# UNIT 1 PSYCHOANALYSIS, PYCHOANALYTIC/ 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.

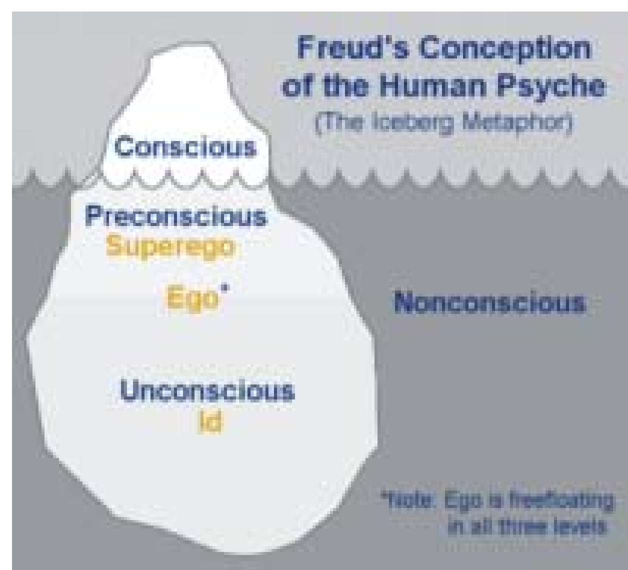
Within the next three years, as the child interacts more and more with the world, the second part of the personality begins to develop. Freud called this part as the Ego. The Ego is based on the reality principle. The ego understands that other people have needs and desires and that sometimes being impulsive 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 |

| | | |
|---|---|---|
| Intellectual-isation | 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 |
| Rational-isation | 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

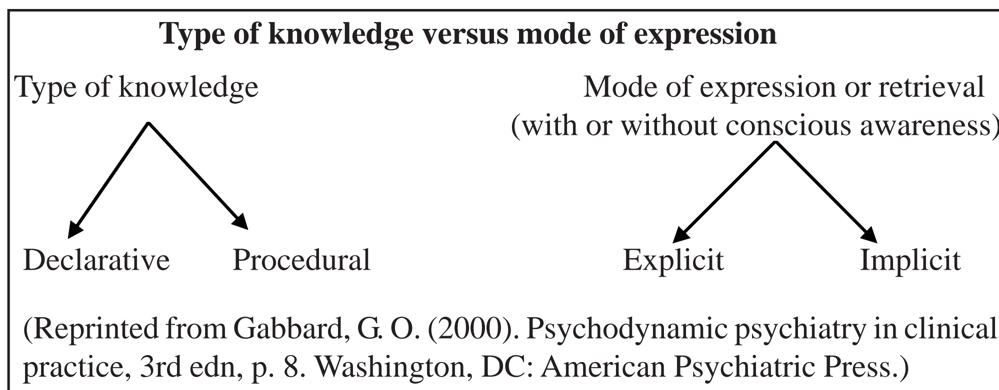
A number of basic tenets and concepts are central to psychodynamic psychotherapy. These include the following:

**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

**Type of knowledge versus mode of expression**




(Reprinted from Gabbard, G. O. (2000). Psychodynamic psychiatry in clinical practice, 3rd edn, p. 8. Washington, DC: American Psychiatric Press.)

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 transferential 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.

# 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 Frederich 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.

# 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
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- 3.4.4 Anxiety-Provoking and Anxiety-Suppressive Therapies
- 3.4.5 The Work of James Mann
- 3.4.6 Cognitive and Behavioural Approaches
- 3.4.7 Cognitive Behaviour Therapy and Cognitive Therapy
- 3.4.8 Interpersonal Therapy
- 3.4.9 Problem-Solving Therapy (PST)
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3.5 Relational Approaches

- 3.5.1 Time Limited Dynamic Psychotherapy (TLDP)
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- 3.5.4 Cognitive Analytic Therapy (CAT)

3.6 Pragmatic, Eclectic Therapies

- 3.6.1 Interpersonal, Developmental and Existential Therapy (IDE)
- 3.6.2 The Work of Garfield
- 3.6.3 Winston and Winston
- 3.6.4 Very Brief Therapy
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- 3.6.6 Solution-Focused Brief Therapy (SFBT)
- 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 TDLP 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-evoke 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 warded-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 REASDINGS

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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# UNIT 1 BEHAVIOUR MODIFICATION TECHNIQUES

**Structure**

1.0 Introduction

1.1 Objectives

1.2 Behaviour Modification

- 1.2.1 Characteristics of Behaviour Modification
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## 1.0 INTRODUCTION

In the last few years some writers have used the term *behaviour modification* to refer to almost any practice that alters human behaviour. But this is not the case. More specifically, behaviour modification is not brainwashing or mind control, and behaviour modifiers do not use psychosurgery or electroshock therapy and only occasionally use drugs as a temporary adjunct to a change procedure. Rather, behaviour modification is structured learning in which new skills and other behaviours are learned, undesired reactions and habits are reduced, and the client becomes more motivated for the desired changes. Behaviour modification is experimentally based. The goal of this unit is to describe basic principles of behaviour so that you can learn how environmental events influence human behaviour and to describe behaviour modification procedures so that you learn the strategies by which human behaviour may be changed. In this unit you will learn about behaviour modification, the principles and procedures used to understand and change human behaviour.

## 1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour modification;
- Explain the main characteristics of behaviour modification;
- Discuss the historical development of behaviour modification;
- Elucidate the principles of behaviour modification;
- Explain the and procedures of behaviour modification; and
- Analyse the applications of behaviour modification across various settings.

## 1.2 BEHAVIOUR MODIFICATION

Behaviour modification is the field of psychology concerned with analysing and modifying human behaviour.

*Analysing* means identifying the functional relationship between environmental events and a particular behaviour to understand the reasons for behaviour or to determine why a person behaved as he or she did.

*Modifying* means developing and implementing procedures to help people change their behaviour. It involves altering environmental events so as to influence behaviour.

Behaviour modification procedures are developed by professionals and used to change socially significant behaviours, with the goal of improving some aspect of a person's life.

### 1.2.1 Characteristics of Behaviour Modification

Following are the characteristics of behaviour modification:

1) **Focus on behaviour:** Behaviour modification procedures are designed to change behaviour, not a personal characteristic or trait. Therefore, behaviour modification deemphasises labelling. For example, behaviour modification is not used to change autism (a label); rather, behaviour modification is used to change problem behaviours exhibited by children with autism. Behavioural excesses and deficits are targets for change with behaviour modification procedures.

   In behaviour modification, the behaviour to be modified is called the *target behaviour*.

   A *behavioural excess* is an undesirable target behaviour the person wants to decrease in frequency, duration, or intensity. Smoking is an example of a behavioural excess.

   A *behavioural deficit* is a desirable target behaviour the person wants to increase in frequency, duration, or intensity. Exercise and studying are possible examples of behavioural deficits.

2) **Procedures based on behavioural principles:** Behaviour modification is the application of basic principles originally derived from experimental research with laboratory animals.

   The scientific study of behaviour is called the *experimental analysis of behaviour*, or behaviour analysis.

   The scientific study of human behaviour is called the experimental analysis of human behaviour, or *applied behaviour analysis*.

   Behaviour modification procedures are based on research in applied behaviour analysis that has been conducted for more than 40 years.

3) **Emphasis on current environmental events:** Behaviour modification involves assessing and modifying the current environmental events that are functionally related to the behaviour.

   Human behaviour is controlled by events in the immediate environment, and the goal of behaviour modification is to identify those events. Once these controlling variables have been identified, they are altered to modify the behaviour.

   Successful behaviour modification procedures alter the functional relationships between the behaviour and the controlling variables in the environment to produce a desired change in the behaviour.

   Sometimes labels are mistakenly identified as the causes of behaviour. For example, a person might say that a child with autism engages in problem behaviours (such as screaming, hitting himself, refusal to follow instructions) because the child is autistic. In other words, the person is suggesting that autism causes the child to engage in the behaviour. However, autism is simply a label that describes the pattern of behaviours the child engages in. The label cannot be the cause of the behaviour because the label does not exist as a physical entity or event. The causes of the behaviour must be found in the environment (including the biology of the child).

4) **Precise description of behaviour modification procedures:** Behaviour modification procedures involve specific changes in environmental events that are functionally related to the behaviour.

   For the procedures to be effective each time they are used, the specific changes in environmental events must occur each time. By describing procedures precisely, researchers and other professionals make it more likely that the procedures will be used correctly each time.

5) **Treatment implemented by people in everyday life:** Behaviour modification procedures are developed by professionals or paraprofessionals trained in behaviour modification. However, behaviour modification procedures often are implemented by people such as teachers, parents, job supervisors, or others to help people change their behaviour. People who implement behaviour modification procedures should do so only after sufficient training. Precise descriptions of procedures and professional supervision make it more likely that parents, teachers, and others will implement procedures correctly.

6) **Measurement of behaviour change:** One of the hallmarks of behaviour modification is its emphasis on measuring the behaviour before and after intervention to document the behaviour change resulting from the behaviour modification procedures.

   In addition, ongoing assessment of the behaviour is done well beyond the point of intervention to determine whether the behaviour change is maintained in the long run. If a supervisor is using behaviour modification procedures to increase work productivity (to increase the number of units assembled each day), he or she would record the workers' behaviours for a period before implementing the procedures. The supervisor would then implement the behaviour modification procedures and continue to record the behaviours. This recording would establish whether the number of units assembled increased. If the workers' behaviours changed after the supervisor's intervention, he or she would continue to record the behaviour for a further period. Such long term observation would demonstrate whether the workers continued to assemble units at the increased rate or whether further intervention was necessary.

7) **De-emphasis on past events as causes of behaviour:** As stated earlier, behaviour modification places emphasis on recent environmental events as the causes of behaviour. However, knowledge of the past also provides useful information about environmental events related to the current behaviour. For example, previous learning experiences have been shown to influence current behaviour. Therefore, understanding these learning experiences can be valuable in analysing current behaviour and choosing behaviour modification procedures. Although information on past events is useful, knowledge of current controlling variables is most relevant to developing effective behaviour modification interventions because those variables, unlike past events, can still be changed.

8) **Rejection of hypothetical underlying causes of behaviour:** Although some fields of psychology, such as Freudian psychoanalytic approaches, might be interested in hypothesised underlying causes of behaviour, such as an unresolved Oedipus complex, behaviour modification rejects such

hypothetical explanations of behaviour. Skinner (1974) has called such explanations "explanatory fictions" because they can never be proved or disproved, and thus are unscientific. These supposed underlying causes can never be measured or manipulated to demonstrate a functional relationship to the behaviour they are intended to explain.

### 1.2.2 Historical Overview of Behaviour Modification

A number of historical events contributed to the development of behaviour modification. Let's briefly consider some important figures, publications, and organisations in the field.

*Major Figures*

Following are some of the major figures who were instrumental in developing the scientific principles on which behaviour modification is based.

**Ivan P. Pavlov (1849–1936)** Pavlov conducted experiments that uncovered the basic processes of respondent conditioning. He demonstrated that a reflex (salivation in response to food) could be conditioned to a neutral stimulus. In his experiments, Pavlov presented the neutral stimulus (the sound of a metronome) at the same time that he presented food to a dog. Later, the dog salivated in response to the sound of the metronome alone. Pavlov called this a *conditioned reflex* (Pavlov, 1927).

**Edward L. Thorndike (1874–1949**) Thorndike's major contribution was the description of the *law of effect*. The law of effect states that a behaviour that produces a favourable effect on the environment is more likely to be repeated in the future. In Thorndike's famous experiment, he put a cat in a cage and set food outside the cage where the cat could see it. To open the cage door, the cat had to hit a lever with its paw. Thorndike showed that the cat learned to hit the lever and open the cage door. Each time it was put into the cage, the cat hit the lever more quickly because that behaviour—hitting the lever—produced a favourable effect on the environment: It allowed the cat to reach the food (Thorndike, 1911).

**John B. Watson (1878–1958)** In the article "Psychology as the Behaviourist Views It," published in 1913, Watson asserted that observable behaviour was the proper subject matter of psychology, and that all behaviours were controlled by environmental events. In particular, Watson described a stimulus response psychology in which environmental events (stimuli) elicited responses. Watson started the movement in psychology called *behaviourism* (Watson, 1913, 1924).

**B. F. Skinner (1904–1990)**. Skinner expanded the field of behaviourism originally described by Watson. Skinner explained the distinction between respondent conditioning (the conditioned reflexes described by Pavlov and Watson) and operant conditioning, in which the consequence of behaviour controls the future occurrence of the behaviour (as in Thorndike's law of effect). Skinner's research elaborated the basic principles of operant behaviour. In addition to his laboratory research demonstrating basic behavioural principles, Skinner wrote a number of books in which he applied the principles of behaviour analysis to human behaviour. Skinner's work is the foundation of behaviour modification.

*Early Behaviour Modification Researchers*

After Skinner laid out the principles of operant conditioning, researchers continued to study operant behaviour in the laboratory. In addition, in the 1950s,

researchers began demonstrating behavioural principles and evaluating behaviour modification procedures with people. These early researchers studied the behaviour of children, adults, patients with mental illness and individuals with mental retardation. Since the beginning of behaviour modification research with humans in the 1950s, thousands of studies have established the effectiveness of behaviour modification principles and procedures.

*Major Publications and Events*

A number of books heavily influenced the development of the behaviour modification field. In addition, scientific journals such as SEAB, Society for the Experimental Analysis of Behaviour; JEAB, Journal of the Experimental Analysis of Behaviour; AABT, Association for Advancement of Behaviour Therapy; JABA, Journal of Applied Behaviour Analysis were developed to publish research in behaviour analysis and behaviour modification, and professional organisations started to support research and professional activity in behaviour analysis and behaviour modification.

### 1.2.3 Observing and Recording Behaviour

One fundamental aspect of behaviour modification is measuring the behaviour that is targeted for change. Measurement of the target behaviour (or behaviours) in behaviour modification is called behavioural assessment. Behavioural assessment is important for a number of reasons.

Measuring the behaviour before treatment provides information that can help determine whether treatment is necessary.

Behavioural assessment provide information that helps in selecting the best treatment.

Measuring the target behaviour before and after treatment allows determining whether the behaviour changed after the treatment.

There are different methods for behavioural assessment.

## 1.3 RESPONDENT CONDITIONING AND COUNTERCONDITIONING

### 1.3.1 Respondent Conditioning

Someone smiling at us produces a pleasant feeling. Pictures of good food may literally cause our mouths to water. In one type of fetishism a man is sexually aroused by the sight of a woman's shoe. A woman with an automobile phobia may become anxious when she sees a car. Why should these stimuli (smiles, pictures of food, women's shoes, and automobiles) elicit these particular responses (a pleased feeling, salivation, sexual arousal, anxiety)? It is not instinctual that these stimuli elicit these responses; hence it probably is learned.

Perhaps one reason a smile now elicits a pleased feeling is that in a person's learning history the stimulus of a smile was associated with other stimuli, such as affection, which produced a pleasant feeling. The stimulus of the image of the food was associated with the stimulus of the taste of the food, with the taste eliciting salivation. Eventually the image of the food came to elicit salivation. Similarly, the sight of a woman's shoe may have been paired with sexually

arousing stimuli such as from masturbation. The image of an automobile may have been paired with an anxiety producing stimulus such as seeing a close relative die in an automobile accident. The learned associations may have been gradually built up over time, as in the case of the smile and affection, or may have followed a single dramatic learning experience, as in the case of the automobile accident.

This type of learning is called *respondent conditioning,* the learning model in which one stimulus, as the result of being paired with a second stimulus, comes to elicit a response it did not elicit just previously. Usually this new response is similar to the response previously elicited only by the second stimulus. In this model the first stimulus is called the *conditioned stimulus* (CS) and the response it comes to elicit is called the *conditioned response* (CR), while the second stimulus is called the *unconditioned stimulus* (UCS) and the response it already elicited is called the *unconditioned response* (UCR). For example take the case of a child who is gradually developing a dislike for school (CS) because the teacher emphasises the use of corporal punishment (UCS), which makes the child anxious and fearful (UCR). This will be the first step for the children to develop school phobias.

Through association of the CS and UCS, the CS comes to provide information about the occurrence of the UCS. The more probable it is the UCS will follow the CS, the stronger the respondent conditioning and the more probable it is the CR will follow the CS. After the CR begins to occur, it may be rewarded or punished, which affects its occurrence. In this sense the CR is often a response the person makes to prepare for the UCS. Respondent conditioning is often called *classical conditioning* and sometimes *Pavlovian conditioning*.

In human behaviour most of the things that are rewarding (e.g., attention, approval, money, good grades) or punishing (e.g., Ostracism, criticism) acquired their affect through respondent conditioning and are called *conditioned reinforcement* and *conditioned punishment*. In respondent conditioning there are two ways of dealing with undesired behaviours: (i) extinction and (ii) counterconditioning.

### 1.3.2 Extinction

Respondent conditioning is accomplished by establishing a contingency (relationship) between the CS and the UCS

The CS predicts to a certain degree the onset of the UCS.

If we terminate this contingency so that the CS is not associated with the UCS, eventually the CS will no longer elicit the CR.

This process is called *extinction.*

### 1.3.3 Spontaneous Recovery

If a small child is scratched (UCS) by a cat (CS) and hurt (UCR), then the child may develop a fear (CR) of cats. If the child now onwards encounters cats without anything bad happening, then the fear may extinguish. Sometimes following extinction, the CR may gain in strength over time. This is called spontaneous recovery. However, in practical situations, this is usually minimal; and with further extinction the CR will no longer reappear.

### 1.3.4 Procedure for Producing Extinction

There are basically two ways of carrying out extinction:

i) gradual and

ii) not gradual.

The gradual approach consists of moving through a sequence of steps, called a *hierarchy,* toward the object or situation that elicits the strongest CR.

The alternative is to bypass most of these intermediate steps and confront the final situation right away.

(Actually these are not two different approaches, but two points on a continuum of how many steps there are until approaching the final situation.)

For example, if a child had a fear of water at the beach, a gradual approach would involve slowly approaching the water, perhaps first playing on the beach 20 feet away from the water, then playing 10 feet away, then at the edge of the water, then putting feet in the water, and so forth.

The non-gradual alternative may be to put or carry the child into the water until the fear extinguishes.

A variation of the non gradual approach involves bombarding the person with the anxiety producing stimuli and / or keeping the person in the anxiety situation without escape. This approach is called *flooding*.

Although extinction is applicable to any respondently conditioned response, it is most used with anxieties and fears. People are continually confronted with situations that elicit some anxiety, such as standing up to the boss, making a presentation before a class, or talking about something personal. If the person can approach and be in the anxiety situation without anything unpleasant happening, then some of the anxiety should extinguish.

### 1.3.5 Counter Conditioning

Counterconditioning is the reduction of undesired elicited responses by respondently conditioning incompatible responses to the eliciting situations. The first step is to determine the situations that elicit the undesired responses, as for example the sight of spiders may cause excessive anxiety in some people.

The second step is to determine or establish ways to elicit a response incompatible with and dominant to the undesired response, such as some forms of relaxation may be to the spider anxiety.

Finally, the incompatible response is respondently conditioned to the stimuli eliciting the undesired response, as stimuli producing relaxation may be paired with stimuli related to spiders. This counterconditioning is continued until the undesired response that is fear of spiders has been adequately reduced, usually until it no longer occurs.

Counterconditioning is often used to reduce unwanted emotional reactions such as anxiety, anger, or jealousy. Most clinical cases have an anxiety component that needs to be handled in some way. *Desensitisation* is the counterconditioning of anxiety with relaxation.

In other situations, the undesired response is a rewarding, approach response, as occurs in some aspects of alcoholism, drug-addiction, and over-eating. The sight of a bar may elicit a craving for a drink or the taste of one cigarette may lead to smoking another.

In these cases, counterconditioning may involve conditioning in an unpleasant or aversive response to the stimulus situations eliciting the approach response. This is called *aversive counterconditioning*.

It is important in counterconditioning that the incompatible response be dominant to the undesired response. Sometimes this is not a problem. For example, in aversive counterconditioning the aversiveness of electric shock or imagining unpleasant scenes may be dominant to the pleasing effects of having a second piece of cake. However, response dominance is often an issue.

The way to ensure the incompatible response is dominant, is through the use of a hierarchy, similar to the gradual approach of respondent extinction. For example in the case of a person with a fear of spiders, our counterconditioning using relaxation would begin with items low on the hierarchy (such as the word "spider"), work up the hierarchy through intermediate items (such as a picture of a spider), on to items at the top of the hierarchy (such as touching a live spider). The assumption is that the effects of the counterconditioning generalise (carry over to similar stimuli) up the hierarchy, thereby gradually reducing the strength of the undesired response elicited by the various situations.

In the example of the spider anxiety, it may be that at the beginning of treatment the anxiety elicited by a picture of a spider or touching a live spider is dominant to any relaxation we can produce.

But our relaxation is dominant to the anxiety elicited by the word "spider"; so we begin our counterconditioning there.

Now as we countercondition out the anxiety to the word "spider" it is assumed the counterconditioning carries up the hierarchy and reduces somewhat the anxiety to the picture and the live spider.

By the time we get to the picture, our relaxation is dominant to any remaining anxiety, which we can now countercondition out.

And this counterconditioning generalises up the remainder of the hierarchy.

Thus if we choose a hierarchy of related items, have a sufficient number of items in our hierarchy, and do not move through the hierarchy too fast, we can insure that the incompatible response is dominant to the undesired response and Counterconditioning will move in the desired way. This is the approach we take while carrying out systematic desensitisation.

## 1.4 OPERANT CONDITIONING

This section is concerned with learning and motivational changes based on events that follow behaviour and generally are a result of the behaviour. A worker receives his salary following completion of a certain number of hours of work. A student receives a particular grade on a test as a result of achieving a certain test score. A child is reprimanded for using certain words. In these cases there is some

relationship, called a *contingency,* between the person's behaviour (working a number of hours, achieving a test score, using certain words) and some resultant or *contingent* event (salary, grade, reprimand).

***Operant conditioning***

This is also called instrumental conditioning. It is the learning model based on the effects on behaviour of contingent events and the learning of the nature of the contingency.

If the contingent event makes it *more* probable that the person will behave in a similar way when in a similar situation, the event is called a *reinforcer.*

## 1.4.1 Reinforcement and Punishment

Occasionally, when Bobby was put to bed before he wanted, he would cry. His parents dealt with this by reading him a story to quiet him down.

Bobby cried more often when put to bed. In this situation, the parents' reading him a story was reinforcement for Bobby's crying.

On the other hand, if the contingent event makes the behaviour *less* probable, then the event is called a *punisher.*

For a while, Sushila did all her banking at the neighbourhood bank. However, because of poor service there, she gradually shifted most of her business to another bank. Here the poor service is a punishment for using the neighbourhood bank.

Following the behaviour, the contingent event may come on or increase *(positive),* or the contingent event may go off or decrease *(negative).* This produces four combinations:

i) positive reinforcement,

ii) negative reinforcement,

iii) positive punishment, and

iv) negative punishment.

i) Positive reinforcement is an increase in the probability of a behaviour due to an increase in the contingent event. Jane, a new manager in a company, began praising workers for submitting their reports on time. In a couple of weeks, this reinforcement by praise greatly increased on-time reports. Positive reinforcement, when appropriately used, is one of the most powerful of all behaviour change tools.

ii) Negative *reinforcement* is an increase in the probability of behaviour due to a decrease in the contingent event. A person learns to use his relaxation skills to offset anxiety, with the decrease in anxiety being a negative reinforcer. Thus negative reinforcement is based on the decrease of something undesired such as pain or anxiety. Negative reinforcement is not punishment; reinforcement is an increase in the probability of behaviour, while punishment is a decrease.

Negative reinforcement is the basis of *escape conditioning,* learning to escape an aversive situation and being reinforced by the decrease in aversion. Sachin

may learn to leave a neighbour's house when the neighbour gets drunk and obnoxious. Escape conditioning may lead to *avoidance conditioning* in which the person learns to avoid the aversive situation. Sachin may learn to avoid going to his drinking neighbour's house. Many politicians avoid important political issues in which no matter what position they take a moderate number of people will get mad and perhaps later vote against them. Votes and money are two strong reinforcers accounting for much political behaviour.

*Positive punishment* is a decrease in the probability of behaviour due to an increase in the contingent event. This is what most people mean when they use the word "punishment." If every time Ali tells his algebra teacher he is having trouble keeping up with the class he is then given extra remedial Work, then the extra work may act as a punisher resulting in a decrease in asking for help.

*Negative punishment* is a decrease in the probability of behaviour due to a decrease in the contingent event. This corresponds to a decrease in something desirable following some behaviour. If every time a person stutters, he briefly turns off a movie he is watching and if this results in a decrease in stuttering, then the offset of the movie is a negative punisher for stuttering.

## 1.5 OPERANT CONDITIONING PROCEDURES

Now we turn to behaviour change strategies that are based on operant Conditioning. This includes altering the stimulus situations in which behaviours occur *(stimulus control),* getting desirable behaviours to occur and reinforcing them, extinguishing and/or punishing undesired behaviours and reducing the reinforcing effects of events that support undesired behaviours.

### 1.5.1 Stimulus Control

Operant behaviours do not occur in a vacuum; they occur more in some Situations than others and are triggered by external and internal cues. That is, for all operant behaviours there are stimuli, called *discriminative stimuli* (SD), which tend to cue the response. Discriminative stimuli do not elicit the behaviour, as the CS elicits the CR, but rather set the occasion for the behaviour, making it more or less probable the behaviour will occur. Thus we can often alter operant behaviour by altering discriminative stimuli.

**Approach 1:** One approach is to remove discriminative stimuli that cue undesired behaviours. As part of a program to reduce smoking we might remove those stimuli that increase the tendency to smoke, such as ashtrays on the table. When trying to lose weight we might change the route from work to home so it does not pass the pastry shop.

**Approach 2:** A second stimulus control approach, called *narrowing,* involves restricting behaviours to a limited set of stimuli. A person who overeats probably is eating in many situations. This results in many discriminative stimuli (e.g., reading, watching TV, having a drink, socialising) cuing the tendency to eat. To cut back on this, we might restrict the eating to one place and certain times. Or in reducing smoking, we might restrict smoking to when the client is sitting in a particular chair in the basement.

Eliminating cues and narrowing are often combined. For example, in improving study habits an important component is establishing good study areas. If a student sits on the sofa when studying, eating, listening to music, and interacting with friends, then the sofa will cue thoughts, feelings, and behaviour tendencies that may be incompatible with studying. It is preferable to set up an area in which nothing takes place except studying (perhaps a desk in a corner), get out of the area when doing things like daydreaming, and remove from the area stimuli (e.g., pictures, food) that cue behaviours incompatible with studying. Similarly, treatment of insomnia might involve only going to bed when sleepy; leaving the bed when not falling asleep; and not reading, eating, or watching TV when in bed.

**Approach 3:** A third stimulus control approach involves introducing stimuli that tend to inhibit the undesired behaviour and/or cue behaviours incompatible with the undesired behaviour. A person trying to lose weight might put signs and pictures on the refrigerator door. Or a person who has quit smoking may tell all his friends he has quit. Then the presence of one of his friends may be a stimulus to not smoke.

Because a person's behaviour gets tied into the stimuli and patterns of his daily life, it is often desirable to alter as many of these cues as possible. This *stimulus change* may involve a wide range of things such as rearranging furniture, buying new clothes, painting a wall, eating meals at different times, or joining a new club. Stimulus change is useful in situations such as part of marriage counseling or when a client is ready to significantly alter his life-style.

Similarly, removing a person from his usual life situation until the change program is accomplished is often useful, particularly if coupled with stimulus change of the environment the client returns to.

Stimulus control deals with the antecedent side of operant behaviour; the following sections deal with the consequence side.

### 1.5.2 Increasing Desirable Behaviours

The most common operant approach consists of reinforcing desirable behaviours. And this should generally be a component of all operant programs, even when the emphasis is on some other approach, such as extinction.

*Reinforcement*

An important point is that we must identify what actually is reinforcing to the person, not what we expect should be reinforcing to him. A good approach to determine reinforcers is to ask the person what is reinforcing. Similarly, events we may consider not to be reinforcing in fact are. A common example is the teacher who yells at a student as an intended punishment, when really the teacher may be reinforcing the student with attention and/or causing the student to receive social reinforcement from his peers for getting the teacher mad.

Sometimes something will not be reinforcing to the client unless he has had some moderately recent experience with it. Talking on the telephone to a relative may not be reinforcing to a mental patient who has not used the telephone for years. Playing a game may not be reinforcing to an elementary student who is unfamiliar with the game. In these cases, it is often desirable to prime the client

by giving him some free experience with the reinforcer before the operant contingencies are established. This procedure is called *reinforcer sampling* (Ayllon & Azrin, 1968a).

Praise is a common and powerful reinforcer. When appropriately used, it has made dramatic changes in a variety of settings, including elementary classrooms and businesses. Money is another powerful reinforcer already affecting much of our behaviour. Reinforcers for students may include longer recess, opportunity to be the teacher's aide, field trips, dances, or time in a special reward area filled with different things to do. Behaviour modification in business settings and related organisations is also applicable. Potential reinforcers in these settings include recognition and praise, bonuses, equipment and supplies, additional staff, added privileges, participation in decision making, option for overtime, and days and hours off.

A variation of reinforcement is *self-reinforcement,* reinforcement People give themselves. This may be a form of covert verbal reinforcement (e.g., "That was good work.") or a more tangible reinforcer such as buying yourself some treat. Self-reinforcement is often an important part of self control processes in which people reinforce themselves for desired behaviours.

### 1.5.3 Strategies for Initiating Behaviours

To reinforce desirable behaviour the behaviour must first occur. If a catatonic has not said anything for five years, it would not be an effective approach to wait for him to say something to reinforce his talking. Thus an important part of the operant approach is to use ways to help initiate the behaviours to be reinforced. There are many ways to do this, including shaping, modeling, fading, punishment, and guidance.

*Shaping*

Shaping, also called *successive approximation*, is the reinforcing of behaviours that gradually approximate the desired behaviour. The key to shaping is the use of successive approximations that are small enough steps so that there is an easy transition from one step to the next. If one is cultivating the ability to meditate for long periods of time, it may not be desirable to start trying to meditate for an hour. An alternative would be to begin at ten minutes and add one minute every other day, gradually shaping meditation for longer periods of time.

Shaping involves starting where the client is; taking small enough steps so the client's behaviour smoothly changes, providing reinforcement and support for the changes, and catching mistakes or problems early because of the small steps. Practitioners often also need to use shaping when trying to change the philosophy or programs of the agency or organisation where they work.

*Modeling*

Modeling, involves a change in a person's behaviour as a result of observing the behaviour of another person, the model. Thus a way of initiating a behaviour, particularly with a child, is to have the person observe someone doing the desired behaviour and encourage imitation of the behaviour. A client who is learning how to interview for a job may first watch the practitioner model appropriate behaviours in a simulated job interview. Or a teacher who praises one student for good behaviour may find other students imitating this behaviour.

Modeling and shaping combine together well. For example, in *model-reinforcement counseling* the client listens to a tape recording of a counseling interview in which another person is reinforced by a counselor for making a certain class of statements. Then the client is reinforced for making these types of statements. This approach has been used to increase information seeking of high school students engaged in career planning (Krumboltz & Schroeder, 1965) and deliberation and deciding about majors by college students (Wachowiak, 1972).

*Fading*

Fading involves taking a behaviour that occurs in one situation and getting it to occur in a second situation by gradually changing the first situation into the second. A small child might be relaxed and cooperative at home, but frightened and withdrawn if suddenly put into a strange classroom. This fear can be circumvented if the child is gradually introduced to situations that approximate the classroom. Fading is particularly important when a client learns new behaviours in a restricted environment, such as a clinic, hospital, or half-way house. Taking a person out of such a setting and putting him directly back into his home environment may result in a loss in many of his new behaviours and skills. It is preferable to gradually fade from the therapeutic environment to the home environment. Shaping involves approximations on the response side, while fading involves approximations on the stimulus side.

*Punishment*

Punishment of one behaviour suppresses that behaviour and results in other behaviours occurring. Perhaps one of these other behaviours is a desirable behaviour that can be reinforced. This is not a particularly efficient or desirable approach in most cases.

*Guidance*

Guidance consists of physically aiding the person to make some response. Thus as part of contact desensitisation or flooding, the client may be guided to touch a feared object. Guidance may be used to help a client learn a manual skill or help a child who is learning to talk how to form his lips to make specific sounds.

## 1.5.4 Variables of Reinforcement

Several variables affect the effectiveness of reinforcement. The three most important are amount of reinforcement, delay of reinforcement, and schedule of reinforcement.

*Amount of reinforcement*

This refers to both the quality and quantity of reinforcement. Within limits, and with many exceptions, as the amount of reinforcement is increased, the effect of the reinforcement increases.

*Delay of reinforcement*

This refers to the amount of time between the person's behaviour and the reinforcement for that behaviour. As a general rule, you get the best results if the reinforcement occurs right after the behaviour. Praising a child for sharing with a friend is generally most effective if the praise occurs right after the sharing

than if it is mentioned later in the day. As the delay of reinforcement increases, the effectiveness of the reinforcement decreases.

