas: grief, role disputes, role transitions, and interpersonal deficits. Psychodynamic, relational and some eclectic therapies often take an intrapsychic or interpersonal focus, a central emotional dilemma or an issue in personal development. Such a focus is referred to in diverse ways; the 'dynamic focus', 'core conflictual relationship theme', 'core neurotic conflict', 'nuclear conflict', 'central issue', 'interpersonal-developmental-existential focus'.

Omer (1993) describes how the focus in brief therapy has tended to be either symptom focused or person oriented, and argues for the value to the therapeutic alliance of combining the two into an integrative focus.

3.3.3 Therapist Activity

An active therapist is a feature of working in short term therapy. In the behavioural and cognitive methods, therapists have always been active, irrespective of the length of treatment, in collaboratively setting an agenda for the session, teaching, giving advice, using Socratic questions in guiding discovery, setting homework, suggesting structured activities and coaching. In the psychoanalytic and some humanistic traditions, the therapist is relatively less active, waiting for the client to speak at the start of the session, refraining from intervening to end a silence, following the patient's (or client's) train of thought and rarely initiating a topic or actively structuring the session.

In brief psychodynamic therapies, by contrast, the therapist is more active in interpreting the transference, unconscious conflicts and in confronting resistance. Therapists in eclectic, relational, or integrative modes are also active, for example in clarifying and collaboratively exploring the client's material, negotiating treatment goals, structuring sessions, making links between interactions in the therapist-client relationship and past relationship patterns, and possibly setting or discussing between-session tasks.

3.3.4 Range of Applicability

The brief therapies also differ widely in the range of difficulties to which they are considered applicable. The different forms of symptom-focused CBT have

intrinsic selection criteria, with separate therapy ‘packages’ developed for panic, depression, health anxieties, obsessive-compulsive disorders, eating disorders, substance abuse, anger management problems, posttraumatic stress disorders (PTSD), and suicide prevention. Some brief psychodynamic therapies are restrictive, with long lists of exclusion criteria. For example, Sifneos (1972) considers his Short Term Anxiety Provoking Psychotherapy suitable only for people of above average intelligence, who have had at least one meaningful relationship, are able to express emotion in the assessment, have a specific chief complaint, are motivated to work hard, and have realistic expectations of treatment.

Messer (2001) described brief dynamic therapists as avoiding clients who are too severely disturbed to use an insight-oriented approach or those who need more time to work through their problems, but other brief therapists take a more liberal view of suitability. For example, Wolberg (1965, p. 140) states that ‘The best strategy, in my opinion, is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment unless he proves himself refractory to it’. Garfield (1995), has only the three criteria that the client be in touch with reality, is experiencing some discomfort, and has made the effort to seek help.

From this overview of common features of brief therapies from a range of theoretical backgrounds and practice methods, we can discern some general working assumptions for brief therapies.

This way of working tends to see therapy as catalyst for change in a complex system rather than as a ‘one-shot’ curative method.

Therapists aim to maximise the therapeutic alliance and avoid regression.

3.4 OVERVIEW OF BRIEF THERAPIES

In describing the various models and modalities in shorter term and time limited therapy, there are several possible ways to classify them. The categories used here are psychodynamic, cognitive/behavioural, relational, eclectic, and very brief.

3.4.1 Psychodynamic Approaches

Early psychoanalytic therapies were much briefer than their successors. Some of Freud’s early therapies were very brief indeed, famously no longer than a walk in the woods. Modern brief psychodynamic therapies have their roots in the pioneering work of Ferenczi (1920) and Alexander and French (1946). They felt that, although psychoanalysts knew there is no simple correlation between therapeutic results and the length and intensity of treatment, they clung to a belief that quick therapeutic results could not be genuine.

3.4.2 David Malan and the Triangle of Insight

David Malan developed an influential approach to time-limited therapy he first termed as radical and later as intensive (Malan, 1963, 1976, 1979). The implication was that for some carefully assessed and selected patients, the time limit of a shorter therapy could accelerate the process of resolution of the central problem, or at least an important aspect of psychopathology.

Unlike most, this approach favours a time limit (i.e., an agreed end date) rather than a predetermined number of sessions, to avoid the common difficulty of deciding when or whether sessions missed for any reason will count towards the total. However, an upper limit of sessions was set at 30, although most people were seen in fewer.

Malan placed great store by a careful psychodynamic assessment of the patient's family and medical history, past and current relationships, to understand how events precipitating the current difficulty had emotional significance in the light of early experience. The therapist also attends carefully to the quality of the interaction. The assessment allows the therapist to judge whether to attempt a trial interpretation and the patient's response to this is an important factor in deciding whether this form of brief dynamic therapy is likely to be of benefit. The method itself is psychoanalytic, interpreting the transference, linking experience in the therapy relationship with childhood.

Malan described this in terms of two triangles, 'the triangle of conflict' (impulse, anxiety, defense) and 'the triangle of persons' (current relationship, therapist, parent). The two triangles formulation is an economical and clear way for therapists to think about the focal conflict. Holmes (2000) gives the example of someone suffering from agoraphobia defending against anxiety by avoidance and dependency. Underlying this there may be hidden feelings of dissatisfaction and aggression, immediately towards a spouse, and in the past towards a controlling but unaffectionate mother.

The therapist makes links between the anxiety, the defense, and the hidden impulse and between past relationships (usually with a parent), current relationships with others and the therapeutic relationship. In such a way, the patient is helped to tolerate anxiety and express hidden feelings, so that the triangle of conflict is no longer enacted in current relationships.

3.4.3 The Work of Habib Davanloo

Davanloo's (1978, 1990) method relies at heart on an orthodox psychodynamic drive/conflict model, derived from early Freud. He attracted controversy because his method involves pressurising the patient in a relentless pursuit of any prevarication, vagueness, avoidance, or withdrawal, all seen as signs that important anxieties are being warded off. Repeated confrontation elicits anger, which is interpreted in terms of the triangle of persons (i.e., a transference interpretation). This can lead to the powerful re-experiencing of warded-off anger from the past.

3.4.4 Anxiety Provoking and Anxiety Suppressive Therapies

Peter Sifneos (Sifneos 1972, 1979) distinguishes between anxiety suppressive and anxiety-provoking short-term treatments. His anxiety-provoking technique is based upon careful selection criteria, early and active use of transference interpretations, and confrontation. Relatively little attention is paid to termination. Sifneos places a high emphasis on the first meeting with a new patient, seeing it as a microcosm of therapy. Active himself as a therapist, he expects the same response from his patient.

Anxiety-provoking therapy is applicable to any patient with well-circumscribed neurotic symptoms, and aims at limited dynamic change, emphasising problem-

solving and crisis intervention. Anxiety-suppressive therapy is aimed at the more disturbed patient and is more supportive in nature.