*Schedule of reinforcement*

This refers to the pattern by which reinforcers are related to responses. The primary distinction between schedules of reinforcement is based on whether every correct response is reinforced (continuous reinforcement) or whether only some correct responses are reinforced (intermittent reinforcement). Learning is faster with continuous reinforcement than with intermittent reinforcement, but time to extinction is longer with intermittent reinforcement. Therefore, it is often strategic first to teach the behaviour under continuous reinforcement and then gradually switch to intermittent reinforcement to maintain it.

### 1.5.5 Facilitating Generalisation and Maintenance

Often an operant program will be established in a specific setting, such as a clinic, hospital, or classroom. Yet we usually want the behaviours and skills supported and acquired in this setting to carry over and be maintained in other settings. The behaviours usually will generalise, to some degree, from our specific setting to other settings; but it is usually desirable to facilitate this carry over.

Fading, discussed earlier, is one way of accomplishing this. Other ways to facilitate generalisation and maintenance of behaviours include the following:

Phase the client off the behaviour change reinforcements onto more "natural" forms of reinforcement.

Thus we start with a specific set of reinforcers and contingencies, as with patients in a hospital or children in a classroom, and gradually switch to the types of reinforcers that should support the behaviours in the everyday environment, as for example the reinforcers such as social approval and self-reinforcement.

A related approach involves gradually exposing the clients to the types of reinforcement contingencies that occur in the natural social environment. This is accomplished by switching from continuous schedules of reinforcement to intermittent schedules and by gradually helping the clients learn to function under long delays of reinforcement.

Finally, we may wish to reprogram the other environments or enlist the help of others to support the newly acquired behaviours. For example, a school counselor and a teacher may set up a program in one classroom that helps a child learn social skills that improve his ability to get along with his peers and experience less conflict in the classroom. To facilitate these skills occurring in settings other than this one classroom, the counselor may talk with the child's parents and his other teachers about ways to support these new behaviours in various settings.

### 1.5.6 Criticisms

There are many criticisms against programs that use reinforcement, particularly when used in classrooms. For many critics it seems inappropriate to be reinforcing people for something they should be doing; to some critics, this smacks of bribery.

Another common criticism is that people will come to expect rewards for everything they do and will not work otherwise. This may foster greed or teach the person to be bad in order to be rewarded for being good.

Another criticism is based on the fact that some mixed data exist suggesting that in some situations the use of extrinsic reinforcement may reduce intrinsic motivation (Levine & Fasnacht, 1974). That is, reinforcing people for doing something may reduce their motivation to do it when not being reinforced. If children enjoy playing certain games and then we begin reinforcing them for playing the games, when we remove the reinforcement their interest in the games may be less than it was prior to reinforcement.

## 1.6 CONTINGENCY CONTRACTING

A variation of operant procedures is *contingency contracting,*

This is a program in which the operant contingencies are well specified and clearly understood by everyone involved. These contingencies, reinforcements and punishments that can be expected for different behaviours, are formalised into a contract which is often written. Sometimes the contract is imposed on people; but often the best approach is to negotiate, as much as possible, with all people involved about the nature of the contract. Thus the role of the behaviour modifier is often consultant and negotiator about contracting.

Contingency contracting is powerful in classroom situations. The teacher sets up a contract, perhaps with the help of the counselor, specifying what is expected of the students, academically and non academically, and what reinforcements they may expect for behaving these ways.

Thus the students may be required to bring specified supplies, abide by a list of well specified classroom rules, and turn in their homework completed to a specified degree.

### 1.6.1 Reinforcement for Contingency

Reinforcements may include opportunity to spend a certain amount of time in a reward area or opportunity to work on a special project.

Ideally the teacher has negotiated all aspects of the contract with the students and all students fully understand the contract.

Consider the contingencies operative in many classrooms below the college level. To cite an example let us say that teachers have a certain amount of material they wish to cover and work they wish completed. For the students the contingent event for completing some work is more work. Hence the students learn to work well below capacity, the teachers push for more to be done, and a certain amount of antagonism develops between teachers and students. Now with contingency contracting the teacher presents the work that needs to be done and asks the students what reinforcements they would like for completing the work and what sort of classroom rules can be established to facilitate this program. This results in the students and teacher working together to establish a mutually satisfactory contract.

Such an approach generally results in a decrease in behaviour problems, an increase in the students liking the classroom setting, and the students doing the work much faster than would be expected.

Most teachers, particularly with younger children, spend most of their time being policemen.

Contingency contracting provides a behaviour management system that frees the teachers to do more teaching.

### 1.6.2 Consistency in Contingency Contracting

Consistency is a critical aspect of most behaviour change programs, while inconsistency can generate many problems. If a parent or teacher is consistent in dealing with a child, the child can easily learn what contingencies are operative and feels comfortable understanding how part of the world works. Inconsistency, on the other hand, may produce uncertainty, anxiety, tantrums, psychosomatic illness, learned helplessness, and related problems. Children and others also engage in *rule-testing,* the intentional breaking of a rule to determine if the contingency is in effect. If the system is consistent, there will be some rule-testing. If inconsistent, there will be much rule testing. Although consistency is perhaps most important with children, it is also important with others. For example, inconsistency in a business setting may result in a drop in morale, feelings of favoritism, feeling powerless to control events, and not knowing what to expect.

A major strength of contingency contracting is that it teaches and requires people to be consistent. If one person fulfills his part of the contract, the other person must fulfill his part.

All operant conditioning involves reciprocity, a mutual interchange of contingent events, usually reinforcements. For example, in the classroom the teacher reinforces the students for various accomplishments and in turn is reinforced by these accomplishments. Contingency contracting is a way of establishing a level of reciprocity that is most satisfying for the various people involved. Thus it has proved a useful tool in marriage counseling and families in general.

### 1.6.3 Token Economies

In some contingency contracting programs the client is reinforced with *tokens* (e.g., poker chips, stars or marks on a chart, punch holes in a special card) that can later be exchanged for a choice of reinforcers.

Contingency contracting programs using tokens are called *token economies.* There are now a large number of such programs in a wide variety of settings. The tokens a person earns by completing his part of the contract are eventually exchanged for a choice of reinforcers from a *reinforcement menu.*

By having a large number of items and privileges on this menu the tokens are reinforcing for most of the people most of the time, even though people will buy different things at different times. This reduces problems of a person satiating on any particular reinforcer or continually trying to determine what is currently reinforcing to any person.

Strength of token systems is that they deal with the issue of delay of reinforcement discussed earlier.

The tokens are often easily dispensed and can be given fairly immediately after the desired behaviour. For example, a teacher may walk around a classroom putting checks on each student's small clipboard for appropriate behaviour and accomplishment. These checks are immediately reinforcing, even though they will not be cashed in until later.

They can also be dispensed without greatly disrupting the student's work.

Token systems are often used in home situations. A child may earn tokens every day, which maintains his behaviour, even though his purchased reinforcement does not come until the weekend. Or the child may use some of his tokens for small daily rewards (e.g., staying up an extra half hour) and save others over a period of time for a larger reward (e.g., a new toy).

## 1.7 DECREASING UNDESIRED BEHAVIOURS

Operant reinforcement strategies are some of the most powerful behaviour change approaches available. Contingency contracting and token economies are ways of formalising these approaches and thus often making them more effective. Now we turn to operant approaches for decreasing undesired behaviours. But remember that in most situations in which you are decreasing one behaviour, you should be reinforcing and increasing another so that desired behaviours are encouraged and the person continues receiving reinforcement.

### 1.7.1 Extinction

Establishing a contingency between a behaviour and a contingent event is operant conditioning; terminating this contingency is operant *extinction.* Reinforcing a behaviour increases the probability of that behaviour; withholding the reinforcement decreases the probability. A patient in a mental hospital may learn to emit psychotic talk because it gets him extra attention from the staff and other patients. Not reinforcing this type of talk may cause it to extinguish and thus occur less.

However, a person does not learn a simple behaviour to a stimulus, but rather learns a whole hierarchy of behaviours. The behaviour on the top of the hierarchy is the most probable to occur, the second behaviour the next most probable, and on down. The position on the hierarchy and the distance between items on the hierarchy are functions of how many times the behaviours have been reinforced.

If the top behaviour is extinguished, then the second behaviour will occur. And if this behaviour is considered undesirable, it will have to be extinguished.

Thus the problem with the extinction procedure is that considerable time may be spent going through the entire hierarchy or until a desirable behaviour is reached. For this reason the extinction procedure is generally inefficient unless the hierarchy is small, as with many problems with children. It is generally better to emphasise reinforcing a desired behaviour in place of the undesired behaviour.

Another problem is that it may be difficult or undesirable not to attend to some behaviours, such as destructive or disruptive behaviours. Extinction may also have emotional side effects such as frustration, anger, or confusion. These side effects are minimised if we are simultaneously reinforcing alternative behaviours.

### 1.7.2 Punishment

The most common approach people use to reduce undesired behaviours, particularly in others, is punishment. This consists in applying a contingent event to a behaviour that results in a decrease in the probability of the behaviour. As mentioned earlier, there are two types of punishment, (i) positive punishment and (ii) and negative punishment.

*Positive punishment*

Positive punishment is a contingent event whose onset or increase, results in a decrease in the probability of the behaviour it is contingent upon. If each time Raghu starts eating his mother's house plants that she shows disapproval and if this disapproval reduces the probability of Raghu eating the plants in the future, then the disapproval is positive punishment. Disapproval, criticism, pain, and fines are common forms of punishment.

As a behaviour change procedure punishment has many disadvantages and possible bad side effects: Punishing an undesirable behaviour does not necessarily result in desirable behaviours.

Punishing a child in a classroom for throwing things during self work time does not necessarily result in the child shifting to working alone.

Perhaps self work behaviours are not in the child's repertoire.

### 1.7.3 Reactions to Punishment

Punishment may condition in reactions such as fear, anxiety, or hate to the people who administer the punishment or the situations in which it occurs.

Thus children may fear their parents, students may dislike school, criminals may resent society, and workers may not fully cooperate with their foreman.

Related to this is that the person may learn to escape or avoid these people or situations, resulting in such possibilities as a school phobia or an increase in absenteeism from work.

Attempted punishment of an escape or avoidance response may rather increase the strength of the avoidance.

Punishing a child with a fear of the dark for not going into the basement at night alone may actually increase the fear.

The punished person may spend some time making up excuses and passing the blame to others.

The punishing agents may act as models for aggressive behaviour.

Children may model after their parents and learn to hit people when mad.

Workers may model their supervisors and become overcritical of the errors of their subordinates.

Finally, punished people may become generally less flexible and adaptable in their behaviours.

If punishment is to be used, it needs to be applied immediately after the behaviour and applied consistently. The earlier in the response chain the punishment occurs the better, for then it may stop or disrupt a sequence of undesired behaviours.

Punishment should generally be coupled with extinction and reinforcing of alternative behaviours. If possible the punishment should be viewed, by all people involved, as part of a contractual agreement rather than a personal attack.

Punishment is often used more for its disruptive effects than suppressive effects. As part of a self control program a person may wear a rubber band around his wrist which he snaps on the underside of his wrist to disrupt unwanted thoughts or feelings. Also just wearing the rubber band then acts as a reminder about his behaviour.

### 1.7.4 Overcorrection

Alternative form of punishment is *overcorrection*. In *positive practice overcorrection* the client is required to practice correct behaviours each time an episode of the undesired behaviours occurs. For instance, a child marking on the wall might be required to copy a set of patterns with pencil and paper. In the case of an autistic or hyperactive child who is pounding objects or himself, he would be told of his inappropriate behaviour which would be stopped. Then the child would be given verbal instructions, and physical guidance if necessary, for the overcorrection behaviour; in this case a few minutes of instruction for putting hands at sides, then over head, then straight out, and so forth.

In *restitutional overcorrection* or *restitution,* clients must correct the results of their misbehaviour to a better than normal state. A child who marks on the wall may be required to erase the marks and wash the entire wall as well. A child who turns over chairs may be required to set up those chairs and straighten up the rest of the furniture. Screaming may require a period of exceptional quiet.

### 1.7.5 Negative Punishment

Negative punishment is a contingent event whose offset or decrease results in a decrease in the behaviour it is contingent on. This generally consists of taking away something that is reinforcing from a person when he misbehaves. The procedure of negative punishment generally also results in positive punishment and/or extinction. In behaviour modification there are two major forms of negative punishmen and these are:

i) response cost and

ii) time out.

*Response cost*

This refers to the withdrawal or loss of a reinforcement contingent on a behaviour. This may be the loss or fine of tokens in a token system, such as a fine for the use of the wrong words. Response cost has been used to suppress a variety of behaviours such as smoking, overeating, stuttering, psychotic talk, aggressiveness, and tardiness. Possible advantages of response cost are that it may have fewer aversive side effects than positive punishment and it leaves the person in the learning situation, which time out does not.

*Time out (or time out from reinforcement)*

This refers to the punishment procedure in which the punishment is a period of time during which reinforcement is not available. For example, time out has been an effective punishment procedure in classrooms. If a child misbehaves, he may be sent to spend ten minutes in a time out area, perhaps a screened off corner in the back of the classroom. For time out to be effective the area the client is removed from must be reinforcing to him.

The classroom should be a reinforcing place and being in time out may result in a period of time in which the student cannot earn tokens.

Also the time out area should not be reinforcing. In a home, sending a child to his room may not be a good time out, as the room may be filled with reinforcers. Usually just a few minutes in time out are sufficient and it often gives the punished person a chance to cool off.

### 1.7.6 Stimulus Satiation

So far in this unit we have discussed two major ways of reducing undesired behaviours, extinction and punishment.

A third way is to reduce the reinforcing effects of the events supporting the undesired behaviour. Aversive counterconditioning is a way to do this.

A related approach *is stimulus satiation* in which the client is flooded with the reinforcer repeatedly until it loses much or all of its reinforcing effect. A child who keeps playing with matches might be sat down with a large number of matches to strike and light. This would be continued until lighting matches lost their reinforcing effect. It is not known how or why stimulus satiation works, but it seems to contain components of aversive counterconditioning and respondent extinction of reinforcing effects.

Stimulus satiation has been used in the treatment of smoking by dramatically increasing the number of cigarettes smoked and/or the rate of smoking the cigarettes. This stimulus satiation produced a significant reduction in smoking with 60 percent of the subjects abstinent at six months.

## 1.8 AREAS OF APPLICATION

Behaviour modification procedures have been used in many areas to help people change a vast array of problematic behaviours.

### 1.8.1 Developmental Disabilities

More behaviour modification research has been conducted in the field of developmental disabilities than perhaps any other area. People with developmental disabilities often have serious behavioural deficits, and behaviour modification has been used to teach a variety of functional skills to overcome these deficits. In addition, people with developmental disabilities may exhibit serious problem behaviours such as self-injurious behaviours, aggressive behaviours, and destructive behaviours. A wealth of research in behaviour modification demonstrates that these behaviours often can be controlled or eliminated with behavioural interventions (Barrett, 1986; VanHouten & Axelrod, 1993). Behaviour modification procedures also are used widely in staff training and staff management in the field of developmental disabilities (Reid, Parsons, & Green, 1989).

### 1.8.2 Mental Illness

Behaviour modification has been used with patients with chronic mental illness to modify such behaviours as daily living skills, social behaviour, aggressive behaviour, treatment compliance, psychotic behaviours, and work skills. One particularly important contribution of behaviour modification was the

development of a motivational procedure for institutional patients called a *token economy* (Ayllon & Azrin, 1968). Token economies are still widely used in a variety of treatment settings.

### 1.8.3 Education

Great strides have been made in the field of education because of behaviour modification research. Researchers have analysed student–teacher interactions in the classroom, improved teaching methods, and developed procedures for reducing problem behaviours in the classroom (Becker & Carnine, 1981; Madsen, Becker, & Thomas, 1968). Behaviour modification procedures have also been used in higher education to improve instructional techniques, and thus improve student learning.

### 1.8.4 Rehabilitation

Rehabilitation is the process of helping people regain normal function after an injury or trauma, such as a head injury from an accident or brain damage from a stroke. Behaviour modification is used in rehabilitation to promote compliance with rehabilitation routines such as physical therapy, to teach new skills that can replace skills lost through the injury or trauma, to decrease problem behaviours, to help manage chronic pain, and to improve memory performance.

### 1.8.5 Community Psychology

Within community psychology, behavioural interventions are designed to influence the behaviour of large numbers of people in ways that benefit everybody. Some targets of behavioural community interventions include reducing littering, increasing recycling, reducing energy consumption, reducing unsafe driving, reducing illegal drug use, increasing the use of seat belts, decreasing illegal parking in spaces for the disabled, and reducing speeding.

### 1.8.6 Clinical Psychology

In clinical psychology, psychological principles and procedures are applied to help people with personal problems. Typically, clinical psychology involves individual or group therapy conducted by a psychologist. Behaviour modification in clinical psychology, often called *behaviour therapy,* has been applied to the treatment of a wide range of human problems.

### 1.8.7 Business, Industry and Human Services

The use of behaviour modification in the field of business, industry, and human services is called *organisational behaviour modification* or *organisational behaviour management*. Behaviour modification procedures have been used to improve work performance and job safety and to decrease tardiness, absenteeism, and accidents on the job. In addition, behaviour modification procedures have been used to improve supervisors' performances. The use of behaviour modification in business and industry has resulted in increased productivity and profits for organisations and increased job satisfaction for workers.

### 1.8.8 Child Management

Numerous applications of behaviour modification to the management of child behaviour exist. Parents and teachers can learn to use behaviour modification

procedures to help children overcome bedwetting, nail-biting, temper tantrums, noncompliance, aggressive behaviours, bad manners, stuttering, and other common problems.

### 1.8.9 Sports

Behaviour modification is also used widely in the field of sports psychology and are also used to promote health-related behaviours by increasing healthy lifestyle behaviours (such as exercise and proper nutrition) and decreasing unhealthy behaviours (such as smoking, drinking, and overeating).

### 1.8.10 Medical Problems

Behaviour modification procedures are also used to promote behaviours that have a positive influence on physical or medical problems—such as decreasing frequency and intensity of headaches, lowering blood pressure, and reducing gastrointestinal disturbances —and to increase compliance with medical regimens. Applying behaviour modification to health-related behaviours is called *behavioural medicine* or *health psychology.*

**Self Assessment Questions**

Multiple choices:

1) "The consequences of behaviour affect their recurrence" is a basic principle of :
   - Respondent conditioning
   - Wolpian conditioning
   - Hullian conditioning
   - Operant conditioning
2) When using desensitisation with a client, first put the client into
   - a heavy state of relaxation
   - a mild tension-arousing scene
   - an intense tension-arousing scene
   - d a scene in which the client can rationally attack the fear
3) Bill, who has a tremendous fear of public speaking, has to take a literature course that requires an oral presentation. Which of the following should be the last tense scene for desensitisation?
   - Bill preparing for his presentation the night before he has to present it
   - Bill registering for the course
   - Bill finding out the course requirements the first day of class
   - Bill talking to his professor about his fears of making the presentation
4) Which statement concerning punishment is NOT correct?
   - Mild punishment is not as effective as the use of positive rewards.
   - Behaviours learned under punishment conditions extinguish quickly.
   - Punishment has longer lasting effects than positive reinforcement.
   - Punishment may result in unforeseen negative emotional consequences.

5) In the extinction process the
   - client is not permitted to behave
   - client is allowed intermittent reinforcement
   - reinforcement is totally eliminated
   - stimulus satiation is an important factor.

6) Having a client repeat a negative behaviour until it becomes aversive is called
   - stimulus satiation
   - drive satiation
   - response satiation
   - reinforcer satiation

7) Behaviour modification programs work best when
   - the individual is not aware of the consequences of his/her behaviour
   - the behaviour selected for modification occur infrequently
   - there are no baseline data
   - none of the above

8) Which of the following is the best example of punishment through satiation to eliminate an undesirable behaviour?
   - Administering an aversive stimulus whenever the client displays an undesirable behaviour
   - Giving the client an overabundance of whatever he or she wants
   - Withdrawing privileges whenever the client's behaviour becomes excessive
   - Allowing the client to do whatever he or she pleases and rewarding him or her only for desirable behaviour.

## 1.9 LET US SUM UP

Behaviour modification procedures involve analysing and manipulating current environmental events to change behaviour. A behavioural excess or behavioural deficit may be targeted for change with behaviour modification procedures. Behaviour modification procedures are based on behavioural principles derived from scientific research. B. F. Skinner conducted the early scientific research that laid the foundation for behaviour modification.

Behaviour modification procedures often are implemented by people in everyday life. Behaviour is measured before and after the behaviour modification procedures are applied to document the effectiveness of the procedures. Behaviour modification de-emphasises past events and rejects hypothetical underlying causes of behaviour.

Respondent conditioning is the learning model in which a stimulus situation comes to elicit a relatively new response or increase in response because of association with other stimulus situations. Formally, the conditioned stimulus

(CS) comes to elicit the conditioned response (CR) because of the person learning that the CS is associated with (provides information about) the unconditioned stimulus (UCS), which elicits the unconditioned response (UCR).

Respondent conditioning is sometimes used in behaviour modification to establish or strengthen a response, as in the treatment of enuresis. Undesired respondent behaviour is changed by respondent extinction or counterconditioning, both of which may or may not be done gradually with a hierarchy of intermediate steps.

Emphasis of operant conditioning is on changes in the probability of a behaviour in the presence of specific stimuli as a result of events contingent on the behaviour. A reinforcer increases the probability of a behaviour it is contingent on; a punisher decreases the probability.

The contingent event is usually dependent on the behaviour and occurs because of the behaviour. Procedures to get a behaviour to occur to reinforce it include shaping, modeling, fading, punishment, and guidance. Initial learning is usually best when the reinforcer occurs immediately after every example of the correct behaviour (short delay of reinforcement, continuous schedule of reinforcement).

Extinction is the return of the probability of a behaviour toward its initial value (baseline) after the contingent events have been removed. Use of an intermittent schedule of reinforcement increases resistance to extinction.

Punishment as a change procedure should generally be avoided because of undesirable side effects; but it can be used effectively to disrupt or suppress an undesired behaviour while a desired alternative is being strengthened. Positive punishment procedures include administering an aversive event and overcorrection, while negative punishment includes a withdrawal or loss of a reinforcer (response cost) and a period of time during which reinforcers cannot be acquired (time out).

The reinforcing effects of an event can be reduced by aversive counterconditioning or stimulus satiation. Nervous habits can be reduced by negative practice and habit reversal. Contingency contracting is a formalised operant program in which the contingencies are well specified and usually negotiated.

Behaviour modification procedures have been applied successfully to all aspects of human behaviour, including developmental disabilities; mental illness; education and special education; rehabilitation; community psychology; clinical psychology; business, industry, and human services; child management; prevention; sports psychology and health-related behaviours.

## 1.10 UNIT END QUESTIONS

1) What is the basic definition of human behaviour?
2) Identify eight defining characteristics of behaviour modification?
3) Briefly describe the contributions of Pavlov, Thorndike, Watson, and Skinner to the development of behaviour modification?
4) Discuss in depth the various operant procedures in behaviour modification?
5) Discuss respondent conditioning?

## 1.11 SUGGESTED READINGS

Baldwin, John and Janice Baldwin. *Behaviour Principles in Everyday Life*. Upper Saddle River, NJ: Prentice-Hall

Martin, Garry and Joseph Pear. *Behaviour Modification: What It Is and How to Do It*. Upper Saddle River, NJ: Prentice-Hall

## 1.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

**Self Assessment Questions**

1) d, 2) a, 3). a, 4) c, 5) C, 6) C, 7) d, 8) b

# UNIT 2 COGNITIVE BEHAVIOUR THERAPIES (INCLUDING RATIONAL EMOTIVE THERAPY)

**Structure**

2.0 Introduction
2.1 Objectives
2.2 History of Cognitive Behaviour Therapy
2.3 Theory of Causation
    2.3.1 ABC Model
2.4 Dysfunctional Thinking
    2.4.1 The Three Levels of Thinking
    2.4.2 Two Types of Disturbance
    2.4.3 Seven Inferential Distortions
    2.4.4 Evaluations
    2.4.5 Core Beliefs
2.5 Steps in Cognitive Behaviour Therapy
2.6 The Process of Cognitive Behaviour Therapy
    2.6.1 Engage Client
    2.6.2 Assess the Problem, Person and Situation
    2.6.3 Prepare the Client for Therapy
    2.6.4 Implement the Treatment Programme
    2.6.5 Evaluate Progress
    2.6.6 Prepare the Client for Termination
2.7 The Treatment Principles of CBT
2.8 Cognitive Behavioural Techniques
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    2.8.4 Other Strategies
2.9 Applications of CBT
2.10 Limitations and Contraindications
2.11 Let Us Sum Up
2.12 Unit End Questions
2.13 Suggested Readings
2.14 Answers to Self Assessment Questions

## 2.0 INTRODUCTION

Cognitive-Behaviour Therapy (CBT) is based on the concept that emotions and behaviours result (primarily, though not exclusively) from cognitive processes; and that it is possible for human beings to modify such processes to achieve different ways of feeling and behaving. There are a number of 'cognitive-behavioural' therapies, which, although developed separately, have many

similarities. This unit will present an approach that combines Rational emotive behaviour therapy (REBT) and Cognitive therapy (CT); incorporating elements of some other approaches as well. The first half of the unit will cover the history of cognitive behaviour therapy, the theory of cognitive behaviour therapy, explanation of dysfunctional thinking and the second half will deal with the steps, process, practice principles and techniques of cognitive behaviour therapy. Lastly we will cover the applications and limitations of cognitive behaviour therapy.

## 2.1 OBJECTIVES

After reading this unit, you should be able to:

- Know the history and theory and core ideas of cognitive behaviour therapy;
- Discuss the steps, process and treatment principles of cognitive behaviour therapy;
- Describe the different techniques of cognitive behaviour therapy; and
- Describe the applications and limitations of cognitive behaviour therapy.

## 2.2 HISTORY OF COGNITIVE BEHAVIOUR THERAPY

The 'cognitive' psychotherapies can be said to have begun with Alfred Adler, one of Freud's close associate. Adler disagreed with Freud's idea that the cause of human emotionality was 'unconscious conflicts', arguing that thinking was a more significant factor. Cognitive Behaviour Therapy has its modern origins in the mid 1950's with the work of Albert Ellis, a clinical psychologist. Ellis originally trained in psychoanalysis, but became disillusioned with the slow progress of his clients. He observed that they tended to get better when they changed their ways of thinking about themselves, their problems, and the world. Ellis reasoned that therapy would progress faster if the focus was directly on the client's beliefs, and developed a method now known as Rational Emotive Behaviour Therapy (REBT). Ellis' method and a few others, for example Glasser's 'Reality Therapy' and Berne's 'Transactional Analysis', were initially categorised under the heading of 'Cognitive Psychotherapies'.

The second major cognitive psychotherapy was developed in the 1960's by psychiatrist Aaron Beck; who, like Ellis, was previously a psychoanalyst. Beck called his approach Cognitive Therapy (CT). (Note that because the term 'Cognitive Therapy' is also used to refer to the category of cognitive therapies, which includes REBT and other approaches, it is sometimes necessary to check whether the user is alluding to the general category or to Beck's specific variation).

Since the pioneering work of Ellis and Beck, a number of other cognitive approaches have developed, many as offshoots of REBT or CT. The term 'Cognitive Behaviour Therapy' came into usage around the early 1990's, initially used by behaviourists to describe behaviour therapy with a cognitive flavour. In more recent years, 'CBT' has evolved into a generic term to include the whole range of cognitively oriented psychotherapies. REBT and CT have been joined by such developments as Rational Behaviour Therapy (Maxie Maultsby),

Multimodal Therapy (Arnold Lazarus), Dialectical Behaviour Therapy (Marsha Linehan), Schema Therapy (Jeffrey Young) and expanded by the work of such theorists as Ray DiGiuseppe, Michael Mahoney, Donald Meichenbaum, Paul Salkovskis and many others.

All of these approaches are characterised by their view that cognition is a key determining factor in how human beings feel and behave, and that modifying cognition through the use of cognitive and behavioural techniques can lead to productive change in dysfunctional emotions and behaviours.

Though the various versions or 'brands' of cognitive behavioural therapy (CBT) can be distinguished in terms of certain aspects of the client therapist relationship, the cognitive target for change, the assessment of change, the degree of emphasis placed on the client's self-control, and the degree to which cognitive or behavioural change is the focus, treatment principles common to all cognitive behavioural therapies can be identified.

## 2.3 THEORY OF CAUSATION

CBT is not just a set of techniques. It also contains comprehensive theories of human behaviour. CBT proposes a 'biopsychosocial' explanation as to how human beings come to feel and act as they do that is, that a combination of biological, psychological, and social factors are involved. The most basic premise is that almost all human emotions and behaviours are the result of what people think, assume or believe (about themselves, other people, and the world in general). It is what people believe about situations they face not the situations themselves that determine how they feel and behave.

Both REBT and CT, however, argue that a person's biology also affects their feelings and behaviours which is an important point, as it is a reminder to the therapist that there are some limitations on how far a person can change.

### 2.3.1 ABC Model

A useful way to illustrate the role of cognition is with the 'ABC' model. (Originally developed by Albert Ellis, the ABC model has been adapted for more general CBT use). In this framework 'A' represents an event or experience, 'B' represents the beliefs about the A, and 'C' represents the emotions and behaviours that follow from those beliefs. Here is an example of an 'emotional episode', as experienced by a person prone to depression who tends to misinterpret the actions of other people:

A) **Activating event:** Friend passed me in the street without acknowledging me.

B) **Beliefs about A:** He's ignoring me. He doesn't like me.
I'm unacceptable as a friend – so I must be worthless as a person.
For me to be happy and feel worthwhile, people must like me.

C) **Consequence:** Emotions: hurt, depressed.
Behaviours: avoiding people generally.

Note that 'A' doesn't cause 'C': 'A' triggers off 'B'; 'B' then causes 'C'. Also, ABC episodes do not stand alone: they run in chains, with a 'C' often becoming

the 'A' of another episode – we observe our own emotions and behaviours, and react to them. For instance, the person in the example above could observe their avoidance of other people ('A'), interpret this as weak ('B'), and engage in self-downing ('C').

Note, too, that most beliefs are outside conscious awareness. They are habitual or automatic, often consisting of underlying 'rules' about how the world and life should be. With practice, though, people can learn to uncover such subconscious beliefs.

## 2.4 DYSFUNCTIONAL THINKING

We have seen that what people think determines how they feel. But what types of thinking are problematical for human beings?

To describe a belief as 'irrational' is to say that:

It blocks a person from achieving their goals, creates extreme emotions that persist and which distress and immobilise, and leads to behaviours that harm oneself, others, and one's life in general.

It distorts reality (it is a misinterpretation of what is happening and is not supported by the available evidence);

It contains illogical ways of evaluating oneself, others, and the world.

### 2.4.1 The Three Levels of Thinking

Human beings appear to think at three levels:

1) Inferences;
2) Evaluations; and
3) Core beliefs.

Every individual has a set of general 'core beliefs' usually subconscious, that determines how they react to life. When an event triggers off a train of thought, what someone *consciously* thinks depends on the core beliefs they *subconsciously* apply to the event.

Let's say that a person holds the *core belief*:

'For me to be happy, my life must be safe and predictable.' Such a belief will lead them to be hypersensitive to any possibility of danger and overestimate the likelihood of things going wrong. Suppose they hear a noise in the night. Their hypersensitivity to danger leads them to *infer* that there is an intruder in the house. They then *evaluate* this possibility as catastrophic and unbearable, which creates feelings of panic.

Here is an example (using the ABC model) to show how it all works:

Your friend phones and asks if you will help her for a project for the rest of the day. You had already planned to catch up with some reading.

You *infer* that: 'If I say no, she will think badly of me.' You *evaluate* your inference: 'I couldn't stand to have her disapprove of me and see me as selfish.' Your

inference and the evaluation that follows are the result of holding the *underlying core belief*: 'To feel OK about myself, I need to be liked, so I must avoid disapproval from any source.'

You feel anxious and say yes.

Cognitive Therapy focuses mainly on inferential-type thinking, helping the client to check out the reality of their beliefs, and has some sophisticated techniques to achieve this empirical aim.

REBT emphasises dealing with evaluative type thinking (in fact, in REBT, the client's inferences are regarded as part of the 'A' rather than the 'B').

When helping clients explore their thinking, REBT practitioners would tend to use strategies that examine the logic behind beliefs (rather than query their empirical validity).

What REBT and CT do share, though, is an ultimate concern with underlying core beliefs.

### 2.4.2 Two Types of Disturbance

Knowing that there are different levels of thinking does not tell us much about the actual content of that thinking. The various types of CBT have different ideas of what content is important to focus on (though the differences are sometimes a matter of terminology more than anything else).

One way of looking at the content issue that is helpful comes from REBT, which suggests that human beings defeat or 'disturb' themselves in two main ways: (1) by holding irrational beliefs about their 'self' (ego disturbance) and (2) by holding irrational beliefs about their emotional or physical comfort (discomfort disturbance). Frequently, the two go together – people may think irrationally about both their 'selves' and their circumstances – though one or the other will usually be predominant.