In *anxiety-provoking therapy*, Sifneos includes only patients who can be seen to have problems at an oedipal level of functioning. Clinical assessment requires some evidence that the patient's difficulties have originated from the oedipal stage of development, a legacy of a three-person relationship.

A patient thought to evidence pre-oedipal problems, a result of a faulty or disturbed dyadic relationship, is thought to be inappropriate for anxiety provoking therapy, since they would have difficulties establishing the basic trust fundamental to the forging of a working therapeutic alliance and terminating treatment.

This continues to be an important distinguishing criterion used by some contemporary time-limited therapists. Treatment is seen as 'anxiety-provoking' because it confronts the patient's defences directly, rather than attempting to 'interpret the meaning or function of the defences'. Transference is interpreted rigorously, as is any form of resistance. Resistances are attacked directly, but only on the basis of 'data' received from the patient.

Sifneos does not use the framework of a definite termination date. No time limit is set, but the patient is informed from the outset that the treatment will only last 'several months', and is encouraged to share responsibility for the decision of when to terminate. Termination is in part the patient's responsibility, which decreases their dependence and passivity. Sifneos's anxiety-provoking therapy has a maximum of 20 sessions, and mostly lasts between 12 and 16 sessions.

His selection criteria are carefully drawn and include the following. :

- Ability of the patient to present with a circumscribed complaint.
- Evidence of a meaningful relationship during childhood.
- Capacity to relate to the therapist in the first meeting and to be open in expressing feelings.
- Psychological sophistication and intelligence.
- Motivation for change over and above symptom relief.
- Ability to see symptoms as having a psychological dimension.
- Emotional honesty and capacity for introspection.
- Able to participate actively in treatment and curiosity.
- Realistic view of what can be achieved in therapy and a willingness to make 'the necessary sacrifices'.

Sifneos contrasts anxiety-provoking therapy with *anxiety suppressive therapy*. This is aimed at less-healthy patients who might be discomforted by the confrontational stance of anxiety provoking therapy. It is aimed at more disturbed, by implication pre-oedipal patients and is more supportive in nature and includes environmental manipulation, reassurance and if necessary, medication. Crisis support could last up to two months, brief therapy from two months to one year, while for patients with long-standing psychological difficulties and a history of poor interpersonal relationships longer-term therapy may be indicated. However, the selection criteria are similar to those for the anxiety-provoking therapies.

Patients receiving anxiety provoking therapy are seen weekly over a period of time, but anxiety-suppressive patients are frequently seen more intensively, often a number of times in a week, but sometimes only for a few minutes. This reflects the more crisis-oriented and supportive direction of the therapy.

3.4.5 The Work of James Mann

James Mann (1978) was working within a psychoanalytic tradition, but has profoundly influenced the field of brief psychodynamic and relational therapy with his existential method of time-limited psychotherapy. He argues coherently that time is insolubly linked to reality and there is a ubiquitous human yearning to deny time, reality, and death by regaining a lost childhood paradise of timelessness. This is achieved in adulthood by dreams, daydreams, falling in love, drinking, or using drugs, or in mystic states of ecstasy. He describes how brief therapies evoke the horror of the finiteness of time and posits that as soon as the patient learns that the amount of time for help is limited, he or she is subject to magical, timeless, omnipotent fantasies.

Dismissive of eclecticism, Mann advocates one or two intake interviews to establish a formulation of the central conflict, linking current suffering to past sources, tracing the chronically endured pain. The focus for therapy is on improving the patient's self-image, but the formulation will differ according to the underlying difficulties. This formulation is given to the patient with a goal for therapy and an explicit offer of 12 sessions 'no more, no less'.

The frequency and length of sessions within that limit seems to have been quite flexible, however. The calendar is consulted and the time for each appointment given, plus the exact date of the last (12th) meeting. He argues for as little ambiguity or evasion as possible about the time limit, and describes a typical course of therapy of early relief and improvement, a middle phase where enthusiasm wanes and ambivalence is felt (in a re-enactment of earlier relationship patterns).

As the patient moves towards ending, anxiety is evoked of 'separation without resolution from the meaningful, ambivalently experienced person'. In the end phase, affects of sadness, grief, anger, and guilt are intensely experienced and relived in the disappointing ending of therapy. The therapist too feels the pressure to prevaricate and imply that the end is not the end, in order to evade the anxiety of separation without resolution. Mann emphasises that active management of the termination will allow the patient to internalise the therapist and this time the internalisation will be more positive, less anger-laden, less guilt-laden, and thereby making separation a genuine maturational event. Any anger is acknowledged as normal and explored more rather than less.

3.4.6 Cognitive and Behavioural Approaches

Following the development of brief psychodynamic therapies, brief therapies based on behavioural, CBT, and cognitive theories began to appear. These arose from a research-based tradition and over the last 30 years have burgeoned, applied to an every-wider range of difficulties in mental health care, physical health problems, and health promotion. Many authors aggregate all these approaches into a common term as CBT and in routine practice many therapists are rather eclectic in their choice of method within this broad framework. However, there

are important differences between forms of CBT that integrated cognitive concepts into behaviour therapy and those springing from the work of Beck, a different tradition of cognitive therapy that was not based on behaviour therapy.

3.4.7 Cognitive Behaviour Therapy (CBT) and Cognitive Therapy

Both methods were designedly brief, focusing in the first instance on depression, anxiety disorders, and obsessive-compulsive disorders, all without comorbid personality disorders. Since then the range of mental health problems addressed has grown to include PTSDs, eating disorders, and somatic problems. Some of the newer applications are not brief, for example, CBT for personality disorders and psychosis.

CBT emphasises a functional analysis of the problematic behaviour or unwanted emotion in terms of antecedents, cognitions, behaviours, and consequences. This formulation then guides the choice of active techniques such as Psychoeducation, relaxation, imaginal or in vivo exposure, response prevention, cognitive restructuring, and behavioural activation. Cognitive-behavioural therapists tend to emphasise the therapist's role in facilitating new experience and behaviour as well as cognitive changes, maintaining clients' awareness of their success experiences and the differences between their present and past functioning.

Cognitive therapy based on Beck's cognitive model of emotion (Beck, 1967; Beck et al., 1979) emphasises that there are always alternative ways of perceiving and appraising any situation. People with mental health problems are trapped in a specific and unhelpful way of perceiving events, because of particular assumptions or beliefs they learned earlier in life.

The therapist works collaboratively and empirically, inviting the client to explore whether or not there are alternative ways of appraising their situation, and empowering them to have choices over their response. The fundamental concept is of guided discovery of these alternatives, and support in testing out the consequences of new ways of thinking. Cognitive therapists tend to focus less than cognitive-behaviour therapists on the role of behavioural antecedents and consequences including the impact of the patient's behaviour on other people.