### 2.4.3 Seven Inferential Distortions

In everyday life, events and circumstances trigger off two levels of thinking: inferring and evaluating. At the first level, we make guesses or *inferences* about what is 'going on' – what we think has happened, is happening, or will be happening. Inferences are statements of 'fact' (or at least what we think are the facts – they can be true or false). Inferences that are irrational usually consist of 'distortions of reality' like the following:

1) **Black and white thinking:** This refers to seeing things in extremes, with no middle ground that is either good or bad, perfect versus useless, success or failure, right against wrong, moral versus immoral, and so on. This is also known as all ornothing thinking.

2) **Filtering:** This refers to seeing all that is wrong with oneself or the world, while ignoring any positives.

3) **Over-generalisation:** This refers to building up one thing about oneself or one's circumstances and ending up thinking that it represents the whole situation. For example: 'Everything's going wrong', 'Because of this mistake,

I'm a total failure'. Or, similarly, believing that something which has happened once or twice is happening all the time, or that it will be a never-ending pattern: 'I'll always be a failure', 'No-one will ever want to love me', and the like.

4) **Mind-reading:** This involves making guesses about what other people are thinking, such as: 'She ignored me on purpose', or 'He's mad with me'.

5) **Fortune-telling:** Here this refers to treating beliefs about the future as though they were actual realities rather than mere predictions, for example: 'I'll be depressed forever', 'Things can only get worse'.

6) **Emotional reasoning:** This refers to thinking that because we feel a certain way, this is how it really is: 'I feel like a failure, so I must be one', 'If I'm angry, you must have done something to make me so', and the like.

7) **Personalising:** This means assuming, without evidence, that one is responsible for things that happen: 'I caused the team to fail', 'It must have been me that made her feel bad', and so on.

The seven types of inferential thinking described above have been outlined by Aaron Beck and his associates.

### 2.4.4 Evaluations

As well as making inferences about things that happen, we go beyond the 'facts' to evaluate them in terms of what they mean to us. Evaluations are sometimes conscious, sometimes beneath awareness. According to REBT, irrational evaluations consist of one or more of the following four types:

i) Demandingness

ii) Awfulising

iii) Discomfort Intolerance

iv) People rating

These four are being discussed below:

i) **Demandingness:** Described colourfully by Ellis as 'musturbation', demandingness refers to the way people use unconditional should and absolutistic musts, believing that certain things must or must not happen, and that certain conditions (for example success, love, or approval) are absolute necessities.

   Demandingness implies certain 'Laws of the Universe' that must be adhered to. Demands can be directed either toward oneself or others. Some REBT theorists see demandingness as the 'core' type of irrational thinking, suggesting that the other three types derive from it.

ii) **Awfulising:** Exaggerating the consequences of past, present or future events; seeing something as awful, terrible, horrible, that is the worst that could happen.

iii) **Discomfort intolerance:** This is often referred to as *'can't-stand-it-itis'*: This is based on the idea that one cannot bear some circumstance or event.

It often follows awfulising, and leads to demands that certain things do not happen.

iv) **People Rating:** People rating refers to the process of evaluating one's entire self (or someone else's). In other words, trying to determine the total value of a person or judging their worth. It represents an overgeneralisation. The person evaluates a specific trait, behaviour or action according to some standard of desirability or worth. Then they apply the evaluation to their total person as for example, 'I did a bad thing, therefore I am a bad person.' People rating can lead to reactions like self downing, depression, defensiveness, grandiosity, hostility, or over concern with approval and disapproval.

### 2.4.5 Core Beliefs

Guiding a person's inferences and evaluations are their core beliefs. Core beliefs are the underlying, general assumptions and rules that guide how people react to events and circumstances in their lives. They are referred to in the CBT literature by various names: '**schema**'; 'general rules'; 'major beliefs'; 'underlying philosophy', etc. REBT and CT both propose slightly different types of core belief. In this unit we would refer to them as *assumptions* and *rules*.

***Assumptions*** are a person's beliefs about how the world is – how it works, what to watch out for, etc. They reflect the 'inferential' type of thinking. Here are some examples:

My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.

Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.

It is easier to avoid rather than face responsibilities.

***Rules*** are more prescriptive – they go beyond describing what is to emphasise what should be. They are 'evaluative' rather than inferential. Here are some examples:

I need love and approval from those significant to me – and I must avoid disapproval from any source.

To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.

People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.

Things must be the way I want them to be, otherwise life will be unbearable.

I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.

Because they are too much to bear, I must avoid life's difficulties, unpleasantness, and responsibilities.

Everyone needs to depend on someone stronger than themselves.

I should become upset when other people have problems, and feel unhappy when they're sad.

I shouldn't have to feel discomfort and pain – I can't stand them and must avoid them at all costs.

Every problem should have an ideal solution –and it's intolerable when one can't be found.

## 2.5 STEPS IN COGNITIVE BEHAVIOUR THERAPY

The steps involved in helping clients change can be broadly summarised as follows:

i) Help the client understand that emotions and behaviours are caused by beliefs and thinking. This may consist of a brief explanation (Psychoeducation) followed by assignment of some reading.

ii) Show how the relevant beliefs may be uncovered.

The ABC format is useful here. Using an episode from the client's own recent experience, the therapist notes the 'C', then the 'A'. The client is asked to consider (at 'B'): 'What was I telling myself about 'A', to feel and behave the way I did at 'C'? As the client develops understanding of the nature of irrational thinking, this process of 'filling in the gap' will become easier. Such education may be achieved by reading, direct explanation, and by record-keeping with the therapist's help and as homework between sessions.

iii) Teach the client how to dispute and change the irrational beliefs, replacing them with more rational alternatives.

Again, education will aid the client. The ABC format is extended to include 'D' (Disputing irrational beliefs), 'E' (the desired new Effect – new ways of feeling and behaving), and 'F' (Further Action for the client to take). (Refer to table below)

**Table: Rational Self-Analysis**

CBT emphasises teaching clients to be their own therapists. A useful technique to aid this is Rational Self-Analysis (Froggatt, 2003) which involves writing down an emotional episode in a structured fashion. Here is an example of such an analysis using the case example described earlier:

A) **Activating Event** (what started things off):

Friend passed me in the street without acknowledging me.

C) **Consequence** (how I reacted):

Feelings: worthless, depressed. Behaviour: avoiding people generally.

B) **Beliefs** (what I thought about the 'A'):

1) He's ignoring me and doesn't like me. (inference)
2) I could end up without friends for ever. (inference) This would be terrible. (evaluation)

3) I'm not acceptable as a friend (inference)- so I must be worthless as a person. (evaluation)

4) To feel worthwhile and be happy, I must be liked and approved by everyone significant to me. (core belief)

E) **New Effect** (how I would prefer to feel/behave):

Disappointed but not depressed.

D) **Disputation** (of old beliefs and developing new rational beliefs to help me achieve the new reaction):

1) How do I know he ignored me on purpose? He may not have seen me. Even if he did ignore me, this doesn't prove he dislikes me – he may have been in a hurry, or perhaps upset or worried in some way.

2) Even if it were true that he disliked me, this doesn't prove I'll never have friends again. And, even this unlikely possibility would be unpleasant rather than a source of 'terror'.

3) There's no proof I'm not acceptable as a friend. But even if I were, this proves nothing about the total 'me', or my 'worthwhileness'. (And, anyway, what does 'worthwhile' mean?).

4) Love and approval are highly desirable. But, they are not absolute necessities. Making them so is not only illogical, but actually screws me up when I think they may not be forthcoming. Better I keep them as preferences rather than demands.

F) **Further Action** (what I'll do to avoid repeating the same irrational/ thoughts reactions):

1) Re-read material on catastrophising and self-rating.

2) Go and see my friend, check out how things really are (at the same time, realistically accepting that I can't be sure of the outcome).

3) Challenge my irrational demand for approval by doing one thing each day (for the next week) that I would normally avoid doing because of fear it may lead to disapproval.

iv) Help the client to get into action.

Acting against irrational beliefs is an essential component of CBT. The client may, for example, dispute the belief that disapproval is intolerable by deliberately doing something to attract it, to discover that they in fact survive. CBT's emphasis on both rethinking and action makes it a powerful tool for change. The action part is often carried out by the client as 'homework'.

## 2.6 THE PROCESS OF COGNITIVE BEHAVIOUR THERAPY

This section of the unit will deal with the summary of the main components of CBT intervention.

### 2.6.1 Engage Client

The first step is to build a relationship with the client. This can be achieved using the core conditions of empathy, warmth and respect. Watch for any 'secondary disturbances' about coming for help: self-downing over having the problem or needing assistance; and anxiety about coming to the interview. Finally, possibly the best way to engage a client is to demonstrate to them at an early stage that change is possible and that CBT is able to assist them to achieve this goal.

### 2.6.2 Assess the Problem, Person and Situation

Assessment will vary from person to person, but following are some of the most common areas that will be assessed as part of a CBT intervention.

- Start with the client's view of what is wrong for them.
- Determine the presence of any related clinical disorders.
- Obtain a personal and social history.
- Assess the severity of the problem.
- Note any relevant personality factors.
- Check for any secondary disturbance: How does the client feel about having this problem?
- Check for any non-psychological causative factors: physical conditions; medications; substance abuse; lifestyle/environmental factors.

### 2.6.3 Prepare the Client for Therapy

- Clarify treatment goals.
- Assess the client's motivation to change.
- Introduce the basics of CBT, including the biopsychosocial model of causation.
- Discuss approaches to be used and implications of treatment.
- Develop a contract.

### 2.6.4 Implement the Treatment Programme

Most of the sessions will occur in the implementation phase, using activities like the following:

Analysing specific episodes where the target problems occur, ascertaining the beliefs involved, changing them, and developing relevant homework (known as 'thought recording' or 'rational analysis').

Developing behavioural assignments to reduce fears or modify ways of behaving.

Supplementary strategies and techniques as appropriate, e.g. relaxation training, interpersonal skills training, etc.

### 2.6.5 Evaluate Progress

Toward the end of the intervention it will be important to check whether improvements are due to significant changes in the client's thinking, or simply to a fortuitous improvement in their external circumstances.

### 2.6.6 Prepare the Client for Termination

It is usually very important to prepare the client to cope with setbacks. Many people, after a period of wellness, think they are 'cured' for life. Then, when they slip back and discover their old problems are still present to some degree, they tend to despair and are tempted to give up self-help work altogether.

Warn that relapse is likely for many mental health problems and ensure the client knows what to do when their symptoms return.

Discuss their views on asking for help if needed in the future. Deal with any irrational beliefs about coming back, like: 'I should be cured for ever', or: 'The therapist would think I was a failure if I came back for more help'.

## 2.7 THE TREATMENT PRINCIPLES OF CBT

The basic aim of CBT is to leave clients at the completion of therapy with freedom to choose their emotions, behaviours and lifestyle (within physical, social and economic restraints); and with a method of self observation and personal change that will help them maintain their gains.

Not all unpleasant emotions are seen as dysfunctional. Nor are all pleasant emotions functional. CBT aims not at 'positive thinking'; but rather at realistic thoughts, emotions and behaviours that are in proportion to the events and circumstances an individual experiences.

Developing emotional control does not mean that people are encouraged to become limited in what they feel – quite the opposite. Learning to use cognitive-behavioural strategies helps oneself become open to a wider range of emotions and experiences that in the past they may have been blocked from experiencing.

There is no 'one way' to practice CBT. It is 'selectively eclectic'. Though it has techniques of its own, it also borrows from other approaches and allows practitioners to use their imagination. There are some basic assumptions and principles, but otherwise it can be varied to suit one's own style and client group.

CBT is educative and collaborative. Clients learn the therapy and how to use it on themselves (rather than have it 'done to them'). The therapist provides the training – the client carries it out. There are no hidden agendas – all procedures are clearly explained to the client. Therapist and client together design homework assignments.

The relationship between therapist and client is seen as important, the therapist showing empathy, unconditional acceptance, and encouragement toward the client. In CBT, the relationship exists to facilitate therapeutic work – rather than being the therapy itself. Consequently, the therapist is careful to avoid activities that create dependency or strengthen any 'needs' for approval.

CBT is brief and time-limited. It commonly involves five to thirty sessions over one to eighteen months. The pace of therapy is brisk. A minimum of time is spent on acquiring background and historical information: it is task oriented and focuses on problem-solving in the present.

CBT tends to be anti-moralistic and scientific. Behaviour is viewed as functional or dysfunctional, rather than as good or evil. CBT is based on research and the principles of logic and empiricism, and encourages scientific rather than 'magical' ways of thinking.

Finally, the emphasis is on profound and lasting change in the underlying belief system of the client, rather than simply eliminating the presenting symptoms. The client is left with self-help techniques that enable coping in the long-term future.

## 2.8 COGNITIVE BEHAVIOURAL TECHNIQUES

There are no techniques that are essential to CBT –one uses whatever works, assuming that the strategy is compatible with CBT theory (the 'selectively eclectic' approach). However, the following are examples of procedures in common use.

### 2.8.1 Cognitive Techniques

*Self-monitoring*

Self-monitoring is an important assessment tool. The therapist instructs the patient to observe and record her own behavioural and emotional reactions. As these reactions are distributed throughout the patient's daily life, self-monitoring tends to be employed as a homework assignment. The therapist and patient collaboratively select the target of monitoring (e.g., a symptom, behaviour, or reaction) based upon the patient's goals and presenting problem list. Self-monitoring serves at least three purposes within a course of CBT:

1) it encourages and effectively trains the patient to observe her own reactions in a more scientific manner;
2) it renders a concrete record of the target symptoms and problems; and
3) new problems can become apparent and targeted for future intervention.

Self-monitoring is especially useful in early sessions as a means of assessing the severity or frequency of a particular problem or symptom. However, self-monitoring is equally useful in later sessions as a means of tracking the patient's progress. Examples of self-monitoring include a record of daily activities and corresponding mood; a frequency count of the number of panic attacks per day; a record of the frequency and content of auditory hallucinations; and a food diary in which time, quantity, and type of food eaten are recorded (J. S. Beck, 1995).

*Rational analysis*

This refers to the analyses of specific episodes to teach client how to uncover and dispute irrational beliefs (as described above). These are usually done in-session at first – as the client gets the idea, they can be done as homework.

*Double-standard dispute*

If the client is holding a 'should' or is self-downing about their behaviour, ask whether they would globally rate another person (e.g. best friend, therapist, etc.) for doing the same thing, or recommend that person hold their demanding core belief. When they say 'No', help them see that they are holding a double-standard.

This is especially useful with resistant beliefs which the client finds hard to give up.

*Catastrophe scale*

This is a useful technique to get **awfulising** into perspective. On a whiteboard or sheet of paper, draw a line down one side. Put 100% at the top, 0% at the bottom, and 10% intervals in between. Ask the client to rate whatever it is they are catastrophising about, and insert that item into the chart in the appropriate place. Then, fill in the other levels with items the client thinks apply to those levels.

You might, for example, put 0%: 'Having a quiet cup of coffee at home', 20%: 'Having to do chores when the cricket is on television', 70%: being burgled, 90%: being diagnosed with cancer, 100%: being burned alive, and so on. Finally, have the client progressively alter the position of their feared item on the scale, until it is in perspective in relation to the other items.

*Devil's advocate*

This is a useful and effective technique (also known as reverse role-playing) which is designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional. It is especially useful when the client now sees the irrationality of a belief, but needs help to consolidate that understanding.

*Reframing*

This is another strategy for getting bad events into perspective is to re-evaluate them as 'disappointing', 'concerning', or 'uncomfortable' rather than as 'awful' or 'unbearable'. A variation of reframing is to help the client see that even negative events almost always have a positive side to them, listing all the positives the client can think of (Note this needs care so that it does not come across as suggesting that a bad experience is really a 'good' one).

### 2.8.2 Imagery Techniques

*Time projection*

This technique is designed to show that one's life and the world in general, continue after a feared or unwanted event has come and gone. Ask the client to visualise the unwanted event occurring, then imagine going forward in time a week, then a month, then six months, then a year, two years, and so on, considering how they will be feeling at each of these points in time. They will thus be able to see that life will go on, even though they may need to make some adjustments.

*The 'worst-case' technique*

People often try to avoid thinking about worst possible scenarios in case doing so makes them even more anxious. However, it is usually better to help the client identify the worst that could happen. Facing the worst, while initially increasing anxiety, usually leads to a longer-term reduction because

1) the person discovers that the 'worst' would be bearable if it happened, and

2) realises that as it probably won't happen, the more likely consequences will obviously be even more bearable; or

3) if it did happen, they would in most cases still have some control over how things turn out.

*The 'blow-up' technique*

This is a variation of 'worst-case' imagery, coupled with the use of humour to provide a vivid and memorable experience for the client. It involves asking the client to imagine whatever it is they fear happening, then blow it up out of all proportion till they cannot help but be amused by it. Laughing at fears helps get them under control.

### 2.8.3 Behavioural Techniques

One of the best ways to check out and modify a belief is to act. Clients can be encouraged to check out the evidence for their fears and to act in ways that disprove them.

*Exposure*

This is possibly the most common behavioural strategy used in CBT involves clients entering feared situations they would normally avoid. Such 'exposure' is deliberate, planned and carried out using cognitive and other coping skills.

The purposes are to

1) test the validity of one's fears (e.g. that rejection could not be survived);
2) deawfulise them (by seeing that catastrophe does not ensue);
3) develop confidence in one's ability to cope (by successfully managing one's reactions); and
4) increase tolerance for discomfort (by progressively discovering that it is bearable).

*Hypothesis testing*

In this, there is a variation of exposure, the client

1) writes down what they fear will happen, including the negative consequences they anticipate, then
2) for homework, carries out assignments where they act in the ways they fear will lead to these consequences (to see whether they do in fact occur).

*Risk-taking*

The purpose is to challenge beliefs that certain behaviours are too dangerous to risk, when reason says that while the outcome is not guaranteed they are worth the chance. For example, if the client has trouble with perfectionism or fear of failure, they might start tasks where there is a chance of failing or not matching their expectations. Or a client who fears rejection might talk to an attractive person at a party or ask someone for a date.

*Stimulus control*

Sometimes behaviours become conditioned to particular stimuli; for example, difficulty sleeping can create a connection between being in bed and lying awake; or the relief felt when a person vomits after bingeing on food can lead to a connection between bingeing and vomiting. Stimulus control is designed to lengthen the time between the stimulus and the response, so as to weaken the

connection. For example, the person who tends to lie in bed awake would get up if unable to sleep for 20 minutes and stay up till tired. Or the person purging food would increase the time between a binge and the subsequent purging.

*Paradoxical behaviour*

When a client wishes to change a dysfunctional tendency, encourage them to deliberately behave in a way contradictory to the tendency. Emphasise the importance of not waiting until they 'feel like' doing it: practising the new behaviour – even though it is not spontaneous – will gradually internalise the new habit.

*Stepping out of character*

This is one common type of paradoxical behaviour. For example, a perfectionist person could deliberately do some things to less than their usual standard; or someone who believes that to care for one self is 'selfish' could indulge in a personal treat each day for a week.

*Postponing gratification*

This is commonly used to combat low frustration tolerance by deliberately delaying smoking, eating sweets, using alcohol, etc.

### 2.8.4 Other Strategies

Problem solving

Activity Scheduling

Skills training, e.g. relaxation, social skills.

Reading (self re-education).

Tape recording of interviews for the client to replay at home.

Probably the most important CBT strategy is ***homework***. This includes reading, self-help exercises such as thought recording, and experiential activities. Therapy sessions can be seen as 'training sessions', between which the client tries out and uses what they have learned.

## 2.9 APPLICATIONS OF CBT

CBT has been successfully used to help people with a range of clinical and non-clinical problems, using a variety of modalities. Typical clinical applications include:

- Depression
- Anxiety disorders, including obsessive compulsive disorder, agoraphobia, specific phobias, generalised anxiety, posttraumatic stress disorder, etc.
- Eating disorders
- Addictions
- Hypochondriasis
- Sexual dysfunction
- Anger management

- Impulse control disorders
- Antisocial behaviour
- Jealousy
- Sexual abuse recovery
- Personality disorders
- Adjustment to chronic health problem, physical disability, or mental disorder
- Pain management
- General stress management
- Child or adolescent behaviour disorders
- Relationship and family problems

The most common use of CBT is with individual clients, but this is followed closely by group work, for which CBT is eminently suited. CBT is also frequently used with couples, and increasingly with families.

## 2.10 LIMITATIONS AND CONTRAINDICATIONS

It is safe to say that CBT has proved quite versatile, having been successfully applied to a wide spectrum of psychological difficulty. The limits of cognitive therapy have yet to be empirically established. However, several factors may make the cognitive-behavioural approach less effective; in fact, these factors may interfere with the efficacy of any psychotherapeutic approach. Low patient motivation, unless appropriately addressed, can impede progress, especially among patients who hold beliefs that they will suffer significant adverse consequences if they comply with treatment. Patients who have positive beliefs about dysfunctional aspects of their disorder likewise need special intervention. Examples include the schizophrenic patient's grandiose delusion (e.g., one who believes he is being persecuted because he is a great deity) and the anorexic patient's social beliefs (e.g., she is superior to others).

Even when motivation is present, the success of cognitive-behavioural methods can be hampered by mental facility. Severely retarded individuals, for example, might not be capable of the reasoning entailed in cognitive restructuring. Self-monitoring might also prove to be too demanding a task for a person with severe intellectual impairment. Behavioural methods may be more appropriate for these individuals than cognitive strategies. Psychopaths (Lykken, 1995) might also have difficulty with certain cognitive interventions; when performing a goal-directed task, they may be less able to attend to peripheral information or to self-regulate, especially under conditions of neutral motivation (Newman et al., 1997).

Finally, cultural differences may impact efficacy if therapists do not tailor the therapy appropriately. Therapists must understand, for example, how these differences may affect the building of a therapeutic alliance and how patients' cultural beliefs affect their thinking and reactions. Different thinking styles and stylistic preferences must often be accommodated for patients to progress.

**Self Assessment Questions 1**

1) What does A, B, C represent in the ABC model used to explain the role of cognitions?

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2) What are the two main ways in which human beings disturb themselves?

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3) What are core beliefs?

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4) Name the main components of CBT intervention?

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5) Explain the technique playing "Devil's advocate'?

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## 2.11 LET US SUM UP

Cognitive behaviour therapy (CBT) is a type of psychotherapeutic treatment that helps patients to understand the thoughts and feelings that influence behaviours. Cognitive behaviour therapy is generally short-term and focused on helping clients deal with a very specific problem. During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behaviour.

The underlying concept behind CBT is that our thoughts and feelings play a fundamental role in our behaviour. For example, a person who spends a lot of time thinking about plane crashes, runway accidents and other air disasters may find themselves avoiding air travel. The goal of cognitive behaviour therapy is to teach patients that while they cannot control every aspect of the world around them, they can take control of how they interpret and deal with things in their environment. Cognitive behaviour therapy has become increasingly popular in recent years with both mental health consumers and treatment professionals. Because CBT is usually a short-term treatment option, it is often more affordable than some other therapeutic options. CBT is also empirically supported and has been shown to effectively help patients overcome a wide variety.

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self help material. There are a number of different approaches to CBT that are regularly used by mental health professionals. These types include Rational Emotive Therapy, Cognitive Therapy and Multimodal Therapy.

Cognitive behaviour therapy has been used to treat people suffering from a wide range of disorders, including anxiety, phobias, depression, addiction and a variety of maladaptive behaviours. CBT is one of the most researched types of therapy, in part because treatment is focused on a highly specific goal and results can be measured relatively easily. Cognitive behaviour therapy is well-suited for people looking for a short-term treatment options that does not necessarily involve pharmacological medication. One of the greatest benefits of CBT is that it helps clients develop coping skills that can be useful both now and in the future.

## 2.12 UNIT END QUESTIONS

1) Discuss the history and theory of Cognitive behaviour therapy?
2) Discuss in detail dysfunctional thinking with examples?
3) Describe the steps and process of cognitive behaviour therapy?
4) What are the treatment principles of CBT?
5) Describe in detail the various cognitive and behavioural techniques in CBT?
6) Write about the applications and limitations of CBT?

## 2.13 SUGGESTED READINGS

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

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

## 2.14 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) 'A' represents an event or experience, 'B' represents the beliefs about the A, and 'C' represents the emotions and behaviours that follow from those beliefs.

2) The human beings defeat or 'disturb' themselves in two main ways: by holding irrational beliefs about their 'self' (ego disturbance) and by holding irrational beliefs about their emotional or physical comfort (discomfort disturbance).

3) Core beliefs are the underlying, general assumptions and rules that guide how people react to events and circumstances in their lives.

4) The main components of CBT are engaging the client; assessing the problem, person and situation; preparing the client for therapy; implementing the treatment program; evaluating progress and lastly preparing the client for termination.

5) Devil's advocate is a useful and effective technique designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional.

# UNIT 3 SOLUTION FOCUSED THERAPY

**Structure**


3.0 Introduction

3.1 Objectives

3.2 Solution Focused Therapy (SFT)

3.3 Ingredients of Solution Focused Therapy

3.3.1 General Ingredients of Solution Focused Therapy

3.3.2 Specific Active Ingredients

3.4 The Practice of Solution Focused Therapy

3.5 Focal Issue

3.6 The Message

3.7 Treatment Principles

3.8 Interventions

3.9 Compatibility with Adjunctive Therapies

3.10 Target Populations

3.11 Let Us Sum Up

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3.13 Suggested Readings

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## 3.0 INTRODUCTION

Solution Focused Therapy (SFT) is a form of brief therapy which builds upon clients' strengths by helping them to evoke and construct solutions to their problems. It emphasises the future, more than the past or the present. In a solution focused approach the counsellor and client devote a greater proportion of time to solution construction than to problem exploration. They try to define as clearly as possible what the clients would like to see in their lives. This unit will offer an overview to the general structure of Solution Focused Therapy. These following sections are included in this unit: overview, description and basic tenets of SFT, ingredients of solution focused therapy, the process and treatment principles of SFT, various intervention techniques and applications of solution focused therapy.

## 3.1 OBJECTIVES

After completing this unit, you should be able to:

- Describe and explain the rationale of solution focused therapy;
- Explain the key ingredients and tenets of solution focused therapy;
- Discuss the practice, issues and treatment principles of SFT; and
- Describe the various interventions and applications of SFT.

## 3.2 SOLUTION FOCUSED THERAPY (SFT)

The Solution focused approach originated in family therapy. Solution Focused Therapy treatment is based on over twenty years of theoretical development, clinical practice, and empirical research of the family therapists Steve de Shazer, Kim Insoo Berg and colleagues at the Brief Family Therapy Centre in Milwaukee, as well as Bill O'Hanlon, a therapist in Nebraska. The members of the Brief Therapy Practice in London pioneered the method in the United Kingdom.

Solution-Focused Therapy is different in many ways from traditional approaches to treatment. It is a competency-based model, which minimises emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. There is a focus on working from the client's understandings of her/ his concern/situation and what the client might want different. The basic tenets that inform Solution-Focus Therapy are as follows:

It is based on solution building rather than problem solving.

The therapeutic focus should be on the client's desired future rather than on past problems or current conflicts.

Clients are encouraged to increase the frequency of current useful behaviours

No problem happens all the time. There are exceptions that is there are times when the problem could have happened but did not. This can be used by the client and therapist to co construct solutions.

Therapists help clients find alternatives to current undesired patterns of behaviour, cognition, and interaction that are within the clients' repertoire or can be co constructed by therapists and clients as such.

Differing from skill building and behaviour therapy interventions, the model assumes that solution behaviours already exist for clients.

It is asserted that small increments of change lead to large increments of change.

Clients' solutions are not necessarily *directly* related to any identified problem by either the client or the therapist.

The conversational skills required of the therapist to invite the client to build solutions are different from those needed to diagnose and treat client problems.

Solution Focused Therapy differs from traditional treatment in that traditional treatment focuses on exploring problematic feelings, cognitions, behaviours, and/ or interaction, providing interpretations, confrontation, and client education (Corey, 1985). In contrast, SFT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources. Even in cases where the client comes to use outside resources to create solutions, it is the client who takes the lead in defining the nature of those resources and how they would be useful.

## 3.3 INGREDIENTS OF SOLUTION FOCUSED THERAPY

### 3.3.1 General Ingredients of Solution Focused Therapy

Most psychotherapy, SFT included, consists of *conversations.* In SFBT there are three main general ingredients to these conversations.

**First**, there are the overall topics. SFT conversations are centred on client concerns; who and what are important to the clients; a vision of a preferred future; clients' exceptions, strengths, and resources related to that vision; scaling of clients' motivational level and confidence in finding solutions; and ongoing scaling of clients' progress toward reaching the preferred future.

**Second**, as indicated in the previous section, SF conversations involve a therapeutic process of co-constructing altered or new meanings in clients. This process is set in motion largely by therapists asking SF questions about the topics of conversation identified in the previous paragraph and connecting to and building from the resulting meanings expressed by clients.

**Third**, therapists use a number of specific responding and questioning techniques that invite clients to co-construct a vision of a preferred future and draw on their past successes, strengths, and resources to make that vision a reality.

### 3.3.2 Specific Active Ingredients

Some of the major active ingredients in SFT include developing a cooperative therapeutic alliance with the client; creating a solution versus problem focus; the setting of measurable changeable goals; focusing on the future through future-oriented questions and discussions; scaling the ongoing attainment of the goals to get the client's evaluation of the progress made; and focusing the conversation on exceptions to the client's problems, especially those exceptions related to what they want different, and encouraging them to do more of what they did to make the exceptions happen.

## 3.4 THE PRACTICE OF SOLUTION FOCUSED THERAPY

The goals of the therapy are the goals which clients bring with them, providing they are ethical and legal. The counselor's role is to help clients to begin to move or continue to move in the direction they want.

They do this by helping:

- to identify and utilise to the full the strengths and competencies which the client brings with him;
- to enable the client to recognise and build upon exceptions to the problem, that is, those times when the client is already doing (thinking, feeling) something which is reducing or eliminating the impact of the problem;
- to help the client to focus in clear and specific terms on what they would consider to be solutions to the problem.

The counsellor acknowledges and validates whatever concerns and feelings the client presents, and seeks to develop a rapport, a cooperative 'joining', in which the counsellor offers the client a warm, positive, accepting relationship and the client feels understood and respected.

In SFT, the counsellor shares expertise with the client by adopting a learning position, 'a one-down position', in which the client is encouraged to teach the counsellor about her way of looking at the world. The counsellor matches the language of the client, offers encouragement and genuine compliments and adapts her stance according to what the client finds helpful. The client is respected as being an expert in her own life, while the counsellor has expertise in creating a therapeutic environment.

It is not the usual practice to offer clients a fixed number of sessions. It is more common to consult with the client at the end of a session to hear what she feels about meeting again, and if a further session is necessary, when that should take place.

## 3.5 FOCAL ISSUE

Solution Focussed therapists (SFT) stress the importance of negotiating a focal or central issue for the work. The clearer and more defined the agenda, the greater the likelihood that the counseling will be efficient and effective.

SFT attends to the problem as presented by the client. The closer the counsellor can keep to the client's agenda, the more likely the client will be motivated to change. It is not always possible to achieve this at the beginning as clients are often confused, anxious, overwhelmed and unsure how counseling can help them.

The priority is to find a common language to describe what the client wants to change and to begin to explore how those changes would affect the client's life. The counsellor needs to find leverage – a solvable problem which the client both wants, and is able, to work upon.

Clients who present with broad, diffuse, and poorly understood problem patterns and who need considerable time to form a trusting alliance are more likely to need an extended period of exploratory work. It is a great advantage when clients can articulate their problem and their goals, but it does not mean that initial vagueness about the future disqualifies them from brief solution focused work. It simply means that the counsellor has to work harder and take longer.

## 3.6 THE MESSAGE

Near the end of each session, the solution focused counsellor will compliment the client on what he is doing, thinking or saying which is helpful. She may also give him a task to perform. At the end of the first session, clients are usually asked to 'notice between now and the next time we meet, those things you would like to see continue in your life and come back and tell me about them'.

## 3.7 TREATMENT PRINCIPLES

There are a number of principles which guide solution focused work. They apply both to how the client should approach the problem and to how the counsellor should conduct the counseling.

If it is not broken do not fix it.

SFT emphasises that people have problems, rather than that they are problems. It avoids a view of clients as being sick or damaged and instead looks for what is healthy and functioning in their lives.

Small change can lead to bigger changes.

Change is regarded as constant and unavoidable. Initiating a force for change can have repercussions beyond the original starting point. Experiencing change can restore the person's sense of choice and control in his or her life and encourage the making of further changes.

If it is working keep doing it.

The client is encouraged to keep doing what she has shown she can already do. This constructive behaviour may have started prior to the counseling. Clients may need to continue with a new pattern of behaviour for some time before they feel confident about maintaining it.

If it is not working stop doing it.

Clients in SFT are encouraged to do something different (almost anything) to break the failure cycle. This may run counter to family scripts such as, 'If at first you don't succeed, try, and try again.'

Keep counseling as simple as possible.

There is a danger that the beliefs of the counsellor, particularly if they demand a search for hidden explanations and unconscious factors, will complicate and prolong the relationship.

## 3.8 INTERVENTIONS

The following interventions are commonly found in solution focused practice. How and when they are used will depend upon the judgment of the therapist.

*Pre-session change*

When making an appointment, the client is asked to notice whether any changes take place between the time of making the appointment and the first session. Typically, the counsellor will enquire about these changes early on in the first session. By granting recognition to pre-session change, the counsellor can build upon what the client has already begun. The client may present the counsellor with clear clues about strategies, beliefs, values and skills which are transferable into solution construction. This 'flying start' helps to accelerate the process of change and increases the likelihood of the counseling being brief. Positive pre-session change is empowering for the client because the changes have taken place independently of the counsellor and, therefore, the credit belongs solely to the client.

*Exception seeking*

The counsellor engages the client in seeking exceptions to the problem, that is, those occasions when the problem is not present, or is being managed better. This includes searching for transferable solutions from other areas of the client's life, or past solutions adopted in similar situations.

*Competence seeking*

The counsellor identifies and affirms the resources, strengths and qualities of the client which can be utilised in solving the problem. Coping mechanisms which the client has previously used are acknowledged and reinforced.

*The miracle question*

This is a central intervention typically used in a first session, but which may also reappear in subsequent sessions. It aims to identify existing solutions and resources and to clarify the client's goals in realistic terms. It is a future-oriented question which seeks to help the client to describe, as clearly and specifically as possible, what her life will be like, once the problem is solved or is being managed better. The question as devised by Steve de Shazer follows a standard formula:

Imagine when you go to sleep one night, a miracle happens and the problems we've been talking about disappear. As you were asleep, you did not know that a miracle had happened. When you wake up what will be the first signs for you that a miracle has happened?

This imaginary format gives the client permission to rise above negative, limited thinking and to develop a unique picture of the solution. An open expression of what they believe they want can either motivate them further towards achieving their goals, or perhaps help them to realise that they really don't want these changes after all. It can also highlight conflicts between what they themselves want and what other people in their life want for them. The counsellor helps the client to develop answers to the miracle question by active listening, prompting, empathising and therapeutic questioning.

*Scaling*

The counsellor uses a scale of 0-10 with clients with 10 representing the morning after the miracle and 0 representing the worst the problem has been, or perhaps how the client felt before contacting the counseling service. The purpose of scaling is to help clients to set small identifiable goals, to measure progress and to establish priorities for action. Scaling questions can also assess client motivation and confidence. Scaling is a practical tool which a client can use between sessions. The use of numbers is purely arbitrary - only the client knows what they really mean.

*Reframing*

Using the technique of reframing, the counsellor helps the client to find other ways of looking at the problem, ones which are at least as valid as any other, but which, in the opinion of the counsellor, increase the chances of the client being able to overcome the problem.

## 3.9 COMPATIBILITY WITH ADJUNCTIVE THERAPIES

SFT can easily be used as an adjunct to other therapies. One of the original and primary tenets of SFT is that if something is working, do more of it. It is suggested that therapists should encourage their clients to continue with other therapies and approaches that are helpful.

For example, clients are encouraged to continue to take prescribed medication, stay in self help groups if it is helping them to achieve their goals, or begin or continue family therapy.

Finally, it is a misconception that SFT is philosophically opposed to traditional substance abuse treatments. Just the opposite is true. If a client is in traditional treatment or has been in the past and it has helped, he or she is encouraged to continue doing what is working. As such, SFT could be used in addition to or as a component of a comprehensive treatment program.

## 3.10 TARGET POPULATIONS

SFBT has been found clinically to be helpful in treatment programs in the U.S. for adolescent and adult outpatients (Pichot & Dolan, 2003), and as an adjunct to more intensive inpatient treatment in Europe. SFT is being used to treat the entire range of clinical disorders, and is also being used in educational and business settings.

Meta-analysis and systematic reviews of experimental and quasi-experimental studies indicate that SFT is a promising intervention for youth with externalising behaviour problems and those with school and academic problems, showing medium to large effect sises (Kim, in press; Kim & Franklin, 1997).

While SFBT may be useful as the primary treatment mode for many individuals in outpatient therapy, those with severe psychiatric, medical problems, or unstable living situations will most likely need additional medical, psychological, and social services. In those situations, SFT may be part of a more comprehensive treatment program.

**Self Assessment Questions**

Multiple Choice Questions:

1) Solution-focused brief therapy is based on:
   - clear diagnostic formulations
   - appreciating the client's resources
   - a detailed description of the client's problem
   - the scientific study of personality.
2) Solution-focused techniques involve:
   - the 'miracle' question
   - paradoxical injunctions
   - careful administration of medication
   - the patient's acceptance of the problem.
3) Solution-focused brief therapy has been effective in the treatment of:
   - drug and alcohol misuse
   - agoraphobia
   - adolescent behavioural problems
   - eating disorders
   - all the above.

4) Solution-focused authors include:
   - de Shazer
   - Rollnick
   - O'Hanlon
   - Both a & c
5) Scaling questions are used to explore:
   - the patient's achievements
   - the patient's description of the symptoms
   - medication requirements
   - Goals of therapy.
   - a & d

## 3.11 LET US SUM UP

Solution focused brief therapy (SFBT) is often referred to as simply 'solution focused therapy' or 'brief therapy'. It focuses on what clients want to achieve through therapy rather than on the problem(s) that made them to seek help. The approach does not focus on the past, but instead, focuses on the present and future. The therapist/counselor uses respectful curiosity to invite the client to envision their preferred future and then therapist and client start attending to any moves towards it whether these are small increments or large changes. To support this, questions are asked about the client's story, strengths and resources, and about exceptions to the problem.

Solution focused therapists believe that change is constant. By helping people identify the things that they wish to have changed in their life and also to attend to those things that are currently happening that they wish to continue to have happen, SFT therapists help their clients to construct a concrete vision of a *preferred future* for themselves. The SFT therapist then helps the client to identify times in their current life that are closer to this future, and examines what is different on these occasions. By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, the therapists helps the client move towards the preferred future they have identified.

Solution focused work can be seen as a way of working that focuses exclusively or predominantly at two things. 1) Supporting people to explore their preferred futures. 2) Exploring when, where, with whom and how pieces of that preferred future are already happening. While this is often done using a social constructionist perspective the approach is practical and can be achieved with no specific theoretical framework beyond the intention to keep as close as possible to these two things.

## 3.12 UNIT END QUESTIONS

1) What do you think about the idea that it is preferable to spend more time exploring solutions than understanding problems?
2) Counselling should be as brief as possible so that people can get on with their lives. Discuss.

3) Write about the treatment principles and interventions in SFT?

4) Answer the miracle question in relation to a problem area in your own life and share your observations with a colleague.

## 3.13 SUGGESTED READINGS

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

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.

Palmer, Stephan. (2000). *Introduction to Counseling and Psychotherapy.* New Delhi: Sage Publications.

## 3.14 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) b, 2) a, 3) e, 4) d, 5) e

# UNIT 4 INTEGRATIVE AND MULTIMODAL THERAPIES

**Structure**

4.0 Introduction
4.1 Objectives
4.2 Definition of Integrative Psychotherapy
4.3 Historical Overview of the Integrative Movement
4.4 Variables Responsible for Growth of Psychotherapy Integration
4.5 Different Ways to Psychotherapy Integration
 4.5.1 Eclecticism
 4.5.2 Differences between Eclecticism and Psychotherapy Integration
 4.5.3 Theoretical Integration
 4.5.4 Assimilative Integration
 4.5.5 The Common Factor Approach
 4.5.6 Multitheoretical Approaches
 4.5.7 The Transtheoretical Model
 4.5.8 Brooks-Harris' Multitheoretical Model
 4.5.9 Helping Skills Approach to Integration
4.6 Evidence-Based Therapy and Integrative Practice
 4.6.1 Implementation of EBP in Practice
4.7 Future of Psychotherapy Schools and Therapy Integration
4.8 Multimodal Therapy
4.9 Development of Multimodal Therapy
4.10 Basic Concepts
 4.10.1 Modalities
 4.10.2 Principle of Parity
 4.10.3 Thresholds
4.11 The Development and Maintenance of Problems
 4.11.1 Misinformation
 4.11.2 Issing Information
 4.11.3 Defensive Reactions
 4.11.4 Lack of Self Acceptance
4.12 Psychological Health
4.13 Practice of Multimodal Therapy
 4.13.1 Goals of Multimodal Therapy
 4.13.2 The Relationship between the Therapist and Client
 4.13.3 The Process of Change
4.14 Applications and Limitations
4.15 Let Us Sum Up
4.16 Unit End Questions
4.17 Suggested Readings
4.18 Answers to Self Assessment Questions

## 4.0 INTRODUCTION

A major emphasis of this unit is on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy. Throughout the world, when you ask a psychologist or counsellor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation, you will integrate one or more of the theories presented in this block. This unit explores in detail the integrative and multimodal approach to therapy. The first part of this unit traces the historical development, variables responsible for, the different models and future of integrative approach. The second half of this unit will explore multimodal therapy. This part will cover the development of theory, basic concepts, explanations for development and maintenance of problems, practice, applications and limitations of multimodal therapy.

## 4.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the foundational aspects and variables responsible for integration;
- Describe the different paths to integration and future of integrative approach;
- Discuss the concept and development of multimodal therapy; and
- Describe the practice, applications and limitations of multimodal therapy.

## 4.2 DEFINITION OF INTEGRATIVE PSYCHOTHERAPY

Integrative psychotherapy is an attempt to combine concepts and counselling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counselling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients.

According to Norcross (2005):

Psychotherapy integration is characterised by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy. (pp. 3–4).

## 4.3 HISTORICAL OVERVIEW OF THE INTEGRATIVE MOVEMENT

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients' problems. From Freud's Wednesday evening meetings

on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviourism was introduced to the field, clashes took place between psychoanalysts and behaviourists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy,* was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published *Psychoanalysis and Behaviour Therapy: Toward an Integration*. In 1979, James Prochaska offered a transtheoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp organised an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy.* By 1991, it began publishing the *Journal of Psychotherapy Integration.* As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

## 4.4 VARIABLES RESPOSIBLE FOR GROWTH OF PSYCHOTHERAPY INTEGRATION

Norcross and Newman (1992) have summarised the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

First, they point out that there was simply a proliferation of separate counselling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation.

Second, they note that practitioners increasingly recognised the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory.

Third, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioural change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement.

Fifth, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments.

Sixth, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fuelled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers' identification of common factors related to successful therapy outcome influenced clinicians' tendency toward psychotherapy integration. Increasingly, therapists began to recognise there were common factors that cut across the various therapeutic schools.

Eighth, the development of professional organisations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.

## 4.5 DIFFERENT WAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, we might feel more comfortable in thinking about how we might pursue this same avenue. Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

### 4.5.1 Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many psychologists accept some features of behaviourism, yet they do not attempt to use the theory to explain all aspects of client behaviour. Eclecticism in psychology has been caused by the belief that many factors influence human behaviour; therefore, it is important to examine a client from a number of theoretical perspectives.

### 4.5.2 Differences between Eclecticism and Psychotherapy Integration

Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counselling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counselling technique, yet not investigate any further why the positive change occurred. In

contrast, an integrative therapist would investigate the how and why of client change. Did the client change because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists.

### 4.5.3 Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behaviour therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

### 4.5.4 Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labelled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioural assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single theoretical approach, and over time many gradually incorporate techniques and methods of other approaches. Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

### 4.5.5 The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers' contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals. Researchers and theorists have transformed Rogers' necessary and sufficient

conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counselling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller, 1999).

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

### 4.5.6 Multitheoretical Approaches

Recently, therapists have developed multitheoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesise two or more theories at the theoretical level. Instead, there is an effort to "bring some order to the chaotic diversity in the field of psychotherapy and "preserve the valuable insights of major systems of psychotherapy" (Prochaska & DiClemente, 2005, p. 148). *The goal of multitheoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multitheoretical frameworks are (1) the transtheoretical approach by Prochaska and DiClemente, and (2) multitheoretical therapy by Brooks-Harris.

### 4.5.7 The Transtheoretical Model

The most widely recognised model using a multitheoretical framework has been the transtheoretical model developed by Prochaska and DiClemente (1984, 2005). The transtheoretical model is a model of behavioural change, which has been the basis for developing effective interventions to promote healthy behaviour change. Key constructs are integrated from other counselling theories. The model describes how clients modify problem behaviour or how they develop a positive behaviour. The central organising construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages:

1) precontemplation,
2) contemplation,
3) preparation,
4) action, and
5) maintenance.

In the precontemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The transtheoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labelled behavioural processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness rising ("I remember information people gave me about how to stop smoking") and social liberation ("I find society changing in ways that make it easier for me to be a non-smoker"). The 5 behavioural processes of change range from (6) stimulus control to (8) counter-conditioning ("I do other things with my hands to stop smoking") to (10) self-liberation ("I make commitments not to smoke").

The transtheoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development. The transtheoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasise different stages and levels of change.

### 4.5.8 Brooks-Harris' Multitheoretical Model

The most recent multitheoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches:

1) cognitive,
2) behavioural,
3) experiential,
4) bio psychosocial,
5) psychodynamic,
6) systemic, and
7) multicultural.

A brief explanation of each of these areas is provided below (table 6.5.2). His framework emphasises at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

**Table: Multi Theoretical Psychotherapy**

| Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts. |
|---|
| Behavioural skills–focal dimension of actions encourage effective client actions to deal with challenges. |
| Experiential interventions result in adaptive feelings. |

| Bio psychosocial strategies emphasise biology and adaptive health practices. |
|---|
| Psychodynamic-interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions. |
| Systemic-constructivist interventions examine the impact of social systems and support adaptive personal narratives. |
| Multicultural-feminist strategies explore the cultural contexts of clients' issues. |

Brooks-Harris presents five principles for psychotherapy integration, which include

1) intentional integration,
2) multidimensional integration,
3) multitheoretical integration,
4) strategy-based integration, and
5) relational integration.

The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualisation, and intervention strategies.

Principle two (multidimensional) proposes that therapists should recognise the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions.

The fourth strategy-based principle states that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled.

The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalogue of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy. To integrate behavioural therapy into one's practice, he suggests some of the following catalogue of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

## 4.5.9 Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools. For instance, the first stage of helping is labelled *exploration.*

Using Rogers' client-centered therapy as the therapy school of choice, Hill (2004) emphasises the counselling skills of attending, listening, and reflection of feelings.

The second stage is termed *insight,* and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed.

The third stage is termed the *action stage,* and this stage is based largely on cognitive-behavioural techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

## 4.6 EVIDENCE-BASED THERAPY AND INTEGRATIVE PRACTICE

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

The American Psychological Association (2006, p. 273) conceptualises evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence-based practice emphasises the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favour of Evidence based Practice (EBP) are reasonable.

First, clients have a right to treatments that have been proven to be effective.

Second, managed care requires counsellor accountability in choosing a method of treatment.

Increasingly, counsellors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder.

Helping professionals may be required to answer for using a therapeutic approach with a specific disorder.

### 4.6.1 Implementation of EBP in Practice

The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun.*

There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration sets standards for reviews of medical, health, and mental health treatments and provides "systematic reviews" of related research by disorder.

Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions.

Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (http:// www.guideline.gov/).

This site contains very good information on medication. Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health

http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm).

**Activity**

Reflection on Therapist Qualities. The purpose of this exercise is to help you identify and assess your own strengths and weaknesses as future therapists and encourage self-reflection and openness in your group. Identify three things about yourself that you believe will assist you in becoming a good therapist. Record these things in your book.

## 4.7 FUTURE OF PSYCHOTHERAPY SCHOOLS AND THERAPY INTEGRATION

What does the future look like for psychotherapy schools that have been presented in this book?

Norcross, Hedges, and Prochaska (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: cognitive-behaviour therapy, culture-sensitive multicultural counselling, Beck's cognitive therapy, interpersonal therapy, family systems therapy, behaviour therapy, technical eclecticism, solution-focused therapy, and exposure therapies.

Therapy orientations that were predicted to decrease the most included classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy.

The poll also showed how psychotherapy is changing. The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease i.e. Short term is in, and long term on its way out.

**Self Assessment Questions**

Fill in the Blanks:

a) ——————————— approach to psychotherapy integration involves having a strong grounding in one system of psychotherapy and a willingness to select practices and views from other systems.

b) ———————————— Psychotherapy maintains that thoughts, actions, and feelings interact with one another and are shaped by biological, interpersonal, systemic, and cultural contexts.

c) ______________________ is a psychotherapy model developed by Prochaska and DiClemente that matches a therapist's approach to a client's readiness to change.

d) ______________________ is an integrative approach that advocates using multiple procedures taken from various therapeutic approaches without specific concern from which theories they come.

e) ______________________ Involves the integration of two or more therapies with an emphasis on integrating the underlying constructs associated with each therapeutic system.

## 4.8 MULTIMODAL THERAPY

Multimodal counselling and therapy is a technically eclectic and systematic approach. The approach is technically eclectic as it uses techniques taken from many different psychological theories and systems, without necessarily being concerned with the validity of the theoretical principles that underpin the different approaches from which it takes its techniques and methods. The techniques and interventions are applied systematically, based on data from client qualities, the counsellor's clinical skills and specific techniques.

The approach uses a unique assessment procedure which focuses on seven different aspects or dimensions (known as modalities) of human personality. Not only is a serious attempt made to tailor the therapy to each client's unique requirements, but the counsellor also endeavours to match his or her interpersonal style and interaction to the individual needs of each client, thereby maximising the therapeutic outcome.

## 4.9 DEVELOPMENT OF MULTIMODAL THERAPY

During the 1950s Arnold Lazarus, a psychologist undertook his formal clinical training in South Africa. The main focus of his training was underpinned by psychodynamic and person-centred theory and methods. In addition, he attended seminars provided by Joseph Wolpe, a psychologist, thereby learning about conditioning therapies based on Behaviour Therapy. During 1957 he spent several months as an intern at the Marlborough Day Hospital in London, where the orientation was Adlerian.

He believed that no one system of therapy could provide a complete understanding of either human development or condition. In 1958 he became the first psychologist to use the terms 'behaviour therapist' and 'behaviour therapy' in an academic article.

Lazarus conducted follow up enquiries into clients who had received behaviour therapy and found that many had relapsed. However, when clients had used both behaviour and cognitive techniques, more durable results were obtained. In the early 1970s he started advocating a broad but systematic range of cognitive-behavioural techniques and his follow-up enquiries indicated the importance of breadth if therapeutic gains were to be maintained. This led to the development of Multimodal Therapy which places emphasis on seven discrete but interactive dimensions or modalities which encompass all aspects of human personality.

## 4.10 BASIC CONCEPTS

### 4.10.1 Modalities

People are essentially biological organisms (neurophysiological/biochemical entities) who behave (act and react), emote (experience emotional responses), sense (respond to olfactory, tactile, gustatory, visual and auditory stimuli), imagine (conjure up sights, sounds and other events in the mind's eye), think (hold beliefs, opinions, attitudes and values), and interact with one another (tolerate, enjoy or endure various interpersonal relationships). These seven aspects or dimensions of human personality are known as modalities. By referring to these seven modalities as Behaviour, Affect, Sensations, Images, Cognitions, Interpersonal and Drugs/biology, the useful acronym and memory aide BASIC I.D. arises from the first letter of each. ('Affect' is a psychological word for emotion and 'cognitions' represent all thoughts, attitudes and beliefs.)

From the multimodal perspective these seven modalities may interact with each other for example an unpleasant image or daydream and a negative thought may trigger a negative emotion such as anxiety or depression. The multimodal approach rests on the assumption that unless the seven modalities are assessed, counselling is likely to overlook significant concerns. Clients are usually troubled by a multitude of specific problems which should be dealt with by a similar multitude of specific interventions or techniques.

For example, a client may suffer from a simple fear of spiders, anxiety about giving presentations at work, sleep disturbances, a lack of exercise and a poor diet. Each problem will probably need a specific intervention to help the client improve his or her condition.

Multimodal therapists have found that individuals tend to prefer some of the BASIC I.D modalities to others. They are referred to as 'imagery reactors' or 'cognitive reactors' or 'sensory reactors' depending upon which modality they favour.

### 4.10.2 Principle of Parity

In multimodal therapy the counsellor and client are considered equal in their humanity (the principle of parity). However, the counsellor may be more skilled in certain areas in which the client has particular deficits. Therefore it is not automatically assumed that clients know how to deal with their problems and have the requisite skills. The counsellor may need to model or teach the client various skills and strategies to help overcome his or her problem(s). It should be understood that having superior skills in certain areas does not make counsellors superior human beings!

### 4.10.3 Thresholds

One key assumption made in multimodal therapy is that people have different thresholds for pain, frustration, stress, external and internal stimuli in the form of sound, light, touch, smell and taste. Psychological interventions can be applied by individuals to help modify these thresholds but often the genetic endowment or predisposition has an overriding influence in the final analysis. For example, a client with a low tolerance to pain may be able to use psychological

distraction techniques such as relaxing imagery, but is still likely to need an anaesthetic when receiving minor fillings at the dentist.

## 4.11 THE DEVELOPMENT AND MAINTENANCE OF PROBLEMS

Problems develop and are maintained for a variety of reasons. Social learning, systems and communication theories all explain some of the ways problems can arise and how they are maintained. Of course, underlying all problems is the biological and genetic dimension which goes to help make up a human being. We will discuss a few additional key factors.

### 4.11.1 Misinformation

Over a period of time people may learn incorrect assumptions and beliefs about life. For example, the beliefs 'I must perform well otherwise I'm a failure', or 'I'm worthless if my partner leaves me', or 'Life should be easy', may be learnt or imbibed by listening to significant others such as peers, parents or teachers. These beliefs may lead to considerable stress when external life events conflict with them. Couples may also hold on to unhelpful beliefs or myths such as 'If you feel guilty, confess.'

Due to misinterpreting their doctor's advice many people have misunderstood medical and health-related issues such as treatment of cancer or heart disease. Unless the health professionals correct these errors then patient compliance to medical procedures may be hindered or even non-existent.

### 4.11.2 Missing Information

Unlike the case with misinformation, with missing information people have not learnt the necessary skills, knowledge or methods to either understand or undertake particular activities or recognise specific problems. For example, people may not have in their repertoire of behaviour job interview skills, friendship skills, communication skills, or assertiveness skills etc. They may not realise that a pain in their left arm could signify heart disease and that it might be strongly advisable to have a medical check-up.

### 4.11.3 Defensive Reactions

People avoid or defend against discomfort, frustration, pain, or negative emotions such as shame, guilt, depression and anxiety. Although it sounds quite natural to avoid fears or the unbearable pain of loss, people do not learn how to conquer them unless they confront them. For example, if a person has a fear of travelling by airplane he or she could easily avoid this mode of transport. However, there might be certain job expectations that require the person to fly across the Atlantic. If the person wanted to keep the job he or she would need to deal with this problem sooner rather than later. According to learning theory the main method of overcoming flying phobia is to experience exposure to flying. Although this can be partially undertaken using the person's imagination, the most effective technique is to fly on the airplane. Initially this might trigger very high levels of anxiety which only gradually subsides or to which the person habituates after an hour or two of exposure to flying. This is no different from the advice given to horse-riders who fall off their horse: 'Get straight back on the horse immediately.'

### 4.11.4 Lack of Self Acceptance

People tend to link their behaviour skills deficits directly to their totality as a human being. Depending upon the particular belief the person holds, this tends to lead to anxiety, shame, anger or depression. For example, a person may believe, 'If I fail my exam, I'm a total failure as a human being.' A more realistic and logical way of looking at the situation could be, 'If I fail my exam all it proves is that I've got exam skills deficits. I can still accept myself as a fallible human being.' The unhelpful beliefs may have been imbibed from parents and other significant people in the child's life but they may be reinforced and perpetuated by the person constantly re-indoctrinating him or herself on a regular basis throughout adulthood. In multimodal therapy the content of self- defeating or unrealistic beliefs is examined and is replaced by more self-helping and realistic beliefs.

## 4.12 PSYCHOLOGICAL HEATH

The key issues discussed above and the path to psychological health can be expressed in the form of the BASIC I.D. modalities below:

Behaviour: ceasing unhelpful behaviours; performing wanted behaviours; stopping unnecessary or irrational avoidances; taking effective behaviours to achieve realistic goals.

Affect: admitting, clarifying and accepting feelings; coping or managing unpleasant feelings and enhancing positive feelings; abreaction (i.e., living and recounting painful experiences and emotions).

Sensation: tension release; sensory pleasuring; awareness of positive and negative sensations; improving threshold tolerance to pain and other stimuli.

Imagery: developing helpful coping images; improving self-image; getting in touch with one's imagination.

Cognition: greater awareness of cognitions; improving problem-solving skills; modifying self-defeating, rigid beliefs; enhancing flexible and realistic thinking; increasing self-acceptance; modifying beliefs that exacerbate low thresholds to frustration or pain (for example, 'I can't stand it' to 'I don't like it but I'm living proof that I can stand it'); correcting misinformation and providing accurate missing information.

Interpersonal: non-judgemental acceptance of others; model useful interpersonal skills; dispersing unhealthy collusions; improve assertiveness, communication, social and friendship skills.

Drugs/biology: better nutrition and exercise; substance abuse cessation; alcohol consumption in moderation; medication when indicated for physical or mental disorders.

## 4.13 PRACTICE OF MULTIMODAL THERAPY

### 4.13.1 Goals of Multimodal Therapy

The goals of multimodal therapy are to help clients to have a happier life and achieve their own realistic goals. Therefore the goals are tailored to each client.

A philosophy of long-term hedonism as opposed to short-term hedonism is advocated whereby the client may need to decide how much pleasure they may want in the present compared to the sacrifices they may have to make to attain their desires and wishes. For example, to go to college and obtain a good degree may necessitate working reasonably hard for a period of three years and not attending as many parties as previously.

### 4.13.2 The Relationship between the Therapist and Client

The relationship is underpinned by core therapeutic conditions suggested by Carl Rogers. These core conditions are empathy, congruence and unconditional positive regard. Although a good therapeutic relationship and adequate rapport are usually necessary, multimodal therapists consider that they are often insufficient for effective therapy. The counsellor-client relationship is considered as the soil that enables the strategies and techniques to take root. The experienced multimodal counsellor hopes to offer a lot more by assessing and treating the client's BASIC I.D., endeavouring to 'leave no stone (or modality) unturned'.

Multimodal counsellors often see themselves in a coach/trainer-trainee or teacher-student relationship as opposed to a doctor-patient relationship, thereby encouraging self-change rather than dependency. Therefore the usual approach taken is active-directive where the counsellor provides information, and suggests possible strategies and interventions to help the client manage or overcome specific problems. However, this would depend upon the issues being discussed and the personality characteristics of the client. Flexible interpersonal styles of the counsellor which match client needs can reduce attrition (i.e. premature termination of therapy) and help the therapeutic relationship and alliance. This approach of the therapist is known in multimodal therapy as being an 'authentic chameleon'.

For example, if a client states that she wants, 'A listening ear to help me get over the loss of my partner' then she may consider an active-directive approach as intrusive and possibly offensive. On the other hand, a client who states, 'I would value your comments and opinions on my problems', may become very irritated by a counsellor who only reflects back the client's sentiments and ideas. Others may want a 'tough, no-nonsense' approach and would find a 'warm, gentle' approach not helpful or conducive to client disclosure.

This flexibility in the counsellor's interpersonal therapeutic style underpins effective multimodal therapy. Counsellors are expected to exhibit different aspects of their own personality to help the therapeutic relationship and clients to reach their goals. The term 'bespoke therapy' has been used to describe the custom-made emphasis of the approach.

**Activity**

Qualities for Effective Therapists. Create your own list of qualities for the effective therapist. Review that list and discuss them with the people in your small group.

### 4.13.3 The Process of Change

The process of change may commence even before the first therapy session as clients are usually sent details about the approach with some explanation of the

key techniques such as relaxation or thinking skills. Occasionally, therefore, the client has already started using simple self-help techniques before the therapy formally commences. In Britain, included with the details is a client checklist of issues the client may want to discuss with the counsellor at the first meeting. This checklist encourages the client to ask the counsellor relevant questions about the approach, the counsellor's qualifications and training and contractual issues, thereby giving the client more control of the session and therapy.

During the course of therapy, the client's problems are expressed in terms of the seven BASIC I.D modalities and client change occurs as the major different problems are managed or resolved across the entire BASIC I.D. Initially, sessions are often held weekly. As client gains are made, then the sessions are held with longer intervals in between, such as a fortnight or a month. Termination of counselling usually occurs when clients have dealt with the major problems on their modality profile or feel that they can cope with the remaining problems.

As multimodal therapy is technically eclectic, it will use techniques and interventions from a variety of different therapies. Although these are largely based on behaviour therapy, cognitive therapy and rational emotive behaviour therapy, techniques are also taken from other approaches, such as psychodynamic and Gestalt therapy.

## 4.14 APPLICATION AND LIMITATIONS

Multimodal therapy has been shown to benefit children, adults and older client groups experiencing a wide range of problems. For example, those suffering from anxiety-related disorders such as agoraphobia, panic attacks, phobias, obsessive- compulsive disorders; depression, post-traumatic stress disorder; sexual problems; anorexia nervosa; obesity; enuresis; substance and alcohol abuse; airsickness; schizophrenia.

As counsellors are expected to adjust their interpersonal style to each client, they may encounter fewer relationship difficulties when compared to other less flexible approaches. This flexible approach should lead to a reduced rate of attrition.

However, as with other therapies, multimodal therapy has its failures. Some clients are not prepared to face their fears, challenge their unhelpful thinking, use coping imagery, practise relaxation techniques, become assertive with significant others, etc. Others may have psychiatric disorders or other difficulties that prevent them from engaging in therapy. Some clients are in the pre-contemplative stage where they have not made up their minds to change and take on the responsibility of counselling. They may need to return to counselling at a later stage in their lives.

**Self Assessment Questions**

Fill in the Blanks:

a) ———————————- is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way.

b) For multimodal therapists, assessment and diagnosis involve a thorough evaluation of the —————.

c) —————————— category of BASIC I.D includes mental pictures or visualisation.

d) ——————————category of BASIC I.D includes all physical or biological areas, including substance use.

e) In multimodal therapy the major emphasis is on —————————————————.

f) Approach of the therapist in multimodal therapy is known as being an————————.

## 4.15 LET US SUM UP

Counselling and psychotherapy are moving toward an integrative approach to psychotherapy. The days of adopting one singular therapy approach and using it for the rest of one's professional development seem to be coming to an end. Psychotherapy integration has become intertwined with the evidence based movement in stressing that various client problems necessitate that the therapist use different solutions. Moreover, increasingly these solutions can be chosen on the basis of empirical outcome research what is known as evidence based studies. One advantage of integrative therapies is that they allow therapists the flexibility to meet the needs of clients who have different presenting issues and who come from a range of cultural contexts.

Psychotherapy integration can take several different paths including assimilative integration, technical eclecticism, common factors integration, and theoretical integration. The movement toward psychotherapy integration encourages therapists to take into consideration the benefits of individual therapeutic approaches. Integrative psychotherapy posits that many treatment methods can be helpful in working with different clients. It is predicted that evidence-based studies will have an important influence on psychotherapy theory integration.

Therapists must understand not only the individual theories so that they can decide for themselves what they feel is appropriate for them, but they also need to establish a multitheoretical or integrative framework from which they can integrate the theories they choose. The framework by Brooks-Harris offers the simplest route to developing your own integrative approach.

Within the next couple of decades, it is predicted that graduate schools will adopt an integrative approach to psychotherapy training because such programs themselves will come under increasing pressure to equip their graduates with therapeutic skills that cross theoretical lines. Ethical guidelines for counsellors and psychologists appear to be headed in the direction of requiring therapists to know evidence-based research (what techniques actually work with what clients with what problems) if they are to exercise an appropriate standard of care for their clients.

Multimodal therapy is a comprehensive, systematic, and holistic approach to psychotherapy that seeks to effect durable change in an efficient and humane way. It is an open system in which the principle of technical eclecticism encourages the constant introduction of new techniques and the refinement or elimination of existing ones, but never in a random or shotgun manner. The major emphasis is

on flexibility. Multimodal therapists subscribe to no dogma other than the principles of theoretical parsimony and therapeutic effectiveness.

Assessments and interventions are structured around seven modalities summarised by the acronym BASIC I.D. (behaviour, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors). This framework allows the therapist to take into account the uniqueness of each individual and to tailor treatment accordingly. The emphasis is constantly on who or what is best for this individual (couple, family, or group). By assessing significant deficits and excesses across the client's BASIC I.D., thorough coverage of diverse interactive problems is facilitated. The therapist's role and the cadence of client-therapist interaction differ from person to person and even from session to session. Some clients respond best to somewhat austere, formal, businesslike transactions; others require gentle, tender, supportive encouragement.