There is sparse discussion of treatment length in cognitive and cognitive-behavioural literature. Therapy length tends to be fixed (either for research purposes or by the constraints of the service setting) or pragmatically negotiated with the client in routine practice. Typically therapies last between 8 and 20 sessions, although the use of follow-up and booster sessions is common, for example in relapse prevention in depression, and in clinical practice many CB therapists not wishing to terminate therapy abruptly will gradually reduce the frequency of sessions and intensity of treatment. For this reason, some CBTs are in practice long term.

3.4.8 Interpersonal Therapy

Interpersonal therapy (IPT) (Klerman et al., 1984) was developed by psychiatrists as an adjunct to medication in the treatment of depression. It was based on the interpersonal psychiatry of Harry Stack Sullivan and others, and on research findings showing the intense impact of the formation, disruption, and renewal of

attachment bonds, and the link between neurosis and deficits in social bonds. Theoretically grounded in social risk factors for depression as an illness, the method avoids an intrapsychic emphasis, whether psychodynamic or object relations, and has been shown to have much in common with CBT in using active techniques to ameliorate present difficulties.

IPT explores four problem areas which are salient for a given patient: grief, role disputes, role transitions, or interpersonal deficits. In the early phase, assessment and negotiation of the treatment contract includes review of symptoms, confirmation of the diagnosis and legitimisation of the sick role, assessment of interpersonal relationships, and choice of problem area, and medication plan. Within a medical model of depression, there is a psychoeducational emphasis in promoting understanding of the effects of depressive illness, hence reducing self-blame.

Therapy continues using specific techniques depending on which of the four foci are agreed. For example, the therapist could aim to facilitate mourning, to identify issues in disputes and alternative actions, could encourage the patient to view role transitions in a positive way, or could work on remediating interpersonal deficits. Therapy is time limited but not constrained to a fixed number of sessions. Typically it lasts between 9 and 12 months.

3.4.9 Problem Solving Therapy (PST)

Problem solving therapy (PST) is a brief psychological treatment for depression based on cognitive behavioural principles (D'Zurilla and Goldfried, 1971; Nezu et al., 1989). It has also been used extensively as a form of crisis intervention following deliberate self-harm or attempted suicide (Hawton and Kirk, 1989).

Like CBT it is structured, collaborative and focuses on generating solutions to current problems. Problem solving is seen as having five stages: adopting a problem-solving orientation; defining the problem and selecting goals; generating alternative solutions; choosing the best solution; and implementing the best solution and evaluating its effects. Methods used include cognitive modelling, prompting, self-instructions, and reinforcement. It is usually delivered in about six treatment sessions.

3.4.10 Computerised CBT and Guided Self-Help

Computerised CBT and guided self-help have also been developed as brief therapy approaches to anxiety and depression, particularly to reduce the time spent in therapist contact, so that CBT can become more accessible to the large numbers of individuals who may benefit from it. The principles of “stepped care” suggest that briefer, simpler, and most accessible therapies should first be offered, and more complex, expensive, and effortful therapies only if the patient has not responded to the simpler approach. A research review of self-help interventions in mental health reported that almost all are based on CBT principles, and that computers may best be seen as another way of providing access to self-help materials (Lewis et al., 2003).

A systematic review of 16 studies of computerised CBT, of which 11 were randomised controlled trials, suggested that for mild to moderate anxiety and depression, CCBT may be as effective as therapist-led CBT and better than standard care, although the evidence was by no means conclusive (Kalenthaler et al., 2003).

3.5 RELATIONAL APPROACHES

A third broad grouping of focal brief therapies can be termed as ‘relational’ in that they see mental health difficulties as fundamentally interpersonal and they explicitly link the interpersonal to the intrapsychic in a ‘two-person’ psychology. Although these approaches have been influenced to a greater or lesser extent by psychoanalytic theory, they all emphasise relational rather than drive or structural aspects. Some have been influenced by cognitive psychology. These therapies pay close attention to the unfolding process within the psychotherapeutic relationship as a metaphor for, or an enactment of, the patient’s problematic and repetitive interpersonal and intrapsychic patterns. They tend to use collaborative methods to guide discovery of these links and are wary of any notion that the therapist can stand aside from “the transference” in order to interpret it authoritatively.

3.5.1 Time Limited Dynamic Psychotherapy (TLDP)

Time-limited dynamic psychotherapy (TLDP) (Schact et al., 1984; Binder and Strupp, 1991) is a collaborative method that avoids the therapist imposing the focus by overtly pushing, manipulating, seducing, coercing, badgering, controlling, extorting or indoctrinating the patient. The aim is to develop a ‘working model’ of interpersonal roles into which patients unconsciously cast themselves, the complementary roles into which they cast others, and the maladaptive interaction sequences, self-defeating expectations, and negative self-appraisals that result. The TLDP focus is a structure for interpersonal narratives, describing human actions, embedded in a context of interpersonal transactions, organised in a cyclical maladaptive pattern, that have been both a current and recurrent source of problems in living. The time limit is not rigid, depending on the clarity with which a treatment focus can be established, but a “time-limited attitude” is maintained.

3.5.2 Psychodynamic Interpersonal Therapy (PIT)

Psychodynamic-interpersonal therapy (PIT) (Hobson, 1985) uses the ‘here-and-now’ relationship as a vehicle for learning about oneself in relation to others. Hobson has a process focus on the therapist and patient collaboratively developing a shared language for feelings. The therapist does not interpret transference, but offers tentative exploratory links, making use of metaphor, and seeking to offer his or her own understanding of the patient’s unarticulated emotions in the context of an authentic human relationship. Also known as the ‘conversational model’ of therapy, because of its emphasis on the therapeutic dialogue, a training manual and other materials have been systematically developed and evaluated in the UK. It has been extensively researched in relation to depression (in both eight-session and 16-session formats), psychosomatic difficulties, with treatment-resistant problems in psychiatric outpatient setting and as a brief intervention following self-poisoning.

3.5.3 Brief Relational Therapy (BRT)

Brief relational therapy (BRT) is a thoroughgoing relational approach developed in the USA by Jeremy Safran and Christopher Muran (2000), based on a dialectical constructivist perspective (Hoffman, 1998). As with Hobson’s method, there is an intense focus on the ‘here-and-now’ of the psychotherapeutic relationship,

where the therapist urges collaborative exploration of both the patient's and the therapist's contributions to the interaction. The therapist is urged to be cautious about making interpretations based on generalised relationship patterns, but to explore the nuances of the patient's experience and the relational meaning of this experience, through unfolding therapeutic enactments. There is extensive use of meta communication about the meaning of what is happening between the therapist and patient, with disclosure of the countertransference.