## 4.16 UNIT END QUESTIONS

1) What key developments stand out in your mind about the integrative movement in psychotherapy?
2) Thoughts about theory integration date back to the 1930s and 1940s. In your opinion, what took so long for the movement to reach its current status?
3) What theories are you considering integrating into your own personal approach to psychotherapy? Explain why.
4) In what ways does multimodal therapy differ from other forms of therapy?
5) Critically discuss the usefulness of the BASIC I.D. assessment procedures.
6) The practice of multimodal therapy places high demands on the therapist. Discuss.
7) Discuss A. Lazarus's view of the authentic chameleon.

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## 4.18 ANSWERS TO SELF ASSESSMENT QUESTIONS

**Self Assessment Questions 1**

1) Assimilative integration
2) Multitheoretical Psychotherapy
3) Stages of Change
4) Technical Eclecticism
5) Theoretical Integration.

**Self Assessment Questions 2**

1) Multimodal therapy
2) BASIC I.D
3) Imagery
4) Drugs and biology
5) Flexibility
6) Authentic chameleon.

# UNIT 1 ROGER'S CLIENT CENTERED THERAPY

**Structure**

1.0 Introduction
1.1 Objectives
1.2 Views of Human Nature
1.3 Goals of Client Centred Therapy
1.4 The Counselling Process
1.4.1 Empathy
1.4.2 Unconditional Positive Regard
1.4.3 Genuineness or Congruence
1.4.4 Transparency
1.4.5 Concreteness
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1.5 Counselling Relationship
1.6 Intervention Strategies
1.6.1 Rogerian View of Psychotherapy
1.6.2 Process of Person Centered Therapy
1.6.3 Therapist's Role and Functions
1.6.4 Therapy / Intervention Goals
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1.6.6 Relationship between Therapist and Client
1.6.7 Contribution of Person Centered Therapy
1.6.8 Summary and Evaluation
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1.6.10 Active Listening
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1.7 Clients Who Can Benefit
1.8 Limitations
1.9 Let Us Sum Up
1.10 Unit End Questions
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## 1.0 INTRODUCTION

Carl Rogers is the founder of this approach to counselling. It is also known by names person centred approach, nondirective counselling and client centred counselling. This approach can be used in any setting where a helper aims to promote human psychological growth. As this method of counselling did not require extensive psychological training, many practising counsellors adopted this approach and it had a great influence on the preparation of new counsellors.

Rogers work is regarded as one of the principal forces in shaping current counselling and psychotherapy. The present unit deals with Roger's Client centered therapy, its characteristic features, its goals and its techniques and principles.

## 1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe Roger's client centred therapy;
- Explain the views of human nature as according to Rogers;
- Elucidate the goals of therapy;
- Describe the counselling process;
- Analyse the importance of counselling relationship; and
- Explain the intervention strategies of client centered therapy

## 1.2 VIEWS OF HUMAN NATURE

In Rogers client centred therapy, human beings are seen as possessing goodness and the desire to become fully functioning i.e. to live as effectively as possible. According to Rogers, if people are permitted to develop freely, they will flourish and become positive, achieving individuals. Because Rogers's theory expresses faith in human nature, it is considered as humanistic approach to counselling.

Rogers client centred therapy is based on a theory of personality referred to as self-theory. An individual's view of self within the context of environment influences his actions and personal satisfactions. If provided with a nurturing environment, people will grow with confidence toward self-actualisation. If they do not receive love and support from significant others, they will likely to see themselves as lacking in worth and see others as untrustworthy. Behaviour will become defensive and growth toward self actualisation will be hampered.

An important principle of self theory is the belief that a person's perceptions of self and environment are reality for that person. For example, if an individual sees himself as incompetent, he will act on that belief, even if others view him as brilliant. This personal reality may be changed through counselling but not by a direct intervention as substituting the judgement of the counsellor for that of the client.

Thus, the client centered therapist's perception of people is based on four key beliefs:

1) People are trustworthy
2) People innately move toward self – actualisation and health
3) People have the inner resources to move themselves in positive directions and
4) People respond to their uniquely perceived world.

## 1.3 GOALS OF CLIENT CENTERED THERAPY

Person centered therapy, which is also known as client centered, non directive, or Rogerian therapy, is an approach to counseling and psychotherapy that places

much of the responsibility for the treatment process on the client, with the therapist taking a nondirective role.

The goal of client centered therapy is to provide a safe, caring environment where clients get in closer touch with essential positive elements of themselves that have been hidden or distorted. Less distortion and more congruence lead to greater trust that their organism can be relied on for effective reactions to people and situations.

Two primary goals of person centered therapy are increased self esteem and greater openness to experience. Some of the related changes that this form of therapy seeks to foster in clients include:

i) Closer agreement between the client's idealised and actual selves

ii) Better self-understanding

iii) Lower levels of defensiveness, guilt, and insecurity

iv) More positive and comfortable relationships with others and

v) An increased capacity to experience and express feelings at the moment they occur.

Rogers believed that people are trustworthy and have vast potential for understanding themselves and resolving their own problems and that they are capable of self directed growth if they are involved in a respectful and trusting therapeutic relationship.

According to Rogers, if the above 3 attitudes are communicated by the helper, those being helped will become less defensive and more open to themselves and their world, and they will behave in socially constructive ways. Therapists use themselves as an instrument of change.

Person centered therapy focuses on the person, not on the person's presenting problem. Goal is to assist clients in their growth so they are better able to cope with both today's problems and future problems.

The basic drive to fulfillment implies that people move toward health if the way seems open for them to do so. Thus, the goals of counseling are to set clients free and to create those conditions that will enable them to engage in meaningful self-exploration.

Therapists concern themselves mainly with the client's perception of self and the world. This approach provides clients with a rare opportunity to be truly listened to without evaluation or judgment.

Therapist does not choose specific goals for the client. (B-203) Primary responsibility for the direction of therapy is on the client.

General goals of therapy are:

a) becoming more open to experience,

b) Achieving self-trust,

c) developing an internal source of evaluation,

d) being willing to continually grow

This added trust results in reduced feelings of helplessness and powerlessness, fewer behaviours are driven by stereotypes and more by productive, creative and flexible decision making.

**Self Assessment Questions**

1) What are the views of human nature in Roger's client centered therapy?

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2) Delineate the goals of client centered therapy.

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3) Describe the general and specific goals of client centered therapy.

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## 1.4 THE COUNSELLING PROCESS

According to Rogers, the counsellor should provide conditions that would permit self discovery and encourage the client's natural tendency toward personal growth. The core conditions of counselling as described by Rogers are *empathy, unconditional positive regard and congruence or genuineness* which is considered necessary and sufficient for therapeutic personality change.

The Person Centred approach remains one of the most popular forms of psychological counselling. It provides a frame of reference as much as if not more than a counselling method. In Carl Rogers' original perspective, clients (as all people) are seen to engage continually in the attempt to self-actualise. This optimistic philosophy led to the promotion of a model of counselling in which clients are regarded as their own best resource for growth and change. Rogers (1951) early Non Directive approach developed into Client Centered therapy which emphasised accuracy in empathy. In its current form, the Person Centered

approach underscores the reciprocal nature of the helping relationship. At the core is a well known set of constructs about the intrinsic nature of people and the functioning of the helping relationship rather than the counselling method (the Core Conditions).

Competent practitioners are thus defined by their level of self awareness and capacity to engage in a meaningful helping relationship rather than any technical knowledge of Person Centred counselling. Valuing the unique phenomenological position of the client, Person Centred counselling still retains the positive and optimistic value base of early work but now elaborates a more sophisticated model of humanity.

The concept of core conditions is inextricably linked to the early work of Rogers (1957). The terminology has since evolved but the fundamental principle of the concept of core conditions remains essentially unchanged. The original strong version of the model holds that core conditions are necessary and sufficient for clients to experience therapeutic change. Later post modern or sophisticated versions of Person Centred counselling posit that the condition are foundations for change and adds other broader requirements (Rennie 1998).

The original shortlist of core conditions has been considerably expanded (Carkhuff 1969):

- Unconditional positive regard
- Empathic understanding
- Genuineness and congruence
- Transparency
- Self disclosure
- Concreteness
- Cultural awareness

Creating trust in the helping relationship is a fundamental tenet of all Person Centred therapy. Not only must the client learn to trust the counsellor, but also the counsellor must trust that the client is the best person to set their own goals and access their own resources to achieve them. The problem is, however, that people often come to counselling because they are thwarted in their capacity to identify or reach their own goals (Haley 1976).

Rather than being a passive "listening post", then, the counsellor must strive to actively listen, actively engaging mind to compare what is being revealed to previous disclosures. Clients in turn use the process to try to make sense of their experience.

Egan (1994) distinguishes primary and advanced empathy. Primary empathy is said to depend on counsellors attending, listening and communicating back their understanding of the clients position as experienced by the client. Advanced empathy, however, also incorporates self-disclosure, directiveness and interpretations. The sophisticated version thus gives a more active role to the counsellors processing and implicit use of a theoretical framework rather than relying on purely experiential nature of the counselling encounter as the main source for the validation of material presented by the client.

There is often an opportunity for relearning emotional experiences through advanced emotional empathy. As the relationship between the client and counsellor develops so it becomes possible for the client to cautiously re-experience feelings. This marks the dawning of self-awareness, recognising links between past and present, preparing the ground for problem resolution (Brems 1999).

The process of therapeutic change in Person centred counselling represents a movement from purely cerebral to feeling states and gives immediacy. It also marks a change to an internal locus of control. Mearns (1994) distinguishes osmotic (slow developing change) and seismic (sudden shift) in experience of the self. The Person centred approach contains much confrontation. Clients may be challenged to construct a new response to long held perceptions. Empathy is itself a confronting activity, challenging clients about the quality and validity of their feelings. The counsellors own congruence can also challenge clients where behaviours are offered as challenge to the counselling situation.

Reframing the client's narrative and confronting discrepancies in their account can open up possibilities for change. Rogers (1980) posits the counselling process is a means of rediscovering denied experiences. It aims to put clients in touch with themselves.

Counsellors confrontation should be born out of respect and a desire to help the client through the struggle to realise their own potential. It is particularly important, however, for counsellors to get the power dynamic right so that the client comes to understand that the counsellor becomes responsible to rather than for the client (Mearns 1994). The aim, then is to help clients realise their own power.

Schmid (1998) points out that Person Centred counselling is in fact a radical approach. The Latin and Greek etymology of "person" is associated with mask or face. Schmid reminds us that in Greek theatre the mask did not hide the character but served to reveal the personification of the gods. Contemporary psychological meaning of the person is defined by two traditions: as an independent being; as a being in a relationship. Both concepts have powerful implications for psychotherapeutic counselling. Rogers's original usage is consistent with the first definition, representing a celebration of selfhood as emancipated from the social milieu. The latter definition, however, implies persons are defined by, and indeed can only exist as, reflections of interactions with others. Schmid also contends the parallel definition creates a tension which finds its way into therapy. The client aims to become their own essential self (independent being). The therapist also tries to manifest self authentically (congruence). Paradoxically, however, it is the therapeutic relationship (being in a relationship) which is the sole vehicle for the journey.

Person Centred counselling retains a humanistic philosophy and a phenomenological focus. Prominence is given to the role of the self in effective psychological functioning. Post modern trends in counselling extend the concept of self to include interpersonal, systemic and socio cultural aspects. Psychological difficulties have to be understood from a variety of subjective meanings and be context sensitive. It is now seen to be a "relational contextual" self in contrast to an "autonomous-independent" self of the early Person Centred formulations

### 1.4.1 Empathy

It refers to the counsellor's ability to understand the client at a deep level. Rogers refers to the *internal frame of reference* to denote the client's unique experience of personal problems. In order to stay within the client's internal frame of reference, it is necessary for the counsellor to listen carefully to what is being conveyed (both verbally and nonverbally) at every stage of counselling. Once the counsellor understands the feelings and experiences of the client, the same thing needs to be communicated to the client.

Rogers also uses the term *external frame of reference* to describe the lack of understanding and contact. When a counsellor perceives the client from an external frame of reference, there is little chance that the client's view will be clearly heard. This does not help the client to benefit from counselling.

### 1.4.2 Unconditional Positive Regard

People need love acceptance, respect and warmth from others but unfortunately these attitudes and feelings are often given conditionally. As many people who come into counselling have experienced these attitudes, Rogers believed that counsellors should convey unconditional positive regard or warmth towards clients if they are to feel understood and accepted. This means that clients are valued without any conditions attached even when they experience themselves as negative, bad, frightened or abnormal. When attitudes and of warmth and acceptance are present in counselling, clients are likely to accept themselves and become more confident in their own abilities to cope.

### 1.4.3 Genuineness and Congruence

The Person Centered Therapy relationship must always be an honest one. The counselor needs to be real and true in the relationship. Individuals who cannot accept others (i.e. because of personal values and beliefs they hold rigidly and apply to all), or who will not listen and try to understand cannot do Person Centered Therapy. The therapist must embody the attitudinal quality of genuineness and to experience empathic understanding from the client's internal frame of reference and to experience unconditional positive regard towards the client. When the client perceives the therapist's empathic understanding and unconditional positive regard, the actualising tendency of the client is promoted.

Congruence means that the counsellor is authentic and genuine. The counsellor does not present an aloof professional facade, but is present and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counsellor is 'really like'.

### 1.4.4 Transparency

Ttransparency means even negative feelings about a client, if any exist, are expressed. The therapist shows a non-possessive feeling of love for the client and is able to, after a time, be empathetic enough to understand the client enough to metaphorically walk in the individual's shoes.

### 1.4.5 Concreteness

The next condition, *concreteness*, is the counsellor's skill in focussing the client's discussion on specific events, thoughts and feelings that matter while discouraging

intellectualised story telling. Concreteness is a precaution against the rambling that can occur when the other three conditions are employed without sufficient attention to identifying the client's themes.

If the counsellor is totally accepting of each client as a person, relates emphatically to the client's reality and behaves in a genuine way, the client will be free to discover and express the positive core of his being. As clients come to perceive themselves more positively in the nurturing environment, they will function more effectively. Counsellors not only provide the nurturing environment that is missing in client's lives but also serve as role models of how fully functioning persons relate with others.

### 1.4.6 Self Disclosure

The issue of degree to which person centered therapists may express and disclose themselves in the person centered relationships is contentious. However there is general agreement that self expression and self disclosure and willingness to be known are different from congruency. The therapist responds to the client from the therapist's frame of reference. The therapist should be willing to be known on the progress and success of therapy.

The issue of the therapist's self disclosure to the client is constantly revisited and many take the view that at times and in limited ways this may be a useful thing to do.

Self disclosure and self expression are most likely to be helpful to the client and the therapeutic relationship when

- They are relevant to client and the client's present experiencing.
- They are a response to the client's experience
- A reaction to the client is persistent and particularly striking.
- In response to the questions and requests from the client, the therapist answers openly and honestly and helps dispel the mystique.
- When it seems the client wants to ask a question but does not directly voices it.
- To make an empathic observation – that is to express a perception of an aspect of the client's communication or emotional expression
- To correct for loss of acceptance or empathy or incongruence.
- To offer insights and ideas.

### 1.4.7 Cultural Awareness in Client Centered Counselling

In Culture-Centered Counseling, recognising the centrality of culture can augment therapy and result in effective treatment of all clients. This approach involves recognising cultural assumptions and acquiring knowledge and skills to get beyond them, something that may be done no matter what treatment model a therapist might use.

Cultural awareness means being cognisant of culture differences that may use different standards for loudness, speed of delivery, spatial distance, silence, eye contact, gestures, attentiveness and response rate during communication.

Some examples of these would be:

- Arab people may avert their eyes when listening or talking to a superior.
- Someone from South America may consider it impolite if you speak with your hands in your pockets.
- Your Russian patients or clients may want to kiss you on the check to express their gratitude.
- If your new colleague is from Norway, they may hesitate to use your first name until they know you better.
- For the Chinese or Japanese, a facial expression that would be recognised around the world as conveying happiness, may actually express anger or mask sadness, both of which are unacceptable to show overtly in their culture.

All this may seem like a lot to consider, but the tips for considering cross cultural communication are really very basic:

1) Use common words
2) Follow basic words of grammar
3) Avoid slang
4) Repeat basic ideas without shouting
5) Paraphrase important points
6) Check for understanding

**Self Assessment Questions**

1) Describe the counselling process of client centered therapy.

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2) What is empathy? How is useful in therapy?

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3) Describe unconditional positive regard.

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4) Elucidate the concepts of congruence, genuineness, transparency and concreteness.

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5) How does client centered counselling incorporate cultural awareness.

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## 1.5 COUNSELLING RELATIONSHIP

The underlying philosophy of human nature is more important in the practice of client-centred therapy than any particular set of techniques or any body of knowledge. In this therapy, helpers learn how to be counsellors rather than how to do counselling. Because clients are seen as having the potential to solve their own problems, counsellors are not perceived as having expert knowledge to share with clients.

The client centred therapy is based on respect for the client, on the establishment of an empathic bond and on the willingness of the counsellor to be open and genuine with the client. In addition to these qualities, there is also an emphasis on facilitating each client's growth or self-actualisation which can be achieved only in the presence of core conditions.

The counselling skills which are essential for the development of a therapeutic relationship between counsellor and client are:

- Active listening
- Responding to clients through reflection of feeling and content
- Paraphrasing and summarising
- Asking open questions
- Responding appropriately to silence and client non- verbal communication

Silence, acceptance, restatement, empathy and immediacy responses occur most frequently with the client taking the lead on what is discussed and being responsible for outcomes. Client centred therapists encourage careful self exploration but they tend to avoid confrontation and interpretation as tools for hastening insight.

The possibility of transference reactions is acknowledged in client centered therapy but they are not highlighted by the counsellors as they become hindrance in helping the clients achieve independence and autonomy. Similarly, the concept of unconscious motivation is also acknowledged in client centred therapy but counsellors do not focus on it or directly ask the client to work with dreams. But as the therapy is person centred, if clients wish to look at dreams or unconscious, they are at liberty to do.

There is little focus on specific action planning except as initiated by the client. It is assumed that as the client becomes free to actualise his potential through the exploration process, behaviour change will occur naturally and without prompting from the counsellor.

## 1.6 INTERVENTION STRATEGIES

The person centered therapy has certain distinctive components and these are given below:

- Therapist's attitude can be necessary and sufficient conditions for change.
- Therapist needs to be immediately present and accessible to clients.
- Intensive, continuous focus on patient's phenomenological world.
- Process marked by client's ability to live fully in the moment.
- Focus on personality change, not structure of personality.

### 1.6.1 Rogerian View of Psychotherapy

- Implied Therapeutic Conditions.
- Client and therapist must be in psychological contact.
- Client must experience distress.
- Client must be willing to receive conditions offered by therapist.

### 1.6.2 Process of Person Centered Therapy

Therapy begins at first contact.In the first interview, a person centered therapist will go where the client goes. For Carl Rogers, empathy, unconditional positive regard, and congruence. (genuineness) were the 3 basic requirements to create a therapeutic environment.

Respect shown immediately for client. In addition to the basic requirements of the therapeutic environment for the therapist, Rogers believed the client must focus on self-concept, locus-of-evaluation and experiencing. Therapy's length is determined by client (In person centered therapy termination is decided by the client).

Quick suggestions and reassurances are avoided.

Empathy involves understanding another individual by "living" in their internal frame of reference.

Person centered therapists believe that empathy, unconditional positive regard, and congruence are necessary and sufficient conditions for therapeutic change.

Congruence as stated above is a correspondence between the thoughts and the behaviour of a therapist. This is very essential if intervention has to be effective. Client centered therapy focuses most heavily on the present. A successful person centered therapy outcome would be defined by the client's evaluation that therapy was beneficial.

### 1.6.3 Therapist's Role and Functions

**Role:** Therapist's attitude and belief in the inner resources of the client, not in techniques, facilitate personal change in the client.

i) Use of self as an instrument of change.

ii) Focuses on the quality of the therapeutic relationship.

iii) Serves as a model of a human being struggling toward greater realness.

iv) Is genuine, integrated, and authentic.

v) Can openly express feelings and attitudes that are present in the relationship with the client.

**Functions:** to be present and accessible to clients, to focus on immediate experience, to be real in the relationship with clients.

Through the therapist's attitude of genuine caring, respect, acceptance, and understanding, clients become less defensive and more open to their experience and facilitate the personal growth.

### 1.6.4 Therapy/ Intervention Goals

The goals are as given below:

i) Helping a person become a fully functioning person.

ii) Clients have the capacity to define their goals.

iii) An openness to experience.

iv) A trust in themselves.

v) An internal source of evaluation.

vi) A willingness to continue growing.

### 1.6.5 Client's Experience in Therapy

Incongruence: discrepancy between self-perception and experience in realityà anxietyà motivation to help.

As clients feel understood and accepted, their defensiveness is less necessary and they become more open to their experiences.

- Therapeutic relationship activate clients' self-healing capacities.
- Relationship between Therapist and Client.
- Emphasises the attitudes and personal characteristics of the therapist and the quality of therapeutic relationship.
- Therapist listening in an accepting way to their clients, they learn how to listen acceptingly to themselves.

### 1.6.6 Relationship between Therapist and Client

A central variable related to progress in person-centered therapy is the relationship between therapist and client.

- A person-centered therapist is a facilitator.
- It is not technique-oriented.
- A misunderstanding—this approach is simply to restate what the client just said or the technique of reflection of feelings (It is incorrect).
- The therapeutic relationship is the primary agent of growth in the client.
- Therapist's presence: being completely engaged in the relationship with clients.
- The best source of knowledge about the client is the individual client.
- Caring confrontations can be beneficial.

### 1.6.7 Contribution of Person Centered Therapy

- Active role of responsibility of client.
- Inner and subjective experience.
- Relationship-centered.
- Focus on therapist's attitudes.
- Focus on empathy, being present, and respecting the clients' values.
- Value multicultural context.

### 1.6.8 Summary and Evaluation

**Limitation**

- Discount the significance of the past.
- Misunderstanding the basic concept: e.g., reflection feelings.
- People in crisis situations often need more directive intervention strategies.
- Client tends to expect a more structured approach.

### 1.6.9 Being Genuine

Client centred therapists need to be knowledgeable about themselves and comfortable with this information. They must be more congruent than their clients. Being genuine does not mean sharing every thought or feeling with the client. It means being a helpful, attentive, caring person who is truly interested in the client and able to demonstrate that interest.

### 1.6.10 Active Listening

The first technique emphasised in client – centered therapy is active listening and its reflection of content and feelings. Demonstrating empathy for the client requires highly attentive and interactive listening skills. The physical steps common to this are facing the clients, leaning toward them and making good eye contact. This position and the use of facial and body expressions that relate to the client's comments will at least initially put the therapists and clients in physical contact. Then the therapists hear and see what is communicated. Both the words and the actions of the client are used to develop an understanding of the content and feelings being presented.

Taking in information is only the first part of active listening. Therapists must then reflect the content and feelings of clients back to them to have value. For example, 'I hear you saying.....," "so you are feeling......" and "you seem to be feeling.... because of..." are the ways counsellors and therapists explore with the client how accurate their empathy is.

The process of active listening helps both counsellor and client clarify the content and feelings of a situation and is a learning process for each participant. Therapists who can treat their own mistakes and growth during this learning process in a genuine manner also help clients accept their uncertainties and weaknesses.

### 1.6.11 Reflection of Content and Feelings

The first step in the empathy exploration process tends to be the recognition and reflection of the actual words stated and the feelings that are most obvious. As client and therapist get to know each other better, an effective therapist would be better able to see behind these surface interactions and begins to see and convey feelings clients do not even recognise they are expressing. Describing to the client what has been recognised is like an extended listening, observing and reflecting of the person's world. Reflection can also bring together complex elements of the client's world that draw a more accurate picture of the client as a whole than the individual elements that provide.

### 1.6.12 Appropriate Self - Disclosure

A genuine relationship enables the client to see relevant parts of the therapist's phenomenological world as well as the client's world. Appropriate self disclosure allows clients to compare their views of the world with the view of another individual whom they have come to trust and value as a significant human being. These comparisons give clients the chance to review and revise their views based on information they might otherwise not have had available or which has been too threatening to accept. The supportive relationship allows the client to try out new thoughts and behaviours at the rate and in a manner most appropriate for them.

### 1.6.13 Immediacy

Immediacy provides a here – and - now approach to the relationship in general and to feelings in particular. The relationship between the therapist and the client is seen as the most important therapeutic factor in part because it is available for immediate examination. Therefore, the feelings that both client and therapist are currently experiencing are often the most therapeutic ones available. Statements that receive primary emphasis are ones like "How are you feeling now?" and "your statements make me feel .....". On the other hand, statements seen as less therapeutically useful might be "Why did you feel that way?" "What did the other person think?" or what did you believe then?'

A major reason for client centered therapist's emphasis on the here and now is that reactions between client and counsellor or therapist can be verified, checked and explored immediately by both participants.

**Case Study**

Sunil, a 30 year old young man was graduated in engineering. He is divorced and no children. He changed three different jobs in 5 years. He approached for counselling as he feels that he has difficulty in having good interpersonal relationships. He found that he cannot interact positively with people and gets easily irritated by others.

The client centered therapist acts as a helper and the main responsibility in the counselling process has to be taken by the client. The first task of the counsellor is building relationship with the client in order to develop trust. At the same time he is encouraged to believe in himself – that he has the capacity to get along with others and to make friends. Instead of relying on case histories, analysis in a traditional sense, probing and questioning, the focus should be on building a relationship that is facilitative.

**Self Assessment Questions**

1) Discuss the various intervention strategies in client centered therapy.

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2) Describe cognitive view of psychotherapy.

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3) Elucidate the roles and unctions of therapist in client centered therapy.

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4) What important does therapist clinet relationship has?

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5) Discuss being genuine, active listening reflecting contents and feelings as part of therapy.

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## 1.7 CLIENTS WHO CAN BENEFIT

This therapy has wide application within the helping professions, voluntary sector, human relations training, group work, education and institutional settings where the goals are to foster good interpersonal skills and respect for others.

This therapy is also useful in dealing with the clients in the first stage of crisis.

Women clients would benefit from this therapy as they are encouraged to consider and identify their own feelings and needs, which many women may never been able to do before.

People with relationship difficulties would also benefit as the client centered therapist gives them respect, understanding and openness which they may not have experienced in everyday life.

The principles of the person centered approach have been applied to a variety of therapeutic situations including marriage counselling and family therapy.

Many self help groups like Alcoholic Anonymous extend core conditions of respect, understanding and openness for people who want to change.

## 1.8 LIMITATIONS

Success is dependent on counsellors and therapists maintaining high trust in the feelings and actions of the client and themselves. Lack of trust often causes therapists to rely on passive reflection responses. These are necessary but become inadequate as the need for a more comprehensive therapeutic relationship develops which includes directness that comes with culturally, situational and personally relevant feelings and interactions.

## 1.9 LET US SUM UP

The client centred model is optimistic in its view of humankind. Clients are seen as basically good and possessing the capabilities for self – understanding, insight, problem solving, decision making, change and growth.

The counsellor's role is that of a facilitator and reflector. The counsellor facilitates a counselee's self understanding and clarifies back to the client the expressed feelings and attitudes of the client. In this therapy, giving information for problem solving is not usually considered a counsellor responsibility. The counsellor would

not seek to direct the mediation of the counselee's inner world but provides a climate in which the counselee could bring about change in himself.

The core conditions of counselling as described by Rogers are empathy, unconditional positive regard and congruence or genuineness which are considered necessary and sufficient for therapeutic personality change.

The counselling skills which are essential for the development of a therapeutic relationship between counsellor and client are active listening, responding to clients through reflection of feeling and content, paraphrasing and summarising, asking open questions and responding appropriately to silence and client non-verbal communication. Silence, acceptance, restatement, empathy and immediacy responses occur most frequently with the client taking the lead on what is discussed and being responsible for outcomes. Client centred therapists encourage careful self exploration but they tend to avoid confrontation and interpretation as tools for hastening insight.

## 1.10 UNIT END QUESTIONS

1) Discuss human nature as a view point from Roger's therapy angle.
2) Elucidate goals of client centered therapy and delineate the counselling process.
3) Discuss the various counselling process of client centered therapy.
4) Explain the importance of relationship between client and therapist.
5) Elucidate the intervention strategies.
6) What are the limitations of the client centered therapy?

## 1.11 SUGGESTED READINGS

Capuzzi, D. &Gross,D.R.(1999). *Counselling and Psychotherapy: Theories and Interventions*. Second edition. Merrill, Columbus, Ohio.

Gibson,R.L. & Mitchell,M.H. (1995) *Introduction to Counseling and Guidance*. Fifth edition.Merrill, Columbus, Ohio.

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# UNIT 2 FAMILY AND GROUP PSYCHOTHERAPY

**Structure**

2.0 Introduction
2.1 Objectives
2.2 Nature and Definition of Family Therapy
  2.2.1 History and Theoretical Frameworks of Family Therapy
  2.2.2 Techniques of Family Therapy
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## 2.0 INTRODUCTION

Family therapy, also referred to as couple and family therapy and family systems therapy, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members. It emphasises family relationships as an important factor in psychological health.

The different schools of family therapy have in common, a belief, that regardless of the origin of the problem, and regardless of whether the clients consider it an

"individual" or "family" issue, involving families in solutions is often beneficial. This involvement of families is commonly accomplished by their direct participation in the therapy session. The skills of the family therapist thus include the ability to influence conversations in a way that catalyses the strengths, wisdom, and support of the wider system.

In early years of the development of the field, many clinicians defined the family in a narrow, traditional manner usually including parents and children. As the field has evolved, the concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood or marriage.

Family therapy has been used effectively in the full range of human dilemmas. There is no category of relationship or psychological problem that has not been addressed with this approach. The conceptual frameworks developed by family therapists, especially those of family systems theorists, have been applied to a wide range of human behaviour, including organisational dynamics. In this unit we will be dealing with family and group therapy. We will trace the historical framework of family therapy, present the techniques of family therapy and discuss the various techniques of family therapy. We then deal with models of family therapy and delve deeply into group psychotherapy.

## 2.1 OBJECTIVES

After reading this unit, you will be able to:

- Understand the following aspects related to family and group psychotherapy:
- History and Theoretical Frameworks of Family Therapy;
- Techniques of Family Therapy;
- Models of Family Therapy;
- History of Group Psychotherapy; and
- Therapeutic principles and settings.

## 2.2 NATURE AND DEFINITION OF FAMILY THERAPY

Family therapy refers to the joint treatment of two or more members of the same family in order to change unhealthy patterns of communication and interaction. Family therapy is generally initiated because of psychological or emotional problems experienced by a single family member, often a child or adolescent. These problems are treated as symptomatic of dysfunction within the family system as a whole. The therapist focuses on the interaction between family members, analysing the role played by each member in maintaining the system. Family therapy can be especially helpful for dealing with problems that develop in response to a particular event or situation, such as divorce or remarriage, or the birth of a new sibling. It can also be an effective means to draw individuals who feel threatened by individual therapy into a therapeutic setting.

### 2.2.1 History and Theoretical Frameworks of Family Therapy

Formal interventions with families to help individuals and families experiencing various kinds of problems have been a part of many cultures, probably throughout history. These interventions have sometimes involved formal procedures or rituals, and often included the extended family as well as non-kin members of the community. These interventions were often conducted by particular members of a community – for example, a chief, priest, physician and so on – usually as an ancillary function.

*Family therapy* as a distinct professional practice had its origins in the social work movements of the 19th century in England and the United States. As a branch of psychotherapy, its roots can be traced somewhat later to the early 20th century with the emergence of the *child guidance* movement and *marriage counseling*. The formal development of family therapy dates to the 1940s and early 1950s with the founding in 1942 of the *American Association of Marriage Counselors* and through the work of various independent clinicians and groups – in England (John Bowlby), the US (John Bell, Nathan Ackerman, Christian Midelfort, Theodore Lidz, Lyman Wynne, Murray Bowen, Carl Whitaker, Virginia Satir), and Hungary (D.L.P. Liebermann) – who began seeing family members together for observation or therapy sessions. There was initially a strong influence from psychoanalysis (most of the early founders of the field had psychoanalytic backgrounds) and social psychiatry, and later from learning theory and behaviour therapy – and significantly, these clinicians began to articulate various theories about the nature and functioning of the family as an entity that was more than a mere aggregation of individuals.

The movement received an important boost in the mid-1950s through the work of anthropologist Gregory Bateson and colleagues – Jay Haley, Donald D. Jackson, John Weakland, William Fry, and later, Virginia Satir, Paul Watzlawick and others – at Palo Alto in the US, who introduced ideas from cybernetics and general systems theory into social psychology and psychotherapy, focusing in particular on the role of communication.

This group was also influenced significantly by the work of US psychiatrist, hypnotherapist, and brief therapist, Milton H. Erickson - especially his innovative use of strategies for change, such as *paradoxical directives*. The members of the Bateson Project had a particular interest in the possible psychosocial causes and treatment of schizophrenia, especially in terms of the putative "meaning" and "function" of signs and symptoms within the family system.

The research of psychiatrists and psychoanalysts Lyman Wynne and Theodore Lidz on *communication deviance* and *roles* (e.g., *pseudo-mutuality*, *pseudo-hostility*, *schism* and *skew*) in families of also became influential with *systems-communications*-oriented theorists and therapists. A related theme, applying to dysfunction and psychopathology more generally, was that of the "identified patient" or *"presenting problem"* as a manifestation of or surrogate for the family's or even society's problems.

By the mid-1960s a number of distinct schools of family therapy had emerged. From those groups that were most strongly influenced by cybernetics and systems theory, there came MRI Brief Therapy, and slightly later, strategic therapy, Salvador Minuchin's *Structural Family Therapy* and the Milan systems model.

Partly in reaction to some aspects of these *systemic* models, came the *experiential* approaches of Virginia Satir and Carl Whitaker, which downplayed theoretical constructs, and emphasised subjective experience and unexpressed feelings (including the subconscious), authentic communication, spontaneity, creativity, total therapist engagement, and often included the extended family.

Concurrently and somewhat independently, there emerged the various *intergenerational* therapies of Murray Bowen, Ivan Böszörményi-Nagy, James Framo, and Norman Paul, which present different theories about the intergenerational transmission of health and dysfunction, but which all deal usually with at least three generations of a family either directly in therapy sessions, or via *"homework"*, *"journeys home"*, etc.

**Psychodynamic Family Therapy**

This, more than any other school of family therapy, deals directly with individual psychology and the unconscious in the context of current relationships - continued to develop through a number of groups that were influenced by the ideas and methods of Nathan Ackerman, and also by the *British School* of Object Relations and John Bowlby's work on attachment.

**Multiple-Family Group Therapy**

This is a precursor of *psychoeducational family intervention*, emerged, in part, as a pragmatic alternative form of intervention – especially as an adjunct to the treatment of serious mental disorders with a significant biological basis, such as schizophrenia - and represented something of a conceptual challenge to some of the *"systemic"* (and thus potentially "family-blaming") paradigms of pathogenesis that were implicit in many of the dominant models of family therapy.

The late-1960s and early-1970s saw the development of *network therapy* by Ross Speck and Carolyn Attneave, and the emergence of *behavioural marital therapy* (renamed *behavioural couples therapy* in the 1990s) and *behavioural family therapy* as models in their own right.

By the late-1970s the weight of clinical experience – especially in relation to the treatment of serious mental disorders – had led to some revision of a number of the original models and a moderation of some of the earlier stridency and theoretical purism.

There were the beginnings of a general softening of the strict demarcations between schools, with moves toward rapprochement, integration, and eclecticism – although there was, nevertheless, some hardening of positions within some schools. However, there was a growing willingness and tendency on the part of family therapists to work in multi-modal clinical partnerships with other members of the helping and medical professions.

From the mid-1980s to the present, the field has been marked by a diversity of approaches that partly reflect the original schools, but which also draw on other theories and methods from individual psychotherapy. These approaches and sources include brief therapy, structural therapy, constructivist approaches (e.g., Milan systems, *post-Milan/collaborative/conversational*, *reflective*), solution-focused therapy, narrative therapy, a range of cognitive and behavioural approaches, psychodynamic and object relations approaches, attachment and

Emotionally Focused Therapy, *intergenerational* approaches, *network therapy*, and multisystemic therapy (MST). Multicultural, intercultural, and integrative approaches are also being developed.

Many practitioners claim to be "eclectic," using techniques from several areas, depending upon their own inclinations and/or the needs of the client(s), and there is a growing movement toward a single "generic" family therapy that seeks to incorporate the best of the accumulated knowledge in the field and which can be adapted to many different contexts. However, there are still a significant number of therapists who adhere more or less strictly to a particular or limited number of approaches.

### 2.2.2 Techniques of Family Therapy

Family therapy uses a range of counseling and other techniques including:

- communication theory
- media and communications psychology
- psychoeducation
- psychotherapy
- relationship education
- systemic coaching
- systems theory
- reality therapy

The number of sessions depends on the situation, but the average is 5-20 sessions. A family therapist usually meets several members of the family at the same time. This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family.

These patterns frequently mirror habitual interaction patterns at home, even though the therapist is now incorporated into the family system. Therapy interventions usually focus on relationship patterns rather than on analysing impulses of the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do - although some schools of family therapy, for example *psychodynamic* and *intergenerational*, do consider such individual and historical factors (thus embracing both *linear* and *circular* causation) and they may use instruments such as the genogram to help to elucidate the patterns of relationship across generations.

The distinctive feature of family therapy is its perspective and analytical framework rather than the number of people present at a therapy session. Specifically, family therapists are relational therapists. They are generally more interested in what goes on *between* individuals rather than *within* one or more individuals, although some family therapists—in particular those who identify as psychodynamic, object relations, *intergenerational*, EFT, or *experiential* family therapists—tend to be as interested in individuals as in the *systems* those individuals and their relationships constitute. Depending on the conflicts at issue and the progress of therapy to date, a therapist may focus on analysing specific previous instances of conflict, as by reviewing a past incident and suggesting

alternative ways family members might have responded to one another during it, or instead proceed directly to addressing the sources of conflict at a more abstract level, as by pointing out patterns of interaction that the family might have not noticed.

Family therapists tend to be more interested in the maintenance and/or solving of problems rather than in trying to identify a single cause. Some families may perceive cause-effect analyses as attempts to allocate blame to one or more individuals, with the effect that for many families a focus on causation is of little or no clinical utility.

### 2.2.3 Values and Ethics in Family Therapy

Since issues of interpersonal conflict, power, control, values, and ethics are often more pronounced in relationship therapy than in individual therapy, there has been debate within the profession about the different values that are implicit in the various theoretical models of therapy and the role of the therapist's own values in the therapeutic process, and how prospective clients should best go about finding a therapist whose values and objectives are most consistent with their own. Specific issues that have emerged have included an increasing questioning of the longstanding notion of *therapeutic neutrality*, a concern with questions of justice and self-determination, connectedness and independence, "functioning" versus "authenticity", and questions about the degree of the therapist's "pro-marriage/family" versus "pro-individual" commitment.

**Self Assessment Questions**

1) Explain the concept of family therapy.

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2) Discuss the theoretical frameworks of family therapy.

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### 2.2.4 Models of Family Therapy

There are many models of family therapy and these are presented in the table below.

**Models of Family Therapy**

| Theoretical Model | Theorists | Summary | Techniques |
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| Adlerian Family Therapy | Alfred Adler | Also known as "Individual Psychology". Sees the person as a whole. Ideas include compensation for feelings of inferiority leading to striving for significance toward a fictional final goal with a private logic. Birth order and mistaken goals are explored to examine mistaken motivations of children and adults in the family constellation. | Psychoanalysis, Typical Day, Reorienting, Re-educating |
| Attachment Theory | John Bowlby, Mary Ainsworth | Individuals are shaped by their experiences with caregivers in the first three years of life. Used as a foundation for Object Relations Theory. The Strange Situation experiment with infants involves a systematic process of leaving a child alone in a room in order to assess the quality of their parental bond. | Psychoanalysis, Play Therapy |
| Bowenian Family Systems | Murray Bowen, Betty Carter, Philip Guerin, Michael Kerr, Thomas Fogarty, Monica McGoldrick, Edwin Friedman, Daniel Papero | Also known as "Intergenerational Family Therapy" (although there are also other schools of intergenerational family therapy). Family members are driven to achieve a balance of internal and external differentiation, causing anxiety, triangulation, and emotional cut-off. Families are affected by nuclear family emotional processes, sibling positions and multigenerational transmission patterns resulting in an undifferentiated family ego mass. | Detriangulation, Nonanxious Presence, Genograms, Coaching |
| Cognitive Behavioural Family Therapy | John Gottman, Albert Ellis, Albert Bandura | Problems are the result of operant conditioning that reinforces negative behaviours within the family's interpersonal social exchanges that extinguish desired behaviour and promote incentives toward unwanted behaviours. This can lead to irrational beliefs and a faulty family schema. | Therapeutic Contracts, Modelling, Systematic Desensitisation, Shaping, Charting, Examining Irrational Beliefs |
| Collaborative Language Systems | Harry Goolishian, Harlene Anderson, Tom Andersen, Lynn Hoffman, | Individuals form meanings about their experiences within the context of social relationship on a personal and organisational level. Collaborative therapists help families reorganise and dissolve their perceived problems through a transparent dialogue about inner thoughts with a "not-knowing" stance intended to illicit new meaning through | Dialogical Conversation, Not Knowing, Curiosity, Being Public, Reflecting Teams |

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| | Peggy Penn | conversation. Collaborative therapy is an approach that avoids a particular theoretical perspective in favour of a client-centered philosophical process. | |
| Communications Approaches | Virginia Satir, John Banmen, Jane Gerber, Maria Gomori | All people are born into a primary survival triad between themselves and their parents where they adopt survival stances to protect their self-worth from threats communicated by words and behaviours of their family members. Experiential therapists are interested in altering the overt and covert messages between family members that affect their body, mind and feelings in order to promote congruence and to validate each person's inherent self-worth. | Equality, Modeling Communication, Family Life Chronology, Family Sculpting, Metaphors, Family Reconstruction |
| Contextual Therapy | Ivan Boszormenyi Nagy | Families are built upon an unconscious network of implicit loyalties between parents and children that can be damaged when these "relational ethics" of fairness, trust, entitlement, mutuality and merit are breached. | Rebalancing, Family Negotiations, Validation, Filial Debt Repayment |
| Emotion-Focused Therapy | Sue Johnson, Les Greenberg | Couples and families can develop rigid patterns of interaction based on powerful emotional experiences that hinder emotional engagement and trust. Treatment aims to enhance empathic capabilities of family members by exploring deep-seated habits and modifying emotional cues. | Reflecting, Validation, Heightening, Reframing, Restructuring |
| Experiential Family Therapy | Carl Whitaker, David Kieth, Laura Roberto, Walter Kempler, John Warkentin, Thomas Malone, August Napier | Stemming from Gestalt foundations, change and growth occurs through an existential encounter with a therapist who is intentionally "real" and authentic with clients without pretense, often in a playful and sometimes absurd way as a means to foster flexibility in the family and promote individuation. | Battling, Constructive Anxiety, Redefining Symptoms, Affective Confrontation, Co-Therapy, Humor |
| Feminist Family Therapy | Sandra Bern, | Complications from social and political disparity between genders are identified as underlying causes of conflict within a family system. Therapists are encouraged to be aware of these influences in order to avoid perpetuating hidden oppression, biases and cultural stereotypes and to model an egalitarian perspective of healthy family relationships. | Demystifying, Modeling, Equality, Personal Accountability |

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| Milan Systemic Family Therapy | Luigi Boscolo, Gianfranco Cecchin, Mara Selvini Palazzoli, Giuliana Prata | A practical attempt by the "Milan Group" to establish therapeutic techniques based on Gregory Bateson's cybernetics that disrupts unseen systemic patterns of control and games between family members by challenging erroneous family beliefs and reworking the family's linguistic assumptions. | Hypothesising, Circular Questioning, Neutrality, Counterparadox |
| Medical Family Therapy | Goerge Engel, Susan McDaniel, Jeri Hepworth & William Doherty | Families facing the challenges of major illness experience a unique set of biological, psychological and social difficulties that require a specialised skills of a therapist who understands the complexities of the medical system, as well as the full spectrum of mental health theories and techniques. | Grief Work, Family Meetings, Consultations, Collaborative Approaches |
| MRI Brief Therapy | Gregory Bateson, , Heinz von Foerster | Established by the Mental Research Institute (MRI) as a synthesis of ideas from multiple theorists in order to interrupt misguided attempts by families to create first and second order change by persisting with "more of the same," mixed signals from unclear metacommunication and paradoxical double-bind messages. | Reframing, Prescribing the Symptom, Relabeling, Restraining (Going Slow), Bellac Ploy |
| Narrative Therapy | Michael White, David Epston | People use stories to make sense of their experience and to establish their identity as a social and political constructs based on local knowledge. Narrative therapists avoid marginalising their clients by positioning themselves as a co-editor of their reality with the idea that "the person is not the problem, but the problem is the problem." | Deconstruction, Externalising Problems, Mapping, Asking Permission |
| Object Relations Therapy | Hazan & Shaver, David Scharff & Jill Scharff, James Framo, | Individuals choose relationships that attempt to heal insecure attachments from childhood. Negative patterns established by their parents (object) are projected onto their partners. | Detriangulation, Co-Therapy, Psychoanalysis, Holding Environment |
| Psychoanalytic Family Therapy | Nathan Ackerman | By applying the strategies of Freudian psychoanalysis to the family system therapists can gain insight into the interlocking psychopathologies of the family members and seek to improve complementarity | Psychoanalysis, Authenticity, Joining, Confrontation |
| Solution Focused Therapy | Kim Insoo Berg, Steve de Shazer, William O'Hanlon, Michelle Weiner-Davis, Paul Watzlawick | The inevitable onset of constant change leads to negative interpretations of the past and language that shapes the meaning of an individual's situation, diminishing their hope and causing them to overlook their own strengths and resources. | Future Focus, Beginner's Mind, Miracle Question, Goal Setting, Scaling |

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| Strategic Therapy | Jay Haley, Cloe Madanes | Symptoms of dysfunction are purposeful in maintaining homeostasis in the family hierarchy as it transitions through various stages in the family life cycle. | Directives, Paradoxical Injunctions, Positioning, Metaphoric Tasks, Restraining (Going Slow) |
| Structural Therapy | Salvador Minuchin, Harry Aponte, Charles Fishman, Braulio Montalvo | Family problems arise from maladaptive boundaries and subsystems that are created within the overall family system of rules and rituals that governs their interactions. | Joining, Family Mapping, Hypothesising, Reenactments, Reframing, Unbalancing |

## 2.3 GROUP PSYCHOTHERAPY

Group psychotherapy or group therapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. The term can refer to any form of psychotherapy when delivered in a group format, including cognitive behavioural therapy or interpersonal therapy but it is usually applied to psychodynamic group therapy where the group context and group process is explicitly utilised as a mechanism of change by developing, exploring and examining interpersonal relationships within the group.

The broader concept of *group therapy* refers to any helping process that takes place in a group, including support groups, skills training groups (such as anger management, mindfulness, relaxation training or social skills training), and psycho-education groups. The differences between psychodynamic groups, activity groups, support groups, problem-solving and psycoeducational groups are discussed by Montgomery (2002). Other, more specialised forms of group therapy would include non-verbal expressive therapies such as dance therapy, music therapy or the TaKeTiNa Rhythm Process.

### 2.3.1 Group Therapy Vs. Individual Therapy

Group therapy is different from individual therapy in a number of ways, with the most obvious difference being the number of people in the room with the psychologist. Originally, group therapy was used as a cost-saving measure, in institutional settings where many people needed psychological treatment and there were too few psychologists to provide the treatment. However, in conducting research on the effectiveness of these therapy groups, psychologists discovered that the group experience benefited people in many ways that were not always addressed in individual psychotherapy. Likewise, it was also discovered that some people did not benefit from group therapy.

The aim of group psychotherapy is to help with solving the emotional difficulties and to encourage the personal development of the participants in the group. The therapist (called conductor, leader or facilitator) chooses as candidates for the group people who can benefit from this kind of therapy and those who may have a useful influence on other members in the group.

### 2.3.2 History of Group Psychotherapy

The founders of group psychotherapy in the USA were Joseph H. Pratt, Trigant Burrow and Paul Schilder. After World War II group psychotherapy was further developed by Jacob L. Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Ormont. Yalom's approach to group therapy has been very influential not only in the USA but across the world, through his classic text *"The Theory and Practice of Group Psychotherapy"*. Moreno developed a specific and highly structured form of group therapy known as Psychodrama.

In the United Kingdom group psychotherapy initially developed independently, with pioneers S. H. Foulkes and Wilfred Bion using group therapy as an approach to treating combat fatigue in the Second World War. Foulkes and Bion were psychoanalysts and incorporated psychoanalysis into group therapy by recognising that transference can arise not only between group members and the therapist but also among group members. Furthermore the psychoanalytic concept of the unconscious was extended with recognition of a group unconscious, in which the unconscious processes of group members could be acted out in the form of irrational processes in group sessions.

### 2.3.3 Therapeutic Principles

Yalom's therapeutic factors (originally termed *curative factors)* are derived from extensive self-report research with users of group therapy.

**Universality:** The recognition of shared experiences and feelings among group members and that these may be widespread or universal human concerns, serves to remove a group member's sense of isolation, validate their experiences, and raise self-esteem.

**Altruism:** The group is a place where members can help each other, and the experience of being able to give something to another person can lift the member's self esteem and help develop more adaptive coping styles and interpersonal skills.

**Instillation of hope:** In a mixed group that has members at various stages of development or recovery, a member can be inspired and encouraged by another member who has overcome the problems with which they are still struggling.

**Imparting information:** While this is not strictly speaking a psychotherapeutic process, members often report that it has been very helpful to learn factual information from other members in the group. For example, about their treatment or about access to services.

**Corrective recapitulation of the primary family experience:** Members often unconsciously identify the group therapist and other group members with their own parents and siblings in a process that is a form of transference specific to group psychotherapy. The therapist's interpretations can help group members gain understanding of the impact of childhood experiences on their personality, and they may learn to avoid unconsciously repeating unhelpful past interactive patterns in present-day relationships.

**Development of socialising techniques:** The group setting provides a safe and supportive environment for members to take risks by extending their repertoire of interpersonal behaviour and improving their social skills.

**Imitative behaviour:** One way in which group members can develop social skills is through a modeling process, observing and imitating the therapist and other group members. For example, sharing personal feelings, showing concern, and supporting others.

**Cohesiveness:** It has been suggested that this is the primary therapeutic factor from which all others flow. Humans are herd animals with an instinctive need to belong to groups, and personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging, acceptance, and validation.

**Existential factors:** It refers to the learning that one has to take responsibility for one's own life and the consequences of one's decisions.

**Catharsis:** Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.

**Interpersonal learning:** Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behaviour and impact on others.

**Self-understanding:** This factor overlaps with interpersonal learning but refers to the achievement of greater levels of insight into the genesis of one's problems and the unconscious motivations that underlie one's behaviour.

### 2.3.4 Settings

Group therapy can form part of the therapeutic milieu of a psychiatric in-patient unit. In addition to classical "talking" therapy, group therapy in an institutional setting can also include group-based expressive therapies such as drama therapy, psychodrama, art therapy, and non-verbal types of therapy such as music therapy. Group psychotherapy is a key component of Milieu Therapy in a Therapeutic Community. The total environment or milieu is regarded as the medium of therapy, all interactions and activities regarded as potentially therapeutic and are subject to exploration and interpretation, and are explored in daily or weekly community meetings.

In group therapy approximately 6-10 individuals meet face-to-face with a trained group therapist. During the group meeting time, members decide what they want to talk about.

Members are encouraged to give feedback to others. Feedback includes expressing your own feelings about what someone says or does. Interaction between group members are highly encouraged and provides each person with an opportunity to try out new ways of behaving; it also provides members with an opportunity for learning more about the way they interact with others. It is a safe environment in which members work to establish a level of trust that allows them to talk personally and honestly. Group members make a commitment to the group and are instructed that the content of the group sessions are confidential. It is not appropriate for group members to disclose events of the group to an outside person.

### 2.3.5 Construction of Therapy Groups

Therapy groups may be homogeneous or heterogeneous. Homogeneous groups have members with similar diagnostic backgrounds (for example, they may all suffer from depression). Heterogeneous groups contain a mix of individuals with different emotional problems. The number of group members typically ranges from five to 12.

### 2.3.6 Functioning of Therapy Groups

The number of sessions in group therapy depends upon the group's makeup, goals, and setting. Some are time limited, with a predetermined number of sessions known to all members at the beginning. Others are indeterminate, and the group and/or therapist determine when the group is ready to disband. Membership may be closed or open to new members. The therapeutic approach used depends on both the focus of the group and the therapist's orientation.

In group therapy sessions, members are encouraged to discuss the issues that brought them into therapy openly and honestly. The therapist works to create an atmosphere of trust and acceptance that encourages members to support one another. Ground rules may be set at the beginning, such as maintaining confidentiality of group discussions, and restricting social contact among members outside the group.

The therapist facilitates the group process, that is, the effective functioning of the group, and guides individuals in self-discovery. Depending upon the group's goals and the therapist's orientation, sessions may be either highly structured or fluid and relatively undirected. Typically, the leader steers a middle course, providing direction when the group gets off track, yet letting members set their own agenda. The therapist may guide the group by reinforcing the positive behaviours they engage in. For example, if one member shows empathy and supportive listening to another, the therapist might compliment that member and explain the value of that behaviour to the group. In almost all group therapy situations, the therapist will emphasise the commonalities among members to instill a sense of group identity.

Self-help or support groups like Alcoholics Anonymous and Weight Watchers fall outside of the psychotherapy realm. These groups offer many of the same benefits, including social support, the opportunity to identify with others, and the sense of belonging that makes group therapy effective for many. Self-help groups also meet to share their common concern and help one another cope. These groups, however, are typically leaderless or run by a member who takes on the leader role for one or more meetings. Sometimes self-help groups can be an adjunct to psychotherapy groups.

### 2.3.7 Referral of Patients to Group Therapy

Individuals are typically referred for group therapy by a psychologist or psychiatrist. Some may participate in both individual and group therapy. Before a person begins in a therapy group, the leader interviews the individual to ensure a good fit between their needs and the group's. The individual may be given some preliminary information before sessions begin, such as guidelines and ground rules, and information about the problem on which the group is focused.

### 2.3.8 Termination of Therapy Groups

Therapy groups end in a variety of ways. Some, such as those in drug rehabilitation programs and psychiatric hospitals, may be ongoing, with patients coming and going as they leave the facility. Others may have an end date set from the outset. Still others may continue until the group and/or the therapist believe the group goals have been met.

The termination of a long-term therapy group may cause feelings of grief, loss, abandonment, anger, or rejection in some members. The therapist attempts to deal with these feelings and foster a sense of closure by encouraging exploration of feelings and use of newly acquired coping techniques for handling them. Working through this termination phase is an important part of the treatment process.

### 2.3.9 Drop Outs of Group Therapy

Individuals who are emotionally fragile or unable to tolerate aggressive or hostile comments from other members are at risk of dropping out, as are those who have trouble communicating in a group setting. If the therapist does not support them and help reduce their sense of isolation and aloneness, they may drop out and feel like failures. The group can be injured by the premature departure of any of its members, and it is up to the therapist to minimize the likelihood of this occurrence by careful selection and management of the group process.

### 2.3.10 Effectiveness

Studies have shown that both group and individual psychotherapy benefit about 85% of the patients who participate in them. Ideally, patients leave with a better understanding and acceptance of themselves, and stronger interpersonal and coping skills. Some individuals continue in therapy after the group disbands, either individually or in another group setting.

**Self Assessment Questions**

1) Explain any two models of family therapy.

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2) Discuss theoretical principles of group therapy.

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## 2.4 ADVANTAGES OF GROUP THERAPY

1) When people come into a group and interact freely with other group members, they usually recreate those difficulties that brought them to group therapy in the first place. Under the direction of the group therapist, the group is able to give support, offer alternatives, and comfort members in such a way that these difficulties become resolved and alternative behaviours are learned.

2) The group also allows a person to develop new ways of relating to people.

3) During group therapy, people begin to see that they are not alone and that there is hope and help. It is comforting to hear that other people have a similar difficulty, or have already worked through a problem that deeply disturbs another group member.

4) Another reason for the success of group therapy is that people feel free to care about each other because of the climate of trust in a group.

## 2.5 TYPES OF GROUPS

There are many kinds of groups in the group-psychotherapy field. The techniques used in group therapy can be verbal, expressive, psycho dramatic etc. The approaches can vary from psychoanalytic to behavioural, Gestalt or encounter groups. Groups vary from classic psychotherapy groups, where process is emphasised, to psycho educational, which are closer to a class. Psycho educational groups usually focus on the most common areas of concern, notably relationships, anger, stress-management etc. They are frequently more time-limited (10 to 15 sessions) and thus very appealing in a managed care environment.Each approach has its advantages and drawbacks, and the participant should consult the expert which technique matches her/his unique personality. Some unique groups are:

### 2.5.1 T-Groups

These groups are training groups. These are relatively unstructured groups in which the participants become responsible for what they learn and how they learn it. A basic assumption appropriate to T- groups is that learning is more effective when the individual establishes authentic relationships with others.

### 2.5.2 Sensitivity Groups

It is a form of T-group that focuses on personal and interpersonal issues and on the personal growth of the individual. There is an emphasis in sensitivity groups on self – insight, which means that the central focus is not the group and its progress but, the individual member.

### 2.5.3 Encounter Groups

These groups are also in the T- group family, although they are more therapy oriented. This group stresses personal growth through the development and improvement of interpersonal relationships through an experiential group processes. Such groups seek to release the potential of the participant.

### 2.5.4 Marathon Groups

Extended encounter groups are often referred to as marathon groups. The marathon encounter group uses an extended block of time in which massed experience and accompanying fatigue are used to break through the participant's defenses. Though these groups offer great potential for the group members increased self – awareness and sensitivity to others, such groups can create high levels of anxiety and frustration. Therefore, it is essential that if encounter groups are to have maximum potential and minimal risk, they must be conducted by highly skilled and experienced counsellor leaders.

### 2.5.5 Task Groups

These groups are organised to meet organisational needs through task forces or other organisational groups or to serve individual needs of clients through such activities as social action groups. These groups are frequently useful to organisations seeking ways to improve their functioning. Task groups may be organised to assist clients in dealing with a wide range of needs from spiritual to educational.

### 2.5.6 Psycho Education Groups

These emphasise cognitive and behavioural skill development in groups structured to teach these skills and knowledge. These groups are more guidance in nature than counselling or therapy oriented.

### 2.5.7 Mini Groups

A minigroup usually consists of one counsellor and a maximum of four clients. Because of the smaller number of participants, the potential exists for certain advantages resulting from the more frequent and direct interaction of its members. Withdrawal by individuals and the development of factions or cliques are less likely in minigroups.

### 2.5.8 In Groups and Out Groups

These groups can be based on almost any criteria such as socioeconomic status, athletic or artistic accomplishments, a particular ability, etc. In-groups are characterised by associations largely limited with peers of like characteristics where as out groups consist of those excluded from in groups.

Social Networks: These result from the choices that individuals make in becoming members of various groups. As counsellors, we may be concerned with how these choices are made and their impacts on individuals.

## 2.6 LET US SUM UP

Family therapy has a variety of origins. It is related to the long-standing emphasis of psychoanalysis and other psychodynamic approaches on the central role that early family relationships play in the formation of personality and the manifestation of psychological disorders.

Family therapy, either alone or in conjunction with other types of treatment, has been effective in the treatment of children suffering from a variety of problems,

including anxiety, enuresis (bed-wetting), and eating disorders, and also in working with victims of child abuse. In addition to alleviating the child's initial complaint and improving communication within the family unit, family therapy can also help reduce stress and conflict by helping families improve their coping skills.

There are a number of approaches to family therapy. Perhaps the best known is structural family therapy, founded by Salvador Minuchin. It is a short-term method that focuses on the present rather than the past. This school of therapy views a family's behaviour patterns and rituals as central to the problems of its individual members. Poor communication skills play a key role in perpetuating destructive interactions within families, such as the formation of alliances among some family members against others. The goals of structural family therapy include strengthening parental leadership, clarifying boundaries, enhancing coping skills, and freeing family members from their entrenched positions within the family structure. Minuchin divided families' styles of interacting into two basic types—enmeshed and disengaged, considering behaviour at either extreme as pathological, with most families falling somewhere on a continuum between the two. Minuchin believed that the functioning of family systems prevented individuals from becoming healthier emotionally, because the family system relied on its troubled member to play a particular role in order to function in its accustomed way. This stability is disrupted if an individual changes significantly.

Psychodynamically oriented family therapy emphasises unconscious processes and unresolved conflicts in the parents' families of origin. The lasting effects of such traumatic experiences as parental divorce and child abuse are explored. This type of therapy focuses more on family history and less on symptoms, resulting in a lengthier therapeutic process. Therapists who employ an object relations approach emphasise the importance of having the parents in a family work out conflicts with their own parents. Some practitioners include grandparents in their work with families in order to better understand intergenerational dynamics and deeply rooted behaviour patterns. Ivan Boszormenyi-Nagy, a well-known proponent of this orientation, would only treat families when members of three generations could participate in therapy sessions.

Behavioural family therapy views interactions within the family as a set of behaviours that are either rewarded or punished. The behavioural therapist educates family members to respond to each others' behaviour with positive or negative reinforcement. A child might be discouraged from repeating a negative behaviour, for example, by losing some privileges or receiving a "time-out." Positive behaviour might be rewarded with the use of an incentive chart on which points or stickers are accrued and eventually exchanged for a reward. Behavioural approaches sometimes involve the drawing up of behavioural "contracts" by family members, as well as the establishment of rules and reinforcement procedures.

Several other family therapy approaches, including that of Virginia Satir, are primarily concerned with communication. Satir's system combines the teaching of family communication skills, the promotion of self-esteem and the removal of obstacles to the emotional growth so that family members can have full access to their innate resources.

Group therapy is a type of psychotherapy that involves one or more therapists working with several people at the same time. Group therapy sessions generally involve around seven to twelve individuals. The group typically meets once or twice each week for an hour or two. The minimum number of group therapy sessions is usually around six, but a full year of sessions is more common.

The specific manner in which the session is conducted depends largely on the goals of the group and the style of the therapist. Some therapists might encourage a more free-form style of dialogue, where each member participates as he or she sees fit. Other therapists might have a specific plan for each session that might include having clients practice new skills with other members of the group.

There are various types of group therapy; approaches include behaviour therapy, psychoanalytic therapy, sensitivity training, or Gestalt psychology. The composition of groups varies as well, with family therapy and marriage counseling common forms in recent years. Peer group therapy usually consists of a group of individuals who have similar problems, and can be mediated by a psychoanalyst or by the members themselves.

## 2.7 UNIT END QUESTIONS

1) Discuss different models of family therapy.
2) Explain the process of group psychotherapy.
3) What are the advantages of group therapy?

## 2.8 SUGGESTED READINGS

Ackerman, N.W. (1958). *The Psychodynamics of Family Life.* Basic Books: New York.

Ackerman, N.W. (1966). *Treating the Troubled Family.* Basic Books: New York.

Ackerman, N.W. (1970). *Family Process.* Basic Books: New York.

Minuchin, Salvador. *Family Therapy Techniques.* Cambridge: Harvard University Press, 1981.

Nichols, Michael P., and Richard C. Schwartz. *Family Therapy: Concepts and Methods.* Boston: Allyn and Bacon, 1991.

Satir, Virginia. *Conjoint Family Therapy.* Palo Alto, CA: Science and Behaviour Books, 1983.

Yalom, I. D., & Lesczc, M. (2005). *The theory and practice of group psychotherapy.* New York, NY: Basic Books

# UNIT 3 PSYCHODYNAMIC COUPLE THERAPY

**Structure**

3.0 Introduction
3.1 Objectives
3.2 Nature and Definition of Couples Therapy
3.3 Approaches to Couples Therapy
3.3.1 Psychodynamic Therapy and Couples Counselling
3.3.2 Systems Approach and Couple Counselling
3.3.3 Client Centered Therapy
3.3.4 Behavioural Approach
3.4 Psychodynamic Couples Therapy: An Object Relations Approach
3.4.1 Clinical Illustration and Analysis: Conflict as a Sale Haven
3.4.2 Projective Identification
3.4.3 Empathy
3.4.4 Transference
3.4.5 Clinical Illustration and Case Analysis
3.5 Use of Transference in Couples Therapy
3.5.1 Clinical Illustration and Case Analysis
3.5.2 The Frame of Object Relations Couples Therapy
3.6 Let Us Sum Up
3.7 Unit End Questions
3.8 Suggested Readings

## 3.0 INTRODUCTION

The emergence of conflict in a marriage or serious relationship does not necessarily signal disaster ahead. In fact, it might lead to a great opportunity for couples to work with a marriage and family therapist to strengthen the love relationship, restore trust in the relationship, and increase the possibilities for true intimacy.

Relationship problems are far more likely to develop during times of transition for couples and their families, such as when starting a new relationship, bringing a child into the family, dealing with a grandparent's death, or ending a relationship. Whether you hope to save a marriage, plan for a divorce, or sort out all the territory in between, a marriage and family therapist can be an objective source of support and information about love relationships. In this unit we will be dealing with nature and definition of couples therapy and follow it up with approaches to couples therapy. Under this we will discuss the psychodynamic approach, client centered approach, behavioural approach etc. Then we deal with psychodynamic couples therapy and discuss the use of transference in couples therapy.

## 3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the nature and definition of couples therapy;
- Approaches to couples therapy;
- Explain psychodynamic theory to couple counselling with case illustration;
- Process of psychodynamic couple therapy;
- Framework of object relations approach; and
- Discuss the use of transference in couple's therapy.

## 3.2 NATURE AND DEFINITION OF COUPLES THERAPY

The terms couples therapy, marriage counseling and marital therapy are all used interchangeably. These different names have been used to describe the same process, with the difference often based on which psychotherapy theory is favoured by the psychologist.