The therapist refrains from early case formulation or content focus for the sessions. Safran and Muran argue that as the therapist can never stand outside the interaction to create a formulation that is not shaped by unwitting enactment; such a therapist-derived focus is inimical to a fully relational method. As in cognitive analytic therapy (CAT) ruptures and repairs to the therapeutic alliance are seen as a particularly effective way to gain awareness of problematic relationship patterns. Links between the therapy relationship and relationship patterns outside therapy are made tentatively, the therapist making an effort to be aware of his or her own motivations.

3.5.4 Cognitive Analytic Therapy (CAT)

Cognitive analytic therapy (CAT) is an integrative approach developed in the UK by Anthony Ryle (1990) and further extended both theoretically and clinically by others (Ryle and Kerr, 2002). Ryle aimed to integrate the effective elements of various preceding traditions not simply at the level of therapeutic technique, but in the underpinning theory of development, personality, and psychopathology. CAT theory is rooted in Kelly's personal construct theory, cognitive and developmental psychology and in psychoanalytic object relations theory. Theoretically it emphasises repetitive aim-directed sequences of cognition, emotion, behaviour and their consequences (called as procedures), similar to Goldfried's (2003) 'STAIRCASE' (Situation, Thought, Affect, Intention, Response, Consequence, and Self Evaluation) CBT model. However, CAT theory also draws on object relations theory and Vygotsky's activity theory to assert the pervasively dialogic nature of the human world, where internalised self-other relationship patterns become the basis of reciprocal role procedures governing intrapersonal as well as interpersonal relationships.

CAT, while theoretically and methodologically integrative, is therefore a fundamentally interpersonal and relational therapy. In common with BRT it requires the therapist to reflect collaboratively with the patient what reciprocal roles are being enacted in the therapy relationship, particularly at points where the therapeutic alliance is being threatened. In contrast to BRT, however, the initial few sessions of CAT are devoted to an extended assessment leading to a jointly agreed reformulation of a patient's story, its personal meaning and the relation to it of the problem procedures they have brought with them. The narrative account is redrafted on the basis of the patient's feedback and is supplemented by a diagrammatic reformulation. Both forms of reformulation are seen from the Vygotskian perspective as psychological tools, fostering jointly focused attention and the capacity for self-reflection. The reformulation forms the basis of intervention, which often includes cognitive-behavioural methods of procedural revision.

As in psychodynamic brief therapies there is stress on the therapeutic value of the issues provoked by a fixed termination point. Ending is seen from a CAT perspective to minimise regression and avoid protracted, and usually collusive, dependency. It is also an opportunity to work through the unassimilated issues from earlier losses and to enact new reciprocal role procedures. The ending is formally and symbolically celebrated by the therapist writing a further letter of farewell to the patient. This acknowledges the achievements of therapy but also anticipates loss and possible grief and anger. The patient is encouraged to write a farewell letter from his or her own perspective.

3.6 PRAGMATIC, ECLECTIC THERAPIES

A number of brief therapies draw pragmatically on a range of theories and methods to yield approaches that are eclectic.

3.6.1 Interpersonal, Developmental and Existential Therapy (IDE)

‘Interpersonal, developmental and existential therapy’ (IDE; Budman and Gurman 1988) attempts to integrate interpersonal, developmental and existential conflicts into a therapeutic framework which is time-sensitive and highly focused. Taking issue with long-term therapies, which they see as inevitably leading to therapeutic drift, the major feature of IDE is the belief that most therapeutic benefit occurs early in treatment; the law of diminishing returns applies.

Combining developmental, existential and interpersonal paradigms, IDE is based on the premise that during the patient’s early development there has been some ‘faulty learning’. This can be either conscious or unconscious, but importantly becomes ‘a *template* for future behaviour and relationships’. It is this template which influences feelings, behaviour and relationships. The key question is ‘Why has this person come for help now?’, and is viewed from a perspective that is both environmental and developmental (an ‘obsessive fear of death is rather different at age twenty-five than it is at age seventy five’). The focus is then related directly to the patient’s life stage. There is a flexible attitude to time. Therapy appears to be between 20 and 40 sessions in length and includes the variable spacing of sessions. Rather than ‘the more therapy the better’, therapy is seen as the springboard for change which happens outside or after the completion of therapy.

The use of the time can be a major therapeutic variable and an important intervention which needs to be acknowledged for each individual patient. However, the flexible use of time, which in IDE includes follow-up appointments and further courses of therapy when a developmental obstacle is encountered, is very different from using time as a central organising framework for therapy.

3.6.2 The Work of Garfield

Garfield (1989, 1995) describes an eclectic brief therapy model based on maximising the impact of the common factors identified in therapy research. Therapists are engaged in listening, reflection, suggestion, explanation, interpretation, providing information, confrontation, reassurance, homework assignments, modelling and role play, questioning, and cautious self-disclosure. In common with Budman and Gurman and Cummings, he takes a relaxed

approach to treatment length, and to selection criteria. Garfield also challenges the assumption that if people do not respond to short-term therapy, they will benefit from long-term work. He seems this as having little empirical justification, as there has been almost no research on long-term therapy.

3.6.3 Winston and Winston

Winston and Winston (2002) describe a pragmatic eclectic approach, which they term as integrated; although it does not seem fully integrated at the theoretical level, compared with, for example, CAT. Their case formulation method uses the concept of a continuum between psychological sickness and health, according to level of psychopathology, adaptive capacity, self-concept and ability to relate to others. The individual treatment plan depends on the patient's position on this continuum, with cognitive-behavioural methods being used for the more impaired and more psychodynamic, expressive techniques for the least impaired. By this means, a brief intervention can be offered for more severe and complex difficulties, such as borderline disorders.

3.6.4 Very Brief Therapy

This includes Crisis Intervention and Critical Incident Debriefing . Very brief therapies of up to five sessions have been developed in differing treatment modalities. Sheard et al. (2000) describe a one- to three-session CAT-derived method to improve the response of psychiatrists to repeated deliberate self-harm in the context of emergency hospital care. Outcome studies are not yet available.

Newman et al. used a four-session CBT intervention for panic disorder, assisted by the use of palmtop computers for self-monitoring and assessment, with similar results to a 12-session treatment.

3.6.5 Motivational Interviewing

The clinical method of motivational interviewing (Miller and Rollnick, 1991) has been used as a very brief intervention either alone or in addition to standard treatment, particularly for alcohol and substance misuse problems. It was developed on the basis of a review of active ingredients in effective brief therapy with these client groups, which suggested the importance of giving feedback, promoting personal responsibility for change and self-efficacy, giving straightforward advice, and offering a menu of alternative strategies. The method is nondirective and avoids any confrontation with resistance or lack of motivation, instead taking an acceptant and empathic approach to changing motivational states. The aim is to help those reluctant to change problematic behaviours move from the pre-contemplation stage, or ambivalent contemplation, to preparation where change options can be explored and then action and maintenance of change.

3.6.7 Solution-Focused Brief Therapy (SFBT)

Solution-focused brief therapy (de Shazer, 1985; Walter and Peller, 1992) developed from brief strategic therapy in work with families and individuals, and is often delivered over four to five sessions. It pays no attention whatsoever to the origin or etiology of problems and instead focuses on helping clients to change problem-maintaining behaviour, to define their goals (recognising that their own definition may or may not be congruent with problems as perceived by professionals), and to generate solutions to difficulties they face. Questions about

goals are posed in such a way that the client is able to speak about what the world would be like without their current problems. It is in this sense that the method is solution focused rather than problem solving. The focus is on collaborative identification and amplification of the patient's strengths, with extremely positive feedback and an emphasis on small aspects of meaningful change.

3.6.8 Crisis Interventions and Critical Incident Debriefing

There is a wide range of brief interventions aimed at responding to crises. The theory and practice of crisis intervention developed from the work of pioneers in the 1960s, such as the community psychiatrist Caplan (1961), and the psychoanalytic crisis therapist, Jacobson (1980). A fundamental concept is that during crisis, people are unusually receptive to restructuring their psychological processes, providing a window of opportunity for a brief intervention to have a substantial positive effect. Crisis intervention uses the intense affect associated with the crisis state in order to facilitate constructive change. The personal meaning of the crisis is explored, in terms of both present and past aspects (e.g., a loss event could re-evolve feelings associated with an earlier loss), coping resources, and components of crisis that render these ineffective. The crisis may be formulated in a way that gives individuals or family members a cognitive understanding of what has happened, so that the emotional assimilation of this is facilitated, and new coping resources are mobilised.

Critical incident debriefing was designed as a rapid response to a traumatic event, aiming to reduce vulnerability to developing PTSD or other mental health conditions, and usually delivered in a single session. Although intuitively appealing to many clinicians, it is now clear that single-session debriefing immediately after exposure to a traumatic event is ineffective, and that on the contrary there may be an adverse impact for some individuals.

Overall it is clear that single session interventions cannot be recommended as part of routine practice, and the English Department of Health guideline on treatment choice in psychological therapies (2001) explicitly argues against their use. This does not imply that individuals in distress should not be offered support, nor does this general conclusion contraindicate more extended psychological intervention at some point from the initial trauma, if posttraumatic disorder were to develop.

Self Assessment Questions

- 1) What is the difference between brief, very brief and time-limited therapies?

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2) What are the general working assumptions of brief therapies?

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3) What are triangles of insight?

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4) What is the selection criteria for Short term anxiety provoking psychotherapy?

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5) What is Problem-solving therapy?

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6) What is the aim of motivational interviewing?

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3.7 LET US SUM UP

We term one to five sessions as very brief, six to 16 sessions as brief, and 17 to 30 sessions as time-limited therapy. Therapies of up to 25 sessions are the modal form of therapy delivery, either by design or by default. In third-party payment healthcare systems, there is pressure towards brief therapies because of the need to contain costs, but they also have intrinsic value. Well-conducted brief therapies are effective in a range of moderate difficulties, such as anxiety disorders and depression. There is a plethora of brief and very brief interventions within a range of therapeutic paradigms. Some of these emphasise the time limit as a vehicle for assimilating ward-off anxieties; others do not impose a rigid time limit, using follow-up sessions, or intermittent episodes of therapy, to attenuate the ending. Methods are continuing to develop to find time-efficient ways to benefit people with more severe and complex mental health problems. Training in longer-term methods does not equip practitioners to deliver brief therapies competently. Training specific to brief modalities is required, particularly in the key area of competence in maintaining the therapeutic alliance.

3.8 UNIT END QUESTIONS

- 1) Describe in detail the defining features of brief or short term psychotherapies?
- 2) Discuss the different models of brief therapies using psychodynamic approaches?
- 3) Write about the short term therapies under cognitive behavioural approaches?
- 4) Write about cognitive analytic therapy (CAT)?
- 5) What are very brief therapies and discuss motivational interviewing and solution-focused brief therapy?

3.9 SUGGESTED READINGS

Coren, Alex. (2001). *Short-Term Psychotherapy*. London: Palgrave.

Gabbard, Glen O., Beck, Judith S. and Holmes, Jeremy. (2005). *Oxford Textbook of Psychotherapy*, 1st Edition. Oxford: Oxford University Press.

Dewan, Mantosh J., Steenbarger, Brett N., Greenberg, Roger P. (2004). *The Art and Science of Brief Psychotherapies: A Practitioner's Guide*. London: American Psychiatric Publishing, Inc.

UNIT 4 METHODS OF CHILD PSYCHOTHERAPY

Structure

- 4.0 Introduction
- 4.1 Objectives
- 4.2 Psychoanalytic Approaches
 - 4.2.1 Parent Infant Psychotherapy
 - 4.2.2 Mentaliseren Bevorderende Kinder Therapy (MBKT)
- 4.3 Attachment Based Interventions
 - 4.3.1 Dyadic Developmental Psychotherapy
 - 4.3.2 'Circle of Security'
 - 4.3.3 Attachment and Biobehavioural Catch-Up (ABC)
- 4.4 Play Therapy
- 4.5 Parent Child Interaction Therapy (PCIT)
- 4.6 The Developmental, Individual-Difference and Relationship-Based Model (DIR)
- 4.7 Let Us Sum Up
- 4.8 Unit End Questions
- 4.9 Suggested Readings

4.0 INTRODUCTION

Mental health interventions for children vary with respect to the problem being addressed and to the age and other individual characteristics of the child. Although such interventions share some approaches, treatment methods can be quite different from each other. Terms describing child treatments may vary from one part of the world to another, with particular differences in the use of the terms “psychotherapy” and “psychoanalysis”. This unit will cover all types of therapies aimed at children and include behavioural, psychodynamic and other therapies.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the different types of treatment methods employed in child psychotherapy from different theoretical fields;
- Discuss the principles and concepts behind treatment interventions; and
- Understand the techniques employed in different child psychotherapy interventions.

4.2 PSYCHOANALYTIC APPROACHES

There are several different techniques to approach the psychoanalytic treatment of children. For children at a very young age an adapted psychoanalytic technique

might be necessary. In some cases parent-infant psychotherapy is also used. We would be discussing two types of techniques: Parent-Infant Psychotherapy and Mentaliseren Bevorderende Kinder Therapie (MBKT). Parent-Infant Psychotherapy addresses problems with normal relationships between parent and child. MBKT addresses problems with an infant's ability to distinguish reality and fantasy.