Couples therapy focuses on the problems existing in the relationship between two people. But, these relationship problems always involve individual symptoms and problems, as well as the relationship conflicts. For example, if you are constantly arguing with your spouse, you will probably also be chronically anxious, angry or depressed (or all three). Or, if you have difficulty controlling your temper, you will have more arguments with your partner.

In couples therapy, the psychologist will help you and your partner identify the conflict issues within your relationship, and will help you decide what changes are needed in the relationship and in the behaviour of each partner, for both of you to feel satisfied with the relationship.

These changes may be different ways of interacting within the relationship or they may be individual changes related to personal psychological problems. Couples therapy involves learning how to communicate more effectively, and how to listen more closely. Couples must learn how to avoid competing with each other, and need to identify common life goals and how to share responsibilities within their relationship. Sometimes the process is very similar to individual psychotherapy, sometimes it is more like mediation, and sometimes it is educational. The combination of these three components makes it effective.

## 3.3 APPROACHES TO COUPLES THERAPY

There are many different approaches to couples therapy, which may be used alone or combined with other methods by the therapist. Among the oldest is the psychodynamic approach, which attributes problems within a marriage to the unresolved conflicts and needs of each spouse. Each client's personal history and underlying motivations are central to this mode of therapy. Therapists using this approach apply the principles of psychoanalysis in their treatment; they may either treat both marriage partners individually, or treat one spouse in collaboration with another therapist who treats the other.

### 3.3.1 Psychodynamic Therapy and Couples Counseling

As the oldest of the modern therapies, psychodynamic therapy is based in a highly developed and multifaceted theory of human development and interaction. Psychodynamic therapy is an insight oriented approach that focuses on unconscious emotions that manifest in behaviour.

This approach is well suited for working with couples counseling because it works to identify emotions that manifest in behaviour, it allows the focus of the sessions to be on the unique situation of each individual client, and it takes into account how past relationship experiences affect current relationships.

One of the main goals of psychodynamic therapy is client self-awareness and understanding of how the past can influence present behaviour. It can help settle past conflicts as well as issues arising from past dysfunctional relationships. It is derived from the psychoanalytical method that Sigmund Freud researched. Freud felt that the human mind or psyche was made up of several different levels and that it is the unconscious mind which contains events from our past. He felt that forgotten experiences can still affect our present behaviour. In order to treat this, Freud developed a method by which memories and associations could be brought to the surface and examined in order to modify our current behaviour.

The therapeutic relationship in psychodynamic counseling is based on acceptance, empathy and understanding, with an emphasis on developing a good working alliance that fosters trusts. This relationship creates a safe environment that promotes healing.

### 3.3.2 Systems Approach and Couples Counseling

Marriage counseling that follows a systems approach stresses the interaction between partners as the origin of marital difficulties, rather than their actions or personality. Behaviour and communication patterns are analysed as well as the interlocking roles portrayed by the couple or members of the family. Family members may be conditioned to consistently play "the strong one" or "the weak one," or such other roles as "scapegoat," "caretaker," or "clown." Although initially it may seem that only one member of a family system is troubled, on closer inspection his or her difficulties are often found to be symptomatic of an unhealthy pattern in which all the members play an active part.

Systems theory is actually an umbrella term for a range of therapies, and systems-oriented counseling may take a variety of forms, including both short- and long-term therapy.

### 3.3.3 Client Centered Therapy

A popular individual treatment approach also used in marriage counseling is Rogerian or client-centered therapy, also referred to as humanistic therapy. Here, the emphasis is on communication and the open sharing of feelings. Through specially formulated exercises, couples work on improving their speaking and listening skills and enhancing their capacity for emotional honesty.

### 3.3.4 Behavioural Approach

Another widely employed mode of marriage counselling is based on a behavioural approach, in which marital problems are treated as dysfunctional behaviours

that can be observed and modified. Couples are made aware of destructive behaviour patterns, often by systematically recording their behaviour until certain patterns emerge. The therapist then coaches them in various modifying strategies with the goal of achieving positive, mutually reinforcing interactions.

Behaviour oriented therapy also focuses on improving a couple's problem-solving and conflict-resolution skills. Marriage counsellors may conduct therapy sessions with both spouses, treating one as the primary client and the other one only occasionally, while another therapist treats the other spouse. An increasing number of therapists counsel couples in pairs, with married therapists sometimes working together as a team. Theoretically, the relationship between the co-therapists is supposed to serve as a model for their clients. Marriage counselling in groups, which is becoming increasingly common, offers clients some of the same advantages that group therapy offers individuals.

**Self Assessment Questions**

1) Define couple therapy.

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2) Describe the nature of couple's therapy.

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3) Discuss the different approaches to couples counselling.

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4) Elucidate psychodynamic approach to couples counselling.

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5) What is systems approach to couple counselling?

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6) Discuss the application of behavioural approach in couples counselling.

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## 3.4 PSYCHODYNAMIC COUPLES THERAPY: AN OBJECT RELATIONS APPROACH

Object relations couples therapy is a psychoanalytically based method of couple treatment that integrates past with present, conscious with unconscious, and the intrapsychic with the interpersonal. The object relations approach helps couples discern how past life experiences as individuals can limit their possibilities in the present as a couple. It clarifies how unconscious processes can promote conflict and disappointment. It helps partners take ownership for how their individual perceptions, fears, and motivations may be shaping their interactions as a couple.

The most difficult aspect in couple's therapy is the observation of partners blaming each other. It is also a common observation that polarisations within the session in which each partner clings to an unambivalent point of view that is in exact opposition to that of the other.

In the following example from a marital session, I examine how our psychoanalytic approach informs a particular understanding of and intervention in such an argument.

### 3.4.1 Clinical Illustration and Analysis: Conflict as a Safe Haven

For Anitha and Vikram, after years of emotional distancing and conflict, a more friendly relation had gradually evolved during 1½ years of marital therapy. Physical intimacy, however, remained a remote and improbable goal. On the surface, Vikram appeared to be the spouse who sought a sexual connection whereas Anitha disavowed any desire. She blamed her lack of interest on the many ways she felt that Vikram disappointed her. He attributed his lack of sexual initiative to her episodes of hostility.

In the session, the couple opened with what appeared to be a regressive, angry argument, recalling to me the early months of our work. All the old familiar bones of contention were resurrected. Anitha "ragged" on Vikram for his failure to take good care of her by seeking out a higher-paying job. Vikram criticized Anitha for neglecting the needs of the children and letting the housekeeping go. The therapist discovered that the weekend before this fight began the couple had had "good family-together time," and that, more precisely, the retrograde conflict began shortly after the couple had "cuddled in bed." Vikram had drawn close to Anitha and she had responded. This degree of physical closeness had not occurred in ages. As the discussion deepened, therapist learned that, Anitha liked this "cuddling . . . but it also made me mad" because Vikram, she thought, would wrongly conclude she had forgiven him for all his transgressions. Internalising more and more, Anitha revealed that she had recently experienced an awakening sexual desire for Vikram and had asked him to "kiss and hug." She joked that she was afraid to have sex because she would have to talk about it in couples therapy. Anitha said she was reluctant to relinquish her "survival mode"—that is, her determination to depend only on herself and not to allow herself to rely on and come close to Vikram.

For Vikram's part, he admitted that he felt anxious when the couple hugged and kissed at Anitha 's request. She perceived this as a subtle sense of his distancing after their physical contact. Vikram then associated to his fear of being dependent on Anitha and to the death of both his parents when he was quite young.

These seemingly warring adversaries are sharing a common internal ambivalence over closeness, dependency, and intimacy. Their ordinary, consistent way of relating involves maintaining a distance, often hostile, which keeps at bay, for each of them, the anxieties that, would emerge from a more intimate connection. When they "cuddled in bed," Vikram was aware of anxiety, whereas Anitha found herself getting angry at him. With their usual equilibrium destabilised by the sexual contact, shared anxiety led them to dig up the familiar bones of contention and to restore, through arguing, their costly but safer distance.

The object relations couples therapist looks beyond the manifest content of an argument to understand the unconscious factors that may have triggered the conflict in the couples. Every marriage or intimate couple relationship is likely to have significant unresolved issues, bones of contention, which may be managed by compromise or simply tolerated and accepted as a difference, as in "we agreed to disagree." When these "bones" suddenly get reactivated in the relationship, we look for the possible triggers of this current conflict and focus on developing understanding of the underlying issues. This approach is quite different from those couples's therapies that focus entirely on the manifest content of the conflict—for example, with Anitha and Vikram, the therapist attending to complaints about poor housekeeping or not seeking more financial security with a higher-paying job.

### 3.4.2 Projective Identification

Interpersonal conflict reflects the transposition of intrapsychic conflict within each partner on to the couple relationship. The mental mechanism that is

responsible for this transformation is *projective identification,* the core concept of the object relations approach.

Melanie Klein (1946) defined projective identification as "a combination of splitting off parts of the self and projecting them onto another person," later describing it as "the feeling of identification with other people because one has attributed qualities or attributes of one's own to them". Klein saw this as a defensive mode evolving from an early infantile developmental stage in which anxiety is warded off by experiencing intolerable affects, especially aggression, as if they resided in a space external to the self. This defensive "splitting" thereby creates the first *"me–not me boundary."* As the infant matures, and a self–object boundary develops, the preobject *"not me"* realm fuses with the object world, and what is projected is now directed into the mental image of the other. However, what is projected, is not only the disavowed aspects of the self but also those aspects that are cherished.

Much before Klien, Sigmund Freud (1921) provided an example of projective identification in characterising the *"falsification of judgment"* that accompanies the idealisation of loved objects, what we refer to as falling "*head over heels"* in love. The tendency that falsifies judgment in this respect is that of idealisation, but now it is easier for us to find our bearings. We see that the object is being treated in the same way as our own ego, so that when we are in love a considerable amount of narcissistic libido overflows onto the object. It is even obvious, in many forms of love choice, that the object serves as a substitute for some unattained ego ideal of our own ego, and which we should now like to procure in this roundabout way as a means of satisfying our narcissism.

In a more modern and comprehensive view (Zinner 2001), we can say that projective identification is our universal way of perceiving and comprehending others. When we are interacting with another person, our behaviour toward that other is determined by our mental image of him or her. Our consequent behaviour impinges on and affects that other person, but the person we are relating to exists only within our mind as a construct. This created mental image of the other is built from sensory stimuli coming from the outside that are then processed by our own mental apparatus.

We never truly know the other person and what he or she feels. We can only approximate the actuality and subjectivity of the external object by drawing on our own experience and attempting to match it with what our senses are receiving from the outside. We unconsciously regard the actual object as the embodiment of our mental construct and treat him or her accordingly. This unconscious recognition of a projected aspect of our self in the object is the identification process in the mechanism of projective identification. Thus, in this definition, both projection *and* identification occur within the mind of one person, the subject. There appears to be, perhaps, a wired-in propensity to distance oneself from emotional pain by placing its source outside of the self, a generic process we refer to as *externalisation.* When our effort to form a realistic picture of the other is burdened by a simultaneous need to expel a part of our self, the image of the other is thus tainted and distorted by our own defensive or empathic functions.

### 3.4.3 Empathy

It is a form of projective identification that includes an explicit or implicit ongoing examination in an effort to approximate the actuality of the other. Empathy

involves openness and curiosity about the nature and subjectivity of the other as well as a willingness to alter one's perceptions depending on fresh impressions communicated by the other. One hallmark of defensive projective identification is the sense of certainty that the subject has of the nature of the other and the inflexibility of the subject's perceptions regardless of what the other may be communicating that may differ from these perceptions. Thus, in our understanding of the interaction of the couple, we ask ourselves not *whether* projective identification is occurring but rather to what degree it is serving defensive or empathic functions.

In intimate relationships, behaviour generated by projective identification may have a coercive quality that is very likely to evoke in the recipient an experience of himself or herself that resonates with the way the projecting spouse is behaving toward him or her. A loving glance can evoke in the partner a feeling of being lovable. Conversely, a contemptuous sneer from a husband, one of a pattern of such behaviours, is likely to evoke in the wife a sense of being disgusting and contemptible. Because both partners are viewing each other through the filter of projective identification, we can view the entire relationship as a nexus of interlocking projective identifications generated by both partners, in which the experience of the self is strongly affected by the way one is perceived and treated.

Participants in close relationships are often in collusion to sustain their mutual projections—that is, to support each other's defensive operations and to provide experiences through which the other can participate vicariously. It is the subject's unconscious identification with the recipient of his or her projections that allows for this vicarious experience of living through the other. For projective identification to function effectively as a defense, the true nature of the relationship between the self and its projected part must remain unconscious, although the individual may feel an ill-defined bond or kinship with the recipient of his or her projections. The disinheriting of the projected part is not so complete that the subject loses his or her capacity to experience vicariously a wide range of the object's feelings, including those which the subject has himself or herself evoked. These vicarious experiences contain features associated not only with gratification but with punishment and deprivation as well.

In the case of Anitha and Vikram, each experienced considerable unconscious inner conflict over sexual intimacy and its threatening consequence of emotional dependency. As a way of warding off anxiety, both partners colluded in parceling out the elements of their own ambivalence into roles each would assume. Thus, Vikram spoke in behalf of their shared desire for sex, whereas Anitha represented their fear of physical intimacy. In this manner, the intrapsychic conflict of each was transformed into interpersonal conflict within their relationship. It does appear that conflict between partners is often more bearable than conflict within oneself. When Anitha reversed roles with Vikram and initiated sexual contact, their distant but stable equilibrium dissolved. Each became anxious and managed to restore the sexual distance by regenerating conflict in digging up the familiar bones of contention.

### 3.4.4 Transference

It is one form of projective identification, as it appears in the psychotherapeutic setting. The term, however, has been expanded to be almost synonymous with *projective identification* by including many situations in which " *a normal*

*person's perceptions and affective responses vis-à-vis the self and others are heavily influenced by the activation of significant relationship representations from the past"* (Gerber and Peterson 2006).

The operation of projective identification within marriage, however, is more than a matter of externalisation of disavowed or cherished traits. We find that in the defensive mode, the contents of the projected material contain highly conflicted elements of the spouse's object relationships with his or her own family of origin. Although it is commonplace to think of a husband selecting a mate who is "just like the girl who married dear old dad," we are here referring to the unconscious striving to re enact conflictful parent child relations through such an object choice. Highly fluid role attributions occur in which a husband, for example, may parentify his spouse, or, on the other hand, infantilise her by experiencing the wife as the child he once was.

The externalisation of aspects of old nuclear relationships may serve not only a defensive need but also a restorative one, to bring back to life, in the form of the spouse, the individual's lost infantile objects, both good and bad. The perception of the partner coloured by the image of a beloved deceased parent may be salutary, heightening affection for the spouse. On the other hand, it may also be constraining on the object of the perception insofar as it detracts from her individuality and may lead to conflict when she does not conform to the parental image. Thus, recognising the restorative function of these projective identifications may lead the therapist to fruitful exploration of unresolved grief over the death of the parent or other important person.

Our understanding of the impact of projective identification on couple relationships has profound implications for our therapeutic approach. For working with couples, many therapists utilise some form of a focal problem solving approach, often cognitive behavioural in style, with a primary focus on the manifest content of the conflict and perhaps an elaboration of dynamic patterns across conflicts. According to these methods, a couple enters therapy with its disputes, and the therapist seeks to resolve the conflict through identifying strengths, making behavioural contracts, conducting conflict resolution, assigning paradoxical interventions, or promoting fair fighting techniques, among other similar interventions. When a couple's conflict, however, is deeply anchored in interlocking processes of mutual projective identification, it can be very difficult, if not impossible, to make progress with most problem-solving strategies. This follows from our understanding that in these situations, interpersonal conflict is serving the intrapsychic defense of each partner so that there is a strong unconscious motivation for sustaining the couple's disharmony in order to preserve each partner's internal equanimity.

The object relations therapeutic approach is indicated for just these kinds of refractory couple discord. Our theory informs us that the manifest conflict and anger are not the primary targets of our efforts, but rather we seek to uncover the sources of pain within both partners that have caused them to use the relationship as a repository for disavowed aspects of their own selves.

When successful, our exploration of the underpinnings of the manifest conflict reveals a more poignant subtext in which each partner is able to become aware of the emotional pain that led to the expulsion of the distress, appearing as anger, into the interpersonal space. Insofar as the therapist's efforts lead to a shift from

blame to internalisation of conflict within the individual partners, there is a diminution of anger and an increased capacity for empathy, compassion, and respect for one another that was not possible when each spouse was the target or perpetrator of criticism and rage.

The following description of a marital therapy session with Anand and Jaya illustrates the ebb and flow of externalising and internalising processes in the relationship, with concomitant shifts between anger and sadness.

### 3.4.5 Clinical Illustration and Case Analysis

*Conflict as a Defense against Fear of Loss*

When therapist again reminded Jaya that he could not schedule their sessions to an earlier time, She quipped, "Don't *any* of your patients get better?" This response reflected her sense of continued bickering with her husband Anand recently, although not at the level of several weeks ago.

They described a typical fight in which the two of them ended up snapping at each other in front of Rajani (their 3-year-old daughter) after the child fell and hurt herself. Each blamed the other for not keeping a watchful eye on the little girl as she was playing on their bed. This is a typical instance of their taking out their shared anxiety on one another and polarizing over who would bear all the worry.

One scene during this altercation involved Jaya panicking when she noticed some blood in Rajani's mouth and then shouting at Anand to "get off the fucking phone" while he was taking his time, casually conversing with his son. *She* had actually handed the phone to Anand earlier when he had followed the crying Rajani into the room. Jaya commented that after this blowup, both felt "heartsick" at the way they had dealt with Rajani's injury.

They reported several other bickers during which Jaya was nagging Anand while he was dragging his feet on a project because he felt again that giving in to Jaya was being "euchred," which is his expression for being "led by the nose." Their fight seemed to be over the proper height of the wall they were building in the basement. Jaya wanted a higher wall than Anand, and they couldn't agree. The therapist commented that in recent weeks they have been erecting a wall between them such that they're not pulling together as a team under stress and, as Jaya put it earlier, "It's like we're having all our old fights all over again."

Therapist inquired about the deeper layer of concern underlying the wall, and Jaya teared up, saying, "It's because when I need him he's not there. I can't count on him being here." Hearing the reference to Anand's absence, therapist asked Jaya if she had been concerned about Anand's health lately. Anand is considerably older than her and not scrupulous about his health habits. At this she nodded affirmatively and began to cry. The conflict seemed to start while he was away so much recently working so hard on a contract that he, incidentally, just informed me he had successfully completed. She felt like a "single parent" then and imagined him dying and how much worse it would be if he did. She worried about his knees, his hearing, and, above all, about his weight and his drinking. She revealed she carries a fantasy that at any time he could have a heart attack and die. Then she would be all alone with Rajani and unable to remain in their house, because she couldn't afford it even for 6 months. In this recent concern

she pleaded to Anand to draw up an accounting of how much she would be left with, and he did. Of course, he was unaware of the poignant aspect of her request and how frightened she was at the prospect of losing him.

The night before, Jaya arrived home late from work to find Anand devouring a 12-ounce steak. This upset her considerably although she did not mention it to Anand. To her this was an example of his self-neglect. Ordinarily, when she is home and cooking dinner, she prepares meals that are suitable for a man with heart disease, such as beans and rice. She was angry at him in the session for his "not letting yourself use me as a resource," because she is able to prepare for him foods that are tasty and healthful. "Instead, you act like I'm your enemy," she says when she admonishes him for eating foods that are unhealthful for him.

Reflecting on this session, we see that this couple has recently been bickering again as Jaya said, "It's like we're having all our old fights all over again." She is referring to the bones of contention—"our old fights"—unique to this couple. Her guilty perception of their backsliding into conflict is transformed into a wisecracked projective identification in which she blames therapist, in the transference, for not getting "*any* of patients . . . better." Rather than eliciting the manifest content of their recent bickering, there is need to search for the precipitant of this current round of conflict.

Hearing her critical reference to Anand —"I can't count on him being here"— therapist associates to the possibility of her losing him and ask if she is concerned about his health. This question reveals the source of their recent tensions, as Jaya begins to cry and tell how, in the face of Anand's recent prolonged absence, she worries that he might die and leave her and their daughter, Rajani. In their relationship, the fear of death and loss is parceled out by projective identification. Anand is cavalier in his dismissal of the dangers to his health from his very casual attitudes about his eating, drinking, and lack of exercise. Jaya, on the other hand, carries all the worry for the couple about the consequences of his health habits. Because he does not internalise his own concern about dying prematurely, Anand runs the risk of fulfilling that grim prophecy by, for example, gorging on a 12-ounce steak the night before the session. Interestingly, this behaviour may be his way of expressing his own feeling of abandonment by Jaya, who came home too late to cook a healthful dinner for him.

These interactions illustrate a fundamental consequence when a couple uses their relationship as a repository of disavowed and devalued projections. They are unable to work as a team because their polarisation causes them to pull in opposite directions. In distinction, when each partner in a couple is able to internalise intrapsychic conflict and tolerate anxiety, ambiguity, or sadness, the pair can function as a team and benefit from its joint and collaborative efforts. In this connection, Jaya lamented to Anand that "You are not letting me use you as a resource."

Their failure to share anxiety and guilt following Rajani's fall is another example of how defensive projective identification leads to couple conflict and dysfunction. The role of the worrier switched during the interaction so that at first, Aanand was moaning "Oh my gosh! Oh my gosh!" while Jaya handed him the phone so that he could speak with his son, a nonurgent matter. He was bearing the anxiety for both of them. Spotting a small amount of blood in Rajani's mouth, Jaya

panicked, as the defense against her anxiety crumbled. At that point *she* became the worrier and raged at Anand for being on the very phone she had handed him moments before. Because of the work that they had previously done in therapy about their flawed handling of anxiety connected with Rajani, both recognised their return to an old pattern of blaming and felt "heartsick" about what they had allowed to happen.

During their conflict over Rajani's fall, however, what remained constant was the polarisation of attitudes.

Another important feature of object relations couples therapy is to listen for the symbolic and metaphoric quality of the content of marital conflict. In the session with Anand and Jaya, a significant and emotionally charged argument persists over how high to build a wall within their basement. When such an intensity of feeling arises over what would appear to be a manageable difference of opinion, therapists should look for the metaphoric meaning of what is contested. In this case, in recent weeks a "wall" was being erected as the couple distanced itself through "having all of our old fights" after Anand's return from his travels.

A primary goal of object relations couples therapy is to help each partner reinternalise what he or she has projected into the interpersonal sphere in a way that has burdened the relationship. The conflicted internal relationships can only be resolved intrapsychically. When such reinternalisation occurs, there is a striking shift from anger and polarisation within the couple toward sadness, tenderness, and poignancy in each partner. This transition is evident in the session with Anand and Jaya as they finally share the "heartsick" feeling at how they divided and fought over Rajani's fall. Similarly, their arguments over the wall and their old fights are ameliorated when they become aware of their concerns about abandonment and death.

Following the successful reinternalisation of projected elements, there can be considerable individual intrapsychic work done in the course of the couple sessions. What often does occur, however, is that the partners seek out individual psychotherapy with a different therapist as a complement to the couple treatment? Both Anand and Jaya had been in individual therapy before the couples work began and continued with that synergistic combination.

**Self Assessment Questions**

1) Discuss psychodynamic couple's therapy as an object relations approach.

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2) What is projective identification?

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3) Discuss empathy and transference in psychodynamic couple's therapy.

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## 3.5 USE OF TRANSFERENCE IN COUPLES THERAPY

According to the object relations approach, the world of internalised object relationships is transposed onto the world of actual interpersonal relations through the mechanism of projective identification. This transposition occurs in a variety of spheres, not just within the couple relationship. Interactions with children, friends, employers, colleagues, and others are governed by the same psychological mechanism. Transference is the form of projective identification that occurs in the therapeutic relationship.

In couple's therapy, transference feelings and marital issues are often inextricably interwoven threads of the same interpersonal fabric. Because the couple's therapy is a three-person relationship, there is an increase in the permutations; the forms of this transference may take in contrast with individual psychotherapy.

First, as in individual work, there is the focused transference that each partner feels toward the therapist based on that partner's internal object world.

Second, there is a very common triangular transference configuration in which each partner is seeking to be the one preferred by the therapist at the expense of the other.

This three some interaction often re enacts sibling experiences in competition for the favour of their parent.

More often than not, each partner enters couple treatment with the fantasy hope that the therapist will validate his or her point of view and work to change his or her partner's wrongful attitudes and behaviour.

Many of the early efforts by the therapist are devoted to helping the couple understand that each partner is contributing to the problematic interactions in

their relationship. This requires that the therapist actually be able to rise above, in attitude and behaviour, the drumbeat of blaming and fault finding that so frequently take place in an adversarial couple situation. Even handedness and neutrality in the therapist are greatly aided by his or her understanding of the complex and complementary interplay of the internal object world of the partners as it is transposed onto their current relationship.

Third, there is a complex transference that encompasses the experience of the entire three-person group in interaction. One such instance is the *shared fantasy* within the couple that the couple treatment is in itself a danger to the integrity of the relationship and the safety of individual members, rather than a resource for help, healing, and growth.

Especially where words have been used as instruments of aggression rather than of understanding and support, there may be a great fear of becoming open and vulnerable in the session, with a consequent constriction of communication and a perception of the therapist as an agent of harm. It is therefore an early priority that the therapist recognise and explore this shared fantasy that talking is dangerous because language, the very vehicle for healing in therapy, is seen paradoxically as the greatest threat to the safety and security of the couple.

Because of the emotional power inherent in a group, strong counter transference experiences are to be expected in couples therapy, and it is often a challenge to convert these feelings into stimuli for constructive therapeutic reflection and intervention, in contrast to internalising them so that they colour the therapist's self experience in a way that helps no one in the threesome.

This attitude that the treatment situation is one of harm rather than of help is often discovered through the therapist's own counter transference experiences in a variety of ways. For example, the therapist may find himself or herself, in the face of the couple's silence and constricted communication, feeling the need to energise the interaction with frequent superficial interventions.

In the absence of the therapist's forced efforts the group feels lifeless and defeated, and the therapist's sense of himself or herself as helpful and competent may suffer. It is useful for the therapist to be aware of such personal reactions because they serve as a signal that there is some problematic fantasy operating within the threesome that requires explicit exploration. In this instance, the therapist can use his or her sense of ineffectiveness to ask directly about the couple's experience of the therapy and the therapist, and what their fears are of saying what is on their mind in the session.

The elucidation of transference by the therapist offers the valuable opportunity to examine the marital relationship in the here and now of the session. This in-the-moment examination is often more highly affectively charged than the couple's rehearsing of the more remote then-and there events of the previous week. Working in the here and now is especially helpful to the therapist, as he or she has the opportunity to experience and learn from his or her counter transference reactions as the drama unfolds in the session. It is also necessary to address problematic negative transference issues that might lead to acting out or an interruption of treatment if ignored.

### 3.5.1 Clinical Illustration and Case Analysis

Work in the transference is illustrated in the couple treatment of Thrivedi and Tulasi. The session occurs soon after a difficult interruption, involving a lengthy unanticipated absence by the female therapist and the death of Thrivedi's mother. The hour opens with an extended silence and downcast expressions:

Tulasi: I feel so bad. Everything's falling apart. I'm too angry, hurting.

Therapist: Your relationship is falling apart?

Tulasi: Yeah, and between me and myself.

Thrivedi: It's also a hard time for me. I'm feeling very alone. I'm not through feeling the loss of my mother. I'm feeling alone with Tulasi, too, feeling there's not much room for me. I'm not sure what to do about that.

Therapist: You look quite sad.

Thrivedi: I've had pretty sad days. I wrote all the thank-you notes for people who helped a lot. I'm feeling pretty bad, pretty sad. Yesterday, I spent time going back through things . . . greeting cards . . . business stuff. I felt pretty sad, pretty alone.

Therapist: You feel alone in your grieving or without your mother?

Thrivedi: Both . . . [Thrivedi *recounts how he called his uncle and aunt, who were close to his mother*] . . . it's a sad thing.

Therapist: Right now you seem very closed in, inside your grief.

Thrivedi: Yeah.

Therapist: Is your grief complicated? I had the impression your relationship with your mother was not satisfying for you, which would complicate your grief.

Thrivedi: The last few years she tried to reach out and we worked through a lot of stuff. She was a critical person, not easy to talk to. I was always feeling I'd be criticized.

Thrivedi and the therapist engage in a discussion in which the therapist especially questions him about his relationship with his mother. Throughout, Tulasi remains utterly silent, often staring out into space. Thrivedi is responsive to the therapist's interventions. He begins to cry, concluding, "No matter how bad things were, she loved me and now she's gone."

Thrivedi: All these feelings are overwhelming. I don't know how to be with Tulasi when she's having all these feelings, too. Somehow it feels like it has to be either her or me. I don't know how to work it so that we can both be depressed or sad or both be mourning.

Therapist: You have the idea that Tulasi is feeling cut out because I'm talking to you and drawing you out?

Thrivedi: Yeah, I do. And feeling she's resenting it a lot . . . [*silence*] . . . I know part of the problem is I want somebody to take care of me . . . to be kind . . . and I know that's not fair . . . to expect . . . of her. It took me a lot to get to the point where I could recognise that. I just don't know how things are supposed to be anymore.

During the course of the session thus far, the therapist has been acutely aware of Tulasi's conspicuous silence and lack of involvement. The therapist found herself irritated at Tulasi and was determined to keep the channel of communication open with Thrivedi by ignoring Tulasi's efforts to undermine it. This counter transference experience was familiar to her in working with this couple. She had frequently felt as if she were compelled to make a choice between devoting attention to one spouse or the other. The partner not receiving the therapist's attention at the moment would remain silent and sullen. Thus, the interaction had a quality of taking turns rather than of give and take. Aware that she was acting out her own counter transference irritation, the therapist decided to shift to interpretation.

Thrivedi: I've been feeling I have to have something to help me get through this. I don't have Tulasi. I just don't know how to get to her . . . without her feeling resentful. It's like I have to totally be on my own or I have to rely on Tulasi —those two things—the dependency I want isn't good, isn't healthy, but I still want it . . . and I feel like there must be some appropriate halfway point, but I don't know how to get there.

Therapist: You do both look as though if either of you were to want anything from the other you'd be very disappointed. Is that what breaks down so fast, Tulasi? Fall apart very quickly, you said. [*Silence.*]

Tulasi: Sitting here while you've been talking to Thrivedi has been very difficult. I find myself resenting a couple of things you said. I resent the time you're spending with him—I feel very small.

Therapist: When I'm talking to Thrivedi it doesn't feel like you're both getting something because if he's getting something, then you're not.

Tulasi: Yeah.

Therapist: That makes you feel very small.

Tulasi: Well, he's got this enormous grief to deal with and he needs a lot. I shouldn't get mad when you're helping him.

Therapist: It's such a deep loss and both of you have a need for an abiding presence that's just for you. That need is very strong. You're both talking about how you're struggling with the fact that it's not there—a very reliable, immediate, understanding presence—how much you each need it and how much it's not there either from each other or from anyone, really.

Tulasi: That's a lot of what happens to me. It's not there. I don't think I ever really had it. Sometimes I feel I have it, but then I lose it, which I do, then I can't . . . I can get through a session with my individual therapist, and then I can do what I need to do with Thrivedi, except then when something comes up between us, then I can't hold on to it. If I don't have it, then I don't want to deal with all his stuff. But I can't adjust. If I can't have it, then I'm through. . . . Sometimes it feels really good, but there's an awful lot of pain with it, all that pain around therapy this summer, I can't get away from it.

Therapist: You mean my absence and the effect it had on everything?

Tulasi: Yeah. I was afraid, really afraid. I felt badly. I was a little weird. I didn't notice it was a pattern. When I was supposed to see you and I didn't, I'd get weird, but I didn't connect it.

Therapist: Maybe now with things settling down, seeing me for a couple of weeks, maybe now it will be possible to understand these feelings, not just to have to endure them.

Tulasi: Yeah.

This excerpt reveals a highly interwoven blend of transference, countertransference, and marital issues. A triangular configuration is evident, but it is, however, a pre-oedipal, or oral, triangle in which there is a competition not for a sexual relationship with the parent of the opposite sex but rather for the basic supplies of emotional survival. The raw data for the therapist's grasp of the marital unconscious assumption come from several sources. She reflects on the manifest behaviour in the session, which is characterised by the lack of give and take, and the sullen silence of each spouse when the therapist is attending to the other.

She contemplates the manifest verbal content—for example, Thrivedi's regret that "It has to be her or me" but not both who can be sad or mourning. The therapist includes in her consideration Thrivedi's story of a mother who was not warm, but a "critical person, not easy to talk to." A crucial part of the mix is the tension within the therapist over the competition for her attention and her own irritated determination to defy Tulasi's envy to the point of ignoring her. Out of her experience in the here and now, the therapist is able to formulate for herself an unconscious assumption governing the marital relationship. That is, those resources for a basic sense of worth and for psychological survival are limited and only sufficient for one partner. Whatever sustenance is received from the good object, couple, or individual therapist is ephemeral. There is a tenuous capacity for one spouse to give to the other without experiencing envy for what the other is getting and rage at what one is giving up. The couple *shares* this fantasy and, in the session, the transference vision of the therapist as the central source of sustenance.

The specific transference feeling of each spouse toward the therapist at any given moment is different, determined by whether the therapist is seen as attending to or ignoring Thrivedi or Tulasi. In this excerpt, the therapist's capacity to grasp the here-and-now situation inclusive of both transference *and* marital dynamics allows her to focus her intervention on the issue that carries the highest affective charge of the moment. Therapeutic interventions are most effective when directed toward issues linked to strong affects. In the absence of an affectively toned area, interpretations are received with intellectualisation and little emotional impact. In couples therapy, we see this latter phenomenon in the all-too-frequent retrospective bland analyses of the marital fight of the previous week.

### 3.5.2 The Frame of Object Relations Couples Therapy

The frame of the couples treatment and the nature of the therapist's activity follow from the object relations theory. Sessions are held once or more times weekly at a set time. The length of treatment is open-ended, and termination evolves naturally out of completion of the task. Meetings take place only when both partners are able to be present and begin when both have arrived.

Concurrent individual psychotherapy can act in synergy with the couples work, in which the partners each have their own individual therapist who is not also the couples therapist. It is advisable that the couple's therapist not do both forms of treatment. When one partner meets with the couples therapist in the absence of the other partner, there is the risk that the therapist will learn something that would disturb the absent mate should he or she become aware of this information. Thus, the therapist is left with the dilemma of having to protect the confidentiality of the spouse with whom he or she met alone and therefore having to hold a

secret that cannot be shared with the absent partner. This is an untenable position for the therapist, whose responsibility is to the couple as a whole and not to only one spouse. In addition, when the therapist wears both hats in doing the individual and couples work, jealousy and destructive competition can arise, and this only serves to compound the adversarial relationship that existed in the first place.

With separate individual and couples therapists, either the patient can transmit understanding gained across the boundary of the two therapies, or both therapists can confer as needed with permission. The couples therapist's responsibility is to the couple as a unit, and his or her stance should be one of evenhandedness in the presence of conflict. Primarily, the therapist serves as an observer, listener, active formulator, and interpreter of the forces that shape the couple's interaction.

Active behavioural interventions mainly involve encouraging the partners to use direct and attentive communication with each other in the session rather than to speak to each other through the therapist by referring to the spouse as "he" or "she." Homework, such as experimentation with physical intimacy, is a creative product of the couple's imagination rather than a generic exercise determined by the therapist.

Object relations couples therapy attends to both the interpersonal and the intrapsychic simultaneously. It is a flexible approach tailored to the nature of the relational difficulty and to the developmental level of each partner. Thus, the treatment is an approach to formulating and intervening rather than a prescription of specific interventions and tasks that could apply to all couples. What is constant, however, in the object relations approach is the attention to the way in which the world of early internalised relationships has unconsciously come to life again in the current life of the couple.

**Self Assessment Questions**

1) In couples therapy how are transference feelings and marital issues inter related?

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2) What is three person group interactions in couples therapy?

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3) Discuss counter transference experience in couple's therapy.

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4) Discuss active behavioural interventions in couple therapy.

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5) Discuss object relations couples therapy.

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## 3.6 LET US SUM UP

Relationship problems are far more likely to develop during times of transition for couples and their families, such as when starting a new relationship, bringing a child into the family, dealing with a grandparent's death, or ending a relationship. There are different approaches to couples therapy like systems approach, behavioural approach, client – centred therapy and psychodynamic approach.

The central concept of object relations couples therapy is the transposition of the internalised object world of each partner into the interpersonal sphere of the relationship. The mental mechanism that transforms the intrapsychic into the interpersonal is projective identification. Unconscious forces are paramount in choosing intimate partners as well as in guiding the interaction of the couple. The relationship of the couple, in its most refined form, can make possible empathic and collaborative efforts in which the whole is greater than the sum of its parts. In contrast, for defensive purposes, the couple relationship may become the repository of devalued aspects of each partner, leading to conflict, polarisation, and dysfunction. Interpersonal conflict may be more tolerable than intrapsychic distress, leading partners to resist efforts to reduce the level of interpersonal conflict.

The primary goal of object relations couples therapy is to foster reinternalisation of projected devalued aspects of each partner, leading to a reduction in couple

conflict, enhanced empathy, but an increase in individual emotional pain. Those devalued aspects of the self that have become reinternalised are now available for intrapsychic resolution, which may take place as part of the couples therapy as well as in concurrent individual therapy with another therapist.

The couple's therapist seeks the underlying issues that precipitate conflict rather than focusing on resolving the manifest content of the conflict. Anger is seen as reactive to hurt and emotional pain within the individual partners. Use of transference–counter transference phenomena in the here and now of the couple session may provide access to affectively charged and workable dynamics that are central to the couple relationship itself.

## 3.7 UNIT END QUESTIONS

1) Discuss the nature and definition of couples therapy.
2) Discuss the different approaches to couple therapy.
3) Explain the psychodynamic approach to couples counselling.
4) What is systems approach to couple counselling?
5) Discuss the psychodynamic couples therapy as an object relations approach.
6) How is transference used in couple counselling?

## 3.8 SUGGESTED READINGS

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# UNIT 4 PSYCHOTHERAPY INTEGRATION

**Structure**

4.0 Introduction
4.1 Objectives
4.2 Definition of Integrative Psychotherapy
4.3 Historical Overview of the Integrative Movement
4.4 Variables Responsible for Growth of Psychotherapy Integration
4.5 Different Ways to Psychotherapy Integration
  4.5.1 Eclecticism
  4.5.2 Differences between Eclecticism and Psychotherapy Integration
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## 4.0 INTRODUCTION

A major emphasis of this unit is on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy. Throughout the world, when you ask a psychologist or counsellor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation, you will integrate one or more of the theories presented in this block. This unit explores in detail the integrative approach to therapy. This unit traces the historical development, variables responsible for, the different models and future of integrative approach.

## 4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the concept of integrative psychotherapy;
- Describe the historical perspective of the integrative movement;
- Explain the variables responsible for growth of psychotherapy integration;
- Analyse the different ways to psychotherapy integration;

- Explain evidence based therapy and integrative practice; and
- Analyse the future of psychotherapy schools and therapy integration.

## 4.2 DEFINITION OF INTEGRATIVE PSYCHOTHERAPY

Integrative psychotherapy is an attempt to combine concepts and counselling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counselling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients. According to Norcross (2005):

Psychotherapy integration is characterised by dissatisfaction with single school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy.

Within this integrative therapy we have Meaning Therapy which is an integrative approach. Meaning therapy (MT), also known as meaning centered counseling and therapy (MCCT), is an integrative, positive existential approach to counseling and psychotherapy. Originated from logo therapy, MT employs personal meaning as its central organising construct and assimilates various schools of psychotherapy to achieve its therapeutic goal. MT focuses on the positive psychology of making life worth living in spite of sufferings and limitations. It advocates a psycho educational approach to equip clients with the tools to navigate the inevitable negatives in human existence and create a preferred future. The paper first introduces the defining characteristics and assumptions of MT. It then briefly describes the conceptual frameworks and the major intervention strategies. In view of MT's open, flexible and integrative approach, it can be adopted either as a comprehensive method in its own right or as an adjunct to any system of psychotherapy.

Integrative psychotherapy offers a safe environment for the exploration of body, mind, emotion and spirit, and their impact on health, personal fulfilment and relationships.

Because everyone is unique, my therapeutic approach is shaped according to your particular needs and wishes. Together we bring your authentic, true self into focus, calling forth your inner strengths and resiliency while you explore your vulnerabilities and concerns. We may use insight, mindfulness, an interactive style of guided imagery, the Work of Byron Katie, solution focused therapy, EMDR, EFT, and cognitive behavioural therapy, to name a few. EMDR refers to EMDR stands for Eye Movement Desensitisation Reprocessing, a highly effective and well-researched therapeutic method developed in 1987 by Dr. Francine Shapiro, for healing many types of psychological distress including past or recent trauma, self esteem issues, creativity blocks, complex unresolved grief, being the victim of a violent crime, combat experiences, and performance anxiety. It is also used to enhance performance, build self-confidence and inner resiliency.

Our brains can process and integrate most of our experiences without leaving a lasting negative effect. But research in the area of trauma tells us that when an

experience is very intense or threatening, the ability to process the experience can get stuck along with negative interpretations or beliefs. EMDR works to unlock the lodged memories and reengage the brain's natural ability to integrate the experience.

EFT refers to Emotional Freedom Technique or EFT for short. It is one of the most remarkable health innovations in the last 100 years. It is based on impressive discoveries regarding the bodies' energy system. It works on just about every emotional and physical issue you can name. In fact it often works where all else has failed and can work where conventional medicine has no answers. EFT has its basis in Chinese acupuncture and psychology but instead of using needles you simply tap on well established meridian points on the upper body. EFT is a painless and relaxing method of healing.

EFT is a powerful technique and a potent technique that helps you take control of your body and your thoughts. This technique was developed by Gary Craig in 1990 and has originated from acupuncture, kinesiology, and psychology. This wonderful technique has shown amazing results in developing attitude and behaviour, resolving personal problems, decreasing stress, and restoring life balance.

Emotional Freedom Technique is an efficient technique offering solutions to stress related problems and helps in balancing the body's energy system. This painless technique effectively deals with any psychological or physiological problem and shows concrete results within a short time.

EFT aims at returning the mind, body, and emotions of an individual to a balanced and harmonious state so that he or she is free from negative emotions.

EFT is a gentle method that works by balancing the body's energy system.

Many a times we are affected by bad relationships, traumas, or losses. Work related stress, depression, interpersonal problems, and anxieties also affect our mental health. These negative emotions block the flow of energy in our system and have a detrimental effect on our health. EFT helps in releasing these negative emotions and resolving the problem.

EFT involves treating physiological or psychological problems by tapping specific acupressure points with fingers. It is you who taps yourself. I have no need to touch you at all. My role is to tell you where to tap and also what to say as you tap. The procedure can be done over the telephone or the Internet. It is easy to do and I have never had a client who found it difficult.

EFT helps in Pain Management, Addictions, Allergies, Weight Loss, Headaches, Asthma, Trauma, Abuse, Depression, Eating Disorders, Blood Pressure, Anorexia, and many more diseases and maladies.

EFT often works where every other treatment fails. In fact EFT helps with virtually every physical and emotional problem that one can think of.

**Self Assessment Questions**

1) What is integrative psychotherapy?

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2) Describe the characteristics of integrative psychotherapy.

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3) What is EMDR? Explain

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4) Elucidate the EFT technique.

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## 4.3 HISTORICAL OVERVIEW OF THE INTEGRATIVE MOVEMENT

Integrative therapy draws on some of the oldest techniques of psychotherapy. It was developed during the 1970s by Richard G Erskine PHD and at The Institute for Integrative Psychotherapy.

The Integrative psychotherapy model recognises the use of other therapeutic approaches such as humanistic, cognitive, gestalt and psychodynamic and attempts to fuse them into a approach that is of benefit to the individual. The facilitation of a person's 'wholeness' to improve their quality of life.

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients problems. From Freud's Wednesday evening meetings on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviourism was introduced to the field, clashes took place between psychoanalysts and behaviourists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy,* was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published Psychoanalysis and Behaviour Therapy: Toward an Integration. In 1979, James Prochaska offered a trans theoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp organised an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy.* By 1991, it began publishing the *Journal of Psychotherapy Integration.* As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

Integrative therapy is different from eclectic therapy. Integration is like choosing raw ingredients to make a balanced and nutritious meal, from a recipe to be used again, whilst eclecticism is like visiting the salad bar to select prepared food for just that meal, equally nutritious, and a different selection can be made next time.

It is this considered, methodical attempt to bring theories and practices together that sets the integrationists apart from the eclectics.

Paul Wachtel, a central figure in the integrative movement since the seventies, says that eclecticism tends to focus on "what works," and relies heavily on empiricism and statistical analysis to discover what seems to work. For Wachtel, it is this lack of theory that distinguishes the eclectics from the more theoretically grounded integrationists, who should be able to say not only what works, but why it works.

Tullio Carere, a committed integrationist, sketches the history of psychotherapy integration in several phases (www.cyberpsych.org/sepidocs.htm). The first, the "latency" phase, began in the early 1930's but was not a well defined area of interest, he says. The 1970's saw the more clear delineation of integration as a concern, with more concerted efforts being made at rapprochement across the boundaries. An interim phase, he says, was marked by the launch of the Society for the Exploration of Psychotherapy Integration (Sepi) in 1983 and the growing concern with a range of themes in integration and common theoretical and clinical languages.

The third phase, he suggests, is beginning with the new century, and, if successful, will see integrative psychotherapy moving from an area of interest to a scientific discipline.

Psychotherapy integration is not a new school, but there are new schools which, while integrative, are discrete new schools which draw on and systematically integrate the most useful ideas they can find from other schools.

A typical integrative brand of therapy is Eye Movement Desensitisation and Reprocessing, (EMDR). But the history of EMDR is illustrative of the emergence of discrete new schools.

The history of EMDR has been dogged by controversy which makes other, more traditional modality wars look tame by comparison. Those opposed to the method have slated the lack of evidence and theoretical grounds for its claimed efficacy (see page 16 of this edition). In response, its proponents have scrambled for more research-based evidence of its value and recruited thousands of practitioners as trainees and advocates of the method.

To be truly integrative then, means to largely abandon one's religious favour about any particular method, including any discrete approaches or philosophies which are themselves integrative of other approaches. Sound like a difficult balancing act? Well, why do you think it has taken integrationism 70 years to get integrated into our psychotherapeutic repertoires?

## 4.4 VARIABLES RESPONSIBLE FOR GROWTH OF PSYCHOTHERAPY INTEGRATION

Norcross and Newman (1992) have summarized the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

First, they pointed out that there was simply a proliferation of separate counselling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation.

Second, they noted that practitioners increasingly recognised the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory.

Third, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioural change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement.

Fifth, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments.

Sixth, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fuelled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers identification of common factors related to successful therapy outcome influenced clinician's tendency toward psychotherapy integration. Increasingly, therapists began to recognise there were common factors that cut across the various therapeutic schools.

Eighth, the development of professional organisations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.

**Self Assessment Questions**

1) Present the historical overview of integrative psychotherapy movement.

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2) Elucidate the variable responsible for the growth of integrated psychotherapy.

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## 4.5 DIFFERENT WAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, we might feel more comfortable in thinking about how we might pursue this same avenue. Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

### 4.5.1 Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many

psychologists accept some features of behaviourism, yet they do not attempt to use the theory to explain all aspects of client behaviour. Eclecticism in psychology has been caused by the belief that many factors influence human behaviour; therefore, it is important to examine a client from a number of theoretical perspectives.

### 4.5.2 Differences between Eclecticism and Psychotherapy Integration

Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counselling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counselling technique, yet not investigate any further why the positive change occurred. In contrast, an integrative therapist would investigate the *how and why* of client change. Did the client change because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists.

### 4.5.3 Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behaviour therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

### 4.5.4 Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labelled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioural assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single

theoretical approach, and over time many gradually incorporate techniques and methods of other approaches. Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

### 4.5.5 The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers's contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals. Researchers and theorists have transformed Rogers's necessary and sufficient conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counselling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller, 1999).

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

There is no standard list of common factors, but if a list were to be constructed, it surely would include:

- A therapeutic alliance established between the patient and the therapist.
- Exposure of the patient to prior difficulties, either in imagination or in reality.
- A new corrective emotional experience that allows the patient to experience past problems in new and more benign ways.
- Expectations by both the therapist and the patient that positive change will result from the treatment.
- Therapist qualities, such as attention, empathy, and positive regard, that are facilitative of change in treatment.
- The provision by the therapist to the patient of a reason for the problems that are being experienced.

Irrespective of the type of therapy that is practiced, each of these common factors is present. It is difficult to imagine a treatment that does not begin with the *establishment of a constructive and positive therapeutic alliance.* The therapist and the patient agree to work together and they both feel committed to a process of change occurring in the patient. Within every approach to treatment, the second of the common factors, the *exposure of the patient to prior difficulties*, is present. In some instances the exposure is in vivo (occurs in real life), and the patient will be asked directly to confront the source of the difficulties. In many cases, the exposure is verbal and in imagination. However, in every case, the patient must express those difficulties in some manner and, by doing so, re-experiences those difficulties through this exposure.

In successful treatment, the exposure usually is followed by *a new corrective emotional experience*. The corrective emotional experience refers to a situation in which an old difficulty is re-experienced in a new and more positive way. As the patient re-experiences the problem in a new way, that problem can be mastered and the patient can move on to a more successful adjustment.

Having established a therapeutic alliance and being exposed to the problem in a new and more positive context, both the therapist and the patient always *expect positive change* to occur. This *faith and hope* is a common factor that is an integral part of successful therapy. Without this hope and expectation of change, it is unlikely that the therapist can do anything that will be useful, and if the patient does not expect to change, it is unlikely that he or she will experience any positive benefit from the treatment.

The therapist must possess *some essential qualities, such as paying attention to the patient, being empathic with the patient, and making his positive regard* for the patient clear in the relationship. Finally, the patient must be provided with a *credible reason for the problems* that he or she is undergoing. This reason is based in the therapist's theory of personality and change. The same patient going to different therapists may be given different reasons for the same problem. It is interesting to speculate as to whether the reason must be an accurate one or whether it is sufficient that it be credible to the patient and not remarkably at variance with reality. As long as the reason is credible and the patient has a way of understanding what previously had been incomprehensible, that may be sufficient for change to occur.

### 4.5.6 Multi Theoretical Approaches

Recently, therapists have developed multi theoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesise two or more theories at the theoretical level. Instead, there is an effort to "bring some order to the chaotic diversity in the field of psychotherapy and "preserve the valuable insights of major systems of psychotherapy" (Prochaska & DiClemente, 2005, p. 148). *The goal of multi theoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multi theoretical frameworks are (1) the trans theoretical approach by Prochaska and DiClemente, and (2) multi theoretical therapy by Brooks-Harris.

### 4.5.7 The Trans Theoretical Model

The most widely recognised model using a multi theoretical framework has been the trans theoretical model developed by Prochaska and DiClemente (1984, 2005). The trans theoretical model is a model of behavioural change, which has been the basis for developing effective interventions to promote healthy behaviour change. Key constructs are integrated from other counselling theories. The model describes how clients modify problem behaviour or how they develop a positive behaviour. The central organising construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages: (1) pre contemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance.

In the pre contemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate

future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The trans theoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labelled behavioural processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness rising and social liberation. The 5 behavioural processes of change range from stimulus control to counter-conditioning to self-liberation.

The trans theoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development.

The trans theoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasise different stages and levels of change.

### 4.5.8 Brooks-Harris' Multi Theoretical Model

The most recent multi theoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches: (1) cognitive, (2) behavioural, (3) experiential, (4) bio psychosocial, (5) psychodynamic, (6) systemic, and (7) multicultural. A brief explanation of each of these areas is provided below (table 6.5.2). His framework emphasises at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

**MULTI THEORETICAL PSYCHOTHERAPY**

Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts.

**Behavioural skills**–focal dimension of actions encourage effective client actions to deal with challenges.

Experiential interventions result in adaptive feelings.

Bio psychosocial strategies emphasise biology and adaptive health practices.

**Psychodynamic** – interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions.

**Systemic** – constructivist interventions examine the impact of social systems and support adaptive personal narratives.

**Multicultural** – feminist strategies explore the cultural contexts of clients' issues.

Brooks-Harris presents five principles for psychotherapy integration, which include

1) Intentional integration,
2) Multidimensional integration,
3) Multi theoretical integration,
4) Strategy-based integration, and
5) Relational integration.

The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualisation, and intervention strategies.

Principle two (multidimensional) proposes that therapists should recognise the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions.

The fourth strategy based principle states that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled.

The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalogue of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy.

To integrate behavioural therapy into one's practice, he suggests some of the following catalogue of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

### 4.5.9 Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools.

The first stage of helping is labelled *exploration.* Using Rogers' client-centered therapy as the therapy school of choice, Hill (2004) emphasises the counselling skills of attending, listening, and reflection of feelings.

The second stage is termed *insight,* and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed.

The third stage is termed the *action stage,* and this stage is based largely on cognitive-behavioural techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

**Self Assessment Questions**

1) What are the ways to integrate psychotherapy?

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2) Differentiate between eclectic therapy and integrative therapy.

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3) What is meant by assimilating integrations?

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4) Explain common factor approach in Integrated Psychotherapy.

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5) Discuss multi theoretical approach.

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6) Explain Brooke Harris Multi theoretical approach to integrative psychotherapy.

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## 4.6 EVIDENCE BASED THERAPY AND INTEGRATIVE PRACTICE

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients culture and treatment issues.

The American Psychological Association (2006, p. 273) conceptualises evidence based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence based practice emphasises the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favour of EBP are reasonable.

First, clients have a right to treatments that have been proven to be effective.

Second, managed care requires counsellor accountability in choosing a method of treatment.

Increasingly, counsellors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder. Helping professionals may be required to answer for using a therapeutic approach with a specific disorder.

How does a therapist implement EBP in practice? The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun.*

There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration (http://www.cochrane.org) sets standards for reviews of medical, health, and mental health treatments and provides "systematic reviews" of related research by disorder. Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions. Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (http://www.guideline.gov/). This site contains very good information on medication.

Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health (http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm).

## 4.7 FUTURE OF PSYCHOTHERAPY SCHOOLS AND THERAPY INTEGRATION

What does the future look like for psychotherapy schools? Norcross, Hedges, and Prochaska (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: *cognitive-behaviour therapy, culture-sensitive multicultural counselling, Beck's cognitive therapy, interpersonal therapy, family systems therapy, behaviour therapy, technical eclecticism, solution-focused therapy, and exposure therapies.*

Therapy orientations that were predicted to decrease the most included *classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy.*

The poll also showed how psychotherapy is changing. The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease i.e. Short term is in, and long term on its way out.

## 4.8 LET US SUM UP

Psychotherapy integration is defined as an approach to psychotherapy that includes a variety of attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives. It is characterised by openness to various ways of integrating diverse theories and techniques.

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualising clients' problems.

Norcross and Newman (1992) have summarized the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counselling and psychotherapy.

Clinicians have used a number of ways to integrate the various counselling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration.

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach. Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

## 4.9 UNIT END QUESTIONS

1) Define the term integrative psychotherapy. Trace the historical overview of integrative psychotherapy movement.

2) Explain the common factors approach to psychotherapy integration.

3. Discuss the difference between technical eclecticism and assimilative integration.

4) What are the possible ways of integrating psychotherapy?

5) What are the arguments in favour of evidence based psychotherapy in practice?

6) What does future hold for psychotherapy schools?

## 4.10 GLOSSARY

**Common Factors** : This term is used when the techniques are common to all approaches to psychotherapy.

**Assimilative Integration** : It is an approach in which the therapist has a commitment to one theoretical approach but also is willing to use techniques from other therapeutic approaches.

**Technical Eclecticism** : In this approach, diversity of techniques is displayed but there is no unifying theoretical understanding that underlies the approach.

**Theoretical Integration** : This model requires integrating theoretical concepts from different approaches, and these approaches may differ in their fundamental philosophy about human behaviour.

**Multitheoretical Approaches :** These approaches provide a framework that one can use for using two or more theories.

**Evidence-based Practice(EBP):** It is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues.

## 4.11 SUGGESTED READINGS

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# UNIT 1 PSYCHOTHERAPY WITH CHILDREN AND ADULTS

**Structure**

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## 1.0 INTRODUCTION

Psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with emotion and behaviour. Although there are different types of psychotherapy, each relies on communication as the basic tool for bringing about change in a person's feelings and behaviour. Psychotherapy may involve an individual child, group, or family. For children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems.

Psychotherapy helps children and adolescents in a variety of ways. They receive emotional support, resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems. Goals for therapy may be specific (change in behaviour, improved relations with friends) or more general (less anxiety, better self- esteem). The length of psychotherapy depends on the complexity and severity of problems. In this unit we would be discussing the

different types of psychotherapies which have been found to be effective with children and adolescents. The first half of this unit will cover psychotherapy with children, which will include psychodynamic psychotherapy (such as play therapy, working with parents), cognitive-behaviour therapy (behaviour modification, individual therapy, etc.) and family therapy. The second half would discuss about the most effective psychotherapies with adolescents for disorders such as depression, anxiety and conduct problems.

## 1.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the different types of psychotherapies used with children such as psychodynamic play therapy, cognitive-behaviour therapy and family therapy;
- Describe, understand and treat adolescent problems from developmental perspective; and
- Discuss the most effective psychotherapeutic methods for treating problems such as depression, anxiety and conduct disorders in adolescents.

## 1.2 PSYCHOTHERAPY WITH CHILDREN

In this section, we will describe and review three of the predominant approaches to working therapeutically with children: psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy. Before dealing with each of these methods, however, it is important to realise that all psychosocial therapies with children need to be adapted to the context of maturational processes, and the social frame that supports or hinders them. Psychotherapy with children and adolescents, across orientations, aims to mobilise developmental processes appropriate to the child's age, replacing behaviours and other patterns typical of earlier development with more mature, adaptive capacities.

### 1.2.1 Psychodynamic Therapy with Children

Play and playing have always been at the core of psychodynamic approaches to working with children. The reasons for this are simple: the content, structure, and function of play are viewed as providing a window to understanding the nature of the child's anxieties and conflicts, and to assessing the internal and relational capacities he has available to organise and regulate his thoughts, feelings, and intentions. Psychodynamic child psychotherapy had its earliest beginnings nearly a hundred years ago, when Sigmund Freud used the principles of psychoanalysis to understand and treat (via the boy's father) the symptoms of Little Hans, a 5-year-old Viennese boy with a dread of horses. It was Hans's play, drawings, and fantasies that helped Freud uncover the conflicts and anxieties thought to lie beneath the child's fears, and that guided the interpretations of these fears that he passed along to the boy's father.

Freud's treatment of Little Hans was in essence the first psychodynamic child therapy, although his reliance upon verbal interpretation would differentiate his approach, derived directly from adult psychoanalysis, from that of psychoanalytically oriented therapy. Pioneered by his daughter, Anna, and another Viennese psychoanalyst, Melanie Klein, psychodynamic child therapy was

oriented around discovering the meaning and function of the child's play. Despite enormous differences in their view of early experience and psychic organisation, Freud and Klein together created the field of child psychoanalysis, and established it for a time as the primary means of treating children suffering from a wide array of psychological disturbances.

For both, play, like dreams, provided a window to the deepest parts of the child's soul, 'a royal road' to the unconscious. They and their followers were the first to fully recognise that children can express in play what they cannot express in words; indeed, until they are nearly adolescent, due to the constraints of development, and the nature of childhood defenses, play is their dominant mode of self-expression. Whereas words and insight were viewed as the primary agents of change in adult psychotherapy, the dynamic and therapeutic aspects of play were thought to be the dominant medium of change in child psychotherapy.

### 1.2.2 Psychodynamic Play Therapy

In the early days of psychodynamic child therapy, verbal interpretation of the unconscious meaning of the child's play was thought crucial to symptom remission and developmental advance. In this early view, resolution is only achieved via interpretation. But interpretation, per se, is no longer emphasised as the primary agent of change in child work; rather, what is thought to be curative is enhancing the child's symbolic, imaginative, and mentalising capacities by increasing the range, depth, and emotional richness of his play. This expansion of the child's capacity to acknowledge various aspects of his self-experience in the safety of play and fantasy is, many believe, what allows developmental progress. Mentalisation in play leads to the development of structures for containing feelings and understanding oneself and others.

The capacity to play is rooted in early relationship experience. Beginning with the earliest playful exchanges with the mother, the child slowly develops the capacity to recognise that he and she have separate and unique minds, and that ideas and feelings are not concrete realities, but rather states that, in play, can be reworked and transformed. The development of these capacities depends upon the establishment of intimate, secure relationships, which permit the discovery of the self and the other, and their separation. In relationships that are disturbed, however, these capacities are also disturbed; putting things into words and into play can be terrifying and disorganising.

It is for these reasons that the child's capacity to establish a relationship with the therapist (and, conversely, the therapist's capacity to establish a relationship with the child) is central to the treatment.

Play therapy is at the core two people, the child and the therapist, playing together. Children enter treatment with varying capacities to play, to talk, and to establish a relationship with the therapist. Most often these variations are linked to the nature and severity of developmental disruptions, emotional disturbance, and trauma. Sometimes the first job of the therapist is to help the child play, even a little. This may mean helping the child with the rudiments of telling a coherent story, it may mean helping him to imagine the inner life of the characters he has created, it may mean helping him find solutions in play that help to contain the intense feelings generated.

Because the relationship is so central to moving development forward, regularity is thought to be an especially crucial aspect of the process of play therapy. The processes inherent to the development of the capacity to pretend fully and imaginatively are complex, and require sustained periods of connection with the therapist. For this reason children are typically seen at least once a week, and many clinicians prefer to work with them twice or three times a week. In many clinical settings this may not be feasible, but there is evidence that increased frequency is critical to developmental change in seriously disturbed children. Equally critical to the child's progress is consistency. Children find change and disruption difficult, as their defenses are typically relatively tenuous or overly rigid; in either case, their capacity to engage in treatment is greatly helped by the therapist's sensitivity to the impact of these changes.

### 1.2.3 Working with Parents

Until recently, not much interest was taken in the psychodynamic child therapy of how to involve the parents in a child's individual treatment. Historically, the parent and his or her actual behaviour with the child were viewed as extraneous to the treatment process. While parents were typically seen occasionally for guidance and general 'catching up' on the child's home and school life, there was little conceptualisation of how to engage dynamically the parent in the child's treatment so as to change ongoing patterns of interaction and relatedness.

The first clinicians to work with the parents were Selma Fraiberg and her colleagues in their work on infant-parent psychotherapy (Fraiberg, 1980; Lieberman and Pawl, 1993). They were consulted by state welfare authorities to decide on troubled young mothers' capacities to care for their children, many of whom were showing signs of trauma and abuse at a very young age. Fraiberg and her colleagues were able to change the parent-child relationship in direct and dramatic ways by working with parents and infants together. They believed that the baby's presence in the room galvanised maternal affects and representations in ways that were transforming and healing, and allowed mothers to separate their own projections from the babies' affiliative and attachment needs. While this approach was virtually unheard of in the late 1970s, it has now become an accepted mode of working with parents and their infants and toddlers.

The aim of most parent work is to effect change in the dynamics and functioning of the actual parent-child relationship, as such changes are believed intrinsic to development in the child. One aspect of this work is to help parents understand critical aspects of their children's development; for example that a 4 year old's lie does not have the same significance or meaning as a 12 year old's. More importantly successful parent work involves engaging the parent's capacity for reflective functioning. Parent work helps a parent separate their own subjective experience of the child from the child's own thoughts, intentions and feelings. A parent's subjective experience of the child can be profoundly influenced by their own conflicts, or by the distorting effects of malevolent projections and representations. The work of the therapist is to help the parent hold the child and his or her subjective experience as separate in mind. This kind of work can powerfully help the parent to become better at managing the child's feelings and behaviour.

## 1.3 COGNITIVE BEHAVIOUR THERAPY WITH CHILDREN

CBT with children has its theoretical foundations in a number of related research traditions particularly behavioural science, social learning theory, cognitive developmental theory, and cognitive theory of emotional disorders.

In current practice, CBT with children and their parents has evolved from a loosely related set of theories, research findings, beliefs, and practice traditions, resulting in a diverse set of therapeutic techniques and practice. Some interventions emphasise the central role of children's cognitions in the etiology and maintenance of childhood disorders and thus aim to change cognitions, whereas others focus more on the behavioural mechanisms thought to be central to achieving change.

### 1.3.1 Behaviour Modification and Parent Training

Historically, techniques of change based on behavioural theory, such as behaviour modification, preceded more cognitive approaches. Behaviour modification applies the theory of classical and operant reinforcement to a wide range of childhood clinical problems such as anxiety disorders (phobias, obsessive-compulsive disorder) conduct problems and early developmental problems (sleep disturbance, enuresis). This approach is based on the notion that problem behaviours are likely to recur if the consequences of such behaviours are rewarding to the child. Formal treatments of this kind begin with a functional analysis, in which the antecedents and consequences of problem behaviours are systematically recorded so as to determine environmental and transactional patterns and responses that support these behaviours.

Interventions are planned to alter these behavioural patterns by focusing on reducing rewarding consequences, and increasing the positive consequences of pro-social behaviours. This approach is most commonly applied by working with the parent, using reported behaviour of the child in the school or home environment. Improvements with respect to reduced frequency or severity of problem behaviours are explicitly celebrated or rewarded. For example, parents are encouraged not to respond to angry outbursts or tantrums in young children with rewarding responses (attention, raised excitement) and to encourage more pro-social behaviours in achieving wishes or negotiating conflict.

Alternatively, treatment focuses on the behaviour and interactions taking place within the treatment session and explicitly structured sessions as opportunities to change the child's behaviour. For example in the Parent-child Game, therapist directly prompts parents (through a one-way screen using an earpiece) to follow behaviour modification principles in changing a child's behaviour.

Parent training has become one of the most widely used of the behavioural approaches. This method has been most comprehensively developed and evaluated by Webster-Stratton (Webster-Stratton