4.2.1 Parent Infant Psychotherapy

If the normal course of secure attachment between parent and infant is disrupted, parent infant psychotherapy is one technique that can be used to restore this bond. This technique requires a three way relationship between the parent, child and therapist. During the therapy sessions the parent expresses his or her thoughts and feelings which are based on a combination of factors including:

- The parent's experiences as a child.
- The parent's expectations and hopes for the child's future.
- The relationships the parent has with other people.

The therapist's role is as an observer and an interpreter of the interaction between the child and the parent.

The therapist might share some of his thoughts about the behaviour of the child with the parent and by doing so offering the parent an alternative way of experiencing the child. This technique helps the parent to resolve issues with his or her own infancy-experiences in order to restore secure attachment with the infant. And it helps lower the risk for psychopathological developments of the child in the future.

4.2.2 Mentaliseren Bevorderende Kinder Therapy (MBKT)

Since 2003, The Nederlands Psychoanalytisch Instituut NPI (Dutch Psychoanalytic Institute) has been working with a form of therapy for children called "*Mentaliseren Bevorderende Kinder Therapie*" (MBKT) which can be roughly translated as "*therapy for children enhancing their ability to mentalise*".

This therapy is partly based on the theory of Fonagy (2002) in which mentalisation is the central theme. Mentalising is accomplished when two developmental concepts i.e., the equivalent modus and the pretend modus can be integrated.

A child that functions according to the equivalent modus only, does not experience a difference between reality and fantasy. Inside and outside are equal. With a child that only functions in the pretend modus there is a difference between reality and fantasy. However they exist separately from each other. The child is not aware of the reality level when he is pretending. When both modus are integrated the child is aware that he is pretending and then mentalisation gets established.

Mentalisation is a conscious as well as an unconscious process which enables people to see that actions and thoughts of themselves and others are motivated by internal thoughts, intentions and attitudes.

A child's development of self regulating mechanisms and ability to mentalise (which, when taken together are called Interpersonal Interpretative Function, IIF) are dependent on their "early attachment relation".

Trauma can cause the child to detach from very painful feelings connected to the events and or persons connected to the trauma. This incapability to integrate those feelings may influence the modus in which the child comes to operate.

An overwhelming flow of anxiety for instance can cause the child to fall back in to an equivalent modus of operating.

Other components which are crucial in the development of the child and also mainly dependent on the quality of the attachment to the parent are “attention regulation” and “affect regulation”.

When the regulation of either is not sufficient a therapy may help to influence the flow of both.

The starting point in “*attention regulation*” is that the child is still functioning from the “*equivalent modus*” which means there are insufficient affect representations.

Here the main goal is to direct and focus the attention of the child to the inner world (feelings, thoughts, wishes and impulses). This focuses their mental being more on physical reality.

In *affect regulation* the often diffuse affects of the child within the therapeutic relation are explored. Here it is important that the child goes through their own feelings and recognise them by forming them into mental representations. As this ‘*mentalisation process*’ develops the child functions in the pretend modus and is capable of using symbolic representations. Interventions are based on improving thinking about mental conditions and mental processes.

MBKT can be qualified as an intensive form of therapy with two to five sessions per week. These sessions are a combination of talk and play. The therapist will play and talk with the child in order to make contact with the inner world of the child and thus shape all the bits and pieces that needs to be integrated. An important tool is the transference/ counter transference. These can lead the way to what needs to be treated.

4.3 ATTACHMENT BASED INTERVENTIONS

Although attachment theory has become a major scientific theory of socio emotional development with one of the broadest, deepest research lines in modern psychology, attachment theory has, until recently, been less clinically applied than theories with far less empirical support. This may be partly due to lack of attention paid to clinical application by Bowlby himself and partly due to broader meanings of the word ‘attachment’ used amongst practitioners. It may also be partly due to the mistaken association of attachment theory with attachment therapy, also known as ‘holding therapy’, a group of unvalidated therapies characterised by forced restraint of children in order to make them relive attachment related anxieties; a practice considered incompatible with attachment theory and its emphasis on ‘secure base’. The approaches mentioned below are examples of recent clinical applications of attachment theory by mainstream attachment theorists and clinicians and are aimed at infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder.

4.3.1 Dyadic Developmental Psychotherapy

Dyadic developmental psychotherapy is an evidence-based treatment approach for the treatment of attachment disorder, Complex Post Traumatic Stress Disorder, and reactive attachment disorder. It was originally developed by psychologist Dr. Daniel Hughes, as an intervention for children whose emotional distress resulted from earlier separation from familiar caregivers. Hughes developed Dyadic developmental psychotherapy with the express intention of developing a therapy removed from the coercive practices of attachment therapy. Hughes cites attachment theory and particularly the work of John Bowlby as the theoretical basis for dyadic developmental psychotherapy. Other sources for this approach include the work of Stern, who referred to the attunement of parents to infants' communication of emotion and needs, and of Tronick, who discussed the process of communicative mismatch and repair, in which parent and infant make repeated efforts until communication is successful. Children who have experienced pervasive and extensive trauma, neglect, loss, and/or other dysregulating experiences may benefit from this treatment.

The basic principles of Dyadic Developmental Psychotherapy are:

- 1) Safety
- 2) Self-regulation
- 3) Self-reflective information processing
- 4) Traumatic experiences integration
- 5) Relational engagement and
- 6) Positive affect enhancement

Dyadic developmental therapy principally involves creating a “playful, accepting, curious, and empathic” environment in which the therapist attunes to the child’s “subjective experiences” and reflects this back to the child by means of eye contact, facial expressions, gestures and movements, voice tone, timing and touch, “co-regulates” emotional affect and “co-constructs” an alternative autobiographical narrative with the child. Dyadic developmental psychotherapy also makes use of cognitive behavioural strategies.

4.3.2 ‘Circle of Security’

This is a parent education and psychotherapy intervention developed by Marvin et al (2002) which is designed to shift problematic or ‘at risk’ patterns of attachment-caregiving interactions to a more appropriate developmental pathway. It is based on contemporary attachment and congruent developmental theories. Its core constructs are Ainsworth’s ideas of a Secure Base and a Haven of Safety (Ainsworth et al 1978). The aim is to present these ideas to the parents in a ‘user friendly’, common-sense fashion that they can understand both cognitively and emotionally. This is done by a graphic representation of the child’s needs and attachment system in circle form, summarising the child’s needs and the safe haven provided by the caregiver. The protocol has so far been aimed at and tested on preschoolers up to the age of 4 years.

The aim of the therapy is:

- To increase the caregivers sensitivity and appropriate responsiveness to the child’s signals relevant to his/her moving away from parents to explore, and moving back for comfort and soothing;

- To increase their ability to reflect on their own and the child's behaviour, thoughts and feelings regarding their attachment-caregiving interactions; and
- To reflect on experiences in their own histories that affects their current caregiving patterns. This latter point aims to address the miscuing defensive strategies of the caregiver.

Its four core principles are that the quality of the child parent attachment plays a significant role in the life trajectory of the child, that lasting change results from parents changing their caregiving patterns rather than by learning techniques to manage their child's behaviours, that parents relationship capacities are best enhanced if they themselves are operating within a secure base relationship and that interventions designed to enhance the quality of child-parent attachments will be especially effective if they are focussed on the caregiver and based on the strengths and difficulties of each caregiver/child dyad.

There is an initial assessment which utilises the 'Strange Situation' procedure, (Ainsworth 1978), observations, a videotaped interview using the Parent Development Interview (Aber et al 1985) and the Adult Attachment Interview (George et al 1984) and caregiver questionnaires regarding the child. The child's attachment pattern is classified using either Ainsworth or the PAC (Preschool Attachment Classification System).

The therapy is then 'individualised' according to each dyads attachment/caregiver pattern. The programme, which takes place weekly over 20 weeks, consists of group sessions, video feedback vignettes and psycho educational and therapeutic discussions. Caregivers learn, understand and then practice observational and inferential skills regarding their children's attachment behaviours and their own caregiving responses.

Circle of Security is being field tested within the 'Head Start/ Early Head Start' programme in the USA. According to the developers the goal of the project is to develop a theory and evidence based intervention protocol that can be used in a partnership between professionals trained in scientifically based attachment procedures, and appropriately trained community based practitioners.

It is reported that preliminary results of data analysis of 75 dyads suggest a significant shift from disordered to ordered patterns, and increases in classifications of secure attachment.

4.3.3 Attachment and Biobehavioural Catch-Up (ABC)

This is an intervention programme aimed at infants who have experienced early adverse care and disruptions in care. It aims to provide specialised help for foster carers in recognition of the fact that a young child placed in foster care has to deal with the loss of attachment figures at a time when maintaining contact with attachment figures is vital. It targets key issues: providing nurturance for infants when the carers are not comfortable providing nurturance, overriding tendencies to respond in kind to infant behaviours and providing a predictable interpersonal environment.

It is essentially a training programme for surrogate caregivers. It has four main components based on four propositions:

“Providing nurturance when it does not come naturally”.

Based on findings that foster children’s attachments are disproportionately likely to be disorganised.

As foster mothers with an unresolved or dismissing state of mind are likely to have children with disorganised attachments, the interpretation of Dozier et al is that foster children have difficulty organising their attachment systems unless they have nurturing foster carers.

The goal is to help foster parents provide nurturing care even if they are non autonomous with regard to their own attachment status.

“Infants in foster care often fail to elicit nurturance”. Foster carers tend to respond ‘in kind’ to infants behaviour. If foster infants behave in an avoidant or resistant manner, foster carers may act as if the infant does not need them. The goal is to train foster carers to act in a nurturing manner even in the absence of cues from the infant.

“Infants in foster care are often dysregulated at physiological, behavioural and emotional levels”. Foster children often show an atypical production of the stress hormone cortisol. It is not established whether this is significant for increased risk for later disorders, but very low or very high levels are associated with some types of psychopathology in adults. The goal here is to help foster parents follow the child’s lead and become more responsive social partners.

“Infants in foster care often experience threatening conditions”. One of the functions of parents is to protect children from real or perceived dangers. This has often broken down for foster children, and worse, the caregiver may have served as a threat themselves. Prime examples are threats contingent upon behaviour to have the child removed or taken away.

Children experiencing frightening conditions have a limited range of responses and often ‘dissociate’ as a way of coping. The aim is to reduce threatening behaviour among foster parents by helping them understand the impact on the child.

Caregiver and child behaviours are assessed before and after intervention, as is the child’s regulation of neuroendocrine function. The intervention consists of 10 sessions administered in caregiver’s homes by professional social workers. Sessions are videotaped for feedback and for fidelity.

The intervention is currently being assessed in a randomised clinical trial involving 200 foster families, supported by the National Institute of Mental Health. Half the infants are assigned to the Developmental Education for Families programme as a comparison intervention. The developers themselves point out that they do not test for caregiver commitment although they state this may or may not be a critical omission as they consider caregiver commitment to be a crucial variable in terms of child outcomes.

4.4 PLAY THERAPY

Play therapy can be defined as a means of creating intense relationship experiences between therapists and children or young people, in which play is the principal medium of communication. Play therapy refers to a method of psychotherapy

with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communication with the child.

The aim of play therapy is to decrease those behavioural and emotional difficulties that interfere significantly with a child's normal functioning. Inherent in this aim is improved communication and understanding between the child and his parents. Less obvious goals include improved verbal expression, ability for self-observation, improved impulse control, more adaptive ways of coping with anxiety and frustration, and improved capacity to trust and to relate to others. In this type of treatment, the therapist uses an understanding of cognitive development and of the different stages of emotional development as well as the conflicts common to these stages when treating the child.

Play therapy is used to treat problems that are interfering with the child's normal development. Such difficulties would be extreme in degree and have been occurring for many months without resolution. Reasons for treatment include, but are not limited to, temper tantrums, aggressive behaviour, non-medical problems with bowel or bladder control, difficulties with sleeping or having nightmares, and experiencing worries or fears. This type of treatment is also used with children who have experienced sexual or physical abuse, neglect and the loss of a family.

Children communicate their thoughts and feelings through play more naturally than they do through verbal communication. As the child plays, the therapist begins to recognise themes and patterns or ways of using the materials that are important to the child. Over time, the clinician helps the child begin to make meaning out of the play.

At times, children in play therapy might also receive other types of treatment. For instance, youngsters who are unable to control their attention, impulses, tendency to react with violence, or who experience severe anxiety may take medication for these symptoms while participating in play therapy. The play therapy would address the child's psychological symptoms. Other situations of dual treatment include children with learning disorders. These youngsters may receive play therapy to alleviate feelings of low self-esteem, excessive worry, helplessness, and incompetency that are related to their learning problems and academic struggles. In addition, they should receive a special type of tutoring called cognitive remediation, which addresses the specific learning issues.

Treatment can be described as occurring in a series of initial, middle and final stages. The initial phase includes evaluation of the problem and teaching both child and parents about the process of therapy. The middle phase is the period in which the child has become familiar with the treatment process and comfortable with the therapist. The therapist is continuing to evaluate and learn about the child, but has a clearer sense of the youngster's issues and has developed, with the child, a means for the two to communicate. The final phase includes the process of ending treatment and saying goodbye to the therapist.

4.5 PARENT CHILD INTERACTION THERAPY (PCIT)

Parent child interaction therapy (PCIT) was first introduced in the 1970's and has been proven effective for abused and at risk children with disruptive behaviours at ages 2 ½ to 8 and their biological or foster caregivers. It uses a unique combination of behavioural therapy, play therapy and parent training to teach more effective discipline techniques and improve the parent child relationship. It is appropriate where parent child relations have broken down, where parent child interaction is poor or where parent child communication is problematic.

Therapists coach parents while they interact with their children during PCIT, by sitting behind a one way mirror and using an “ear bug” audio device to guide parents through strategies that reinforce their children's positive behaviour. The live coaching and treatment of both parent and child together are cornerstones of this approach. PCIT is divided into two stages: relationship development (Child Directed Interaction) and discipline training (Parent Directed Interaction).

The Child Directed Interaction portion of PCIT aims to develop a loving and nurturing bond between the parent and child through a form of play therapy. Parents are taught a list of “Dos” and “Don'ts” to use while interacting with their child. They are asked to use these skills during a daily play period called Special Play Time.

Parents are taught an acronym of skills to use during Special Play Time with their children. This acronym varies from therapist to therapist, but is generally either “*DRIP*” or “*PRIDE*.”

DRIP stands for the following:

D - Describe

R - Reflect

I - Imitate

P - Praise

Likewise, **PRIDE** stands for the following:

P - Praise

R - Reflect

I - Imitate

D - Describe

E - Enthusiasm

These acronyms are reminders that parents should describe the actions of their child, reflect upon what their child says, imitate the play of their child, praise their child's positive actions, and remain enthusiastic throughout Special Play Time.

Phase II, or Parent Directed Interaction, focuses on establishing a structured and consistent approach to discipline; parents are coached during a play situation by

the therapist to use skills in giving clear direct commands, and provide consistent consequences for both compliance and noncompliance.

PCIT reduces behaviour problems in young children by addressing negative parent-child patterns and teaching parents how to model and reinforce constructive ways to manage emotions. PCIT decreases the risk of child physical abuse by interrupting the harmful cycle that can be present between the parent and child, where the parent's negative behaviours such as screaming or threatening, reinforce negative behaviours of the child such as unresponsiveness and disobedience. The model encourages positive interaction, and implementation of consistent and nonviolent discipline techniques. Parent satisfaction with PCIT is typically high. Additionally, the model offers support for caregivers and can be adapted for use with various populations and cultures.

4.6 THE DEVELOPMENTAL, INDIVIDUAL DIFFERENCE AND RELATIONSHIP BASED MODEL (DIR)

The Developmental, Individual Difference, Relationship Based model (DIR) summarises an approach that builds on growing insights regarding functional developmental capacities, biologically based processing differences, and emotionally meaningful learning interactions between families, caregivers, and children.

The “D” stands for functional Developmental levels; i.e., seeing where the child is in her development.

“I” stands for Individual differences in processing; the processing profile in terms of auditory processing, visual/spatial, sensory modulation, motor planning.

“R”, stands for what the Relationships are like.

What are the interactive relationships and use of affects in the family now and what would be the ideal pattern to support enhanced development. ?

The DIR model looks comprehensively at the child and is an advance over the older ways of thinking, because the focus is not just on isolated cognitive skills and on surface behaviours but also on an integrated understanding of human development.

The integrated model of development includes interaction with caregivers and the environment, biologically mediated motor and sensory processing differences, and the child's functional developmental road map, i.e., determining where the child is in terms of the six functional developmental elements, that is

- attention,
- engagement,
- purposeful emotional signalling and gesturing,
- preverbal and verbal problem-solving and
- imaginative interactions,
- thinking, etc.).

These changes the way therapists do assessments and the way they plan interventions.

The DIR model, therefore, serves as a framework to understand the developmental profile of an infant or child and his or her family. It enables caregivers, educators, and clinicians to plan an assessment and intervention program that is tailored to the child's and family's profile. It is not an intervention, but a method of analysis and understanding that helps to organise the many intervention components into a comprehensive program.

DIR based comprehensive program includes semi-structured problem-solving, learning interactions, speech therapy, occupational therapy, peer play opportunities, educational programs, etc.

The DIR model is the most comprehensive conceptual framework available to understand and organise programs of assessment and intervention for children with special needs. It has helped many children with special needs, including autistic spectrum disorders, learn to relate to adults and peers with warmth and intimacy, communicate meaningfully with emotional gestures and words, and think with a high level of abstract reasoning and empathy.

Self Assessment Questions

1) Define the term 'mentalise'?

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2) What are the principles of Dyadic Developmental Psychotherapy?

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3) What are the aims of play therapy?

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4) What is the aim of Child-Directed Interaction phase of PCIT?

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5) What is the goal of Developmental, Individual-Difference, Relationship-Based model?

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4.7 LET US SUM UP

Psychotherapies for children vary with respect to the problem being addressed and to the age and other individual characteristics of the child. There are different types of therapies aimed at children from behavioural, psychodynamic or other fields.

There are several different techniques in the psychoanalytic treatment of children. In this unit we had discussed two types of techniques: Parent-Infant Psychotherapy and Mentaliseren Bevorderende Kinder Therapie (MBKT). Parent-Infant Psychotherapy addresses problems with normal relationships between parent and child. MBKT addresses problems with an infant's ability to distinguish reality and fantasy. Attachment based interventions are aimed at infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder. Dyadic developmental psychotherapy is designed to help parents understand their child's attachment disorder: how the child feels and thinks, and the child's internal psychological dynamics. Second, teaching parents about attachment facilitating parenting methods and the importance of attunement and responsive, sensitive parenting is essential in this therapy. 'Circle of security' is a parent education and psychotherapy intervention designed to shift problematic or 'at risk' patterns of attachment-caregiving interactions to a more appropriate developmental pathway. Attachment and Biobehavioural Catch-Up (ABC) is an intervention programme aimed at infants who have experienced early adverse care and disruptions in care. It aims to provide specialised help for foster carers in recognition of the fact that a young child placed in foster care has to deal with the loss of attachment figures at a time when maintaining contact with attachment figures is vital.

Play therapy refers to a method of psychotherapy with children in which a therapist uses a child's fantasies and the symbolic meanings of his or her play as a medium for understanding and communication with the child. Parent child interaction

therapy (PCIT) has proved to be effective for abused and at-risk children with disruptive behaviours at ages 2 ½ to 8 and their biological or foster caregivers. It teaches more effective discipline techniques and improves the parent-child relationship. It is appropriate where parent child relations have broken down, where parent child interaction is poor or where parent child communication is problematic.

The DIR model serves as a framework to understand the developmental profile of an infant or child and his or her family. It enables caregivers, educators, and clinicians to plan an assessment and intervention program that is tailored to the child's and family's profile.

4.8 UNIT END QUESTIONS

- 1) Discuss the psychoanalytical intervention methods for children?
- 2) Discuss in detail the different attachment based interventions?
- 3) Write about play therapy?
- 4) Describe the process of parent child interaction therapy?
- 5) Discuss DIR model?

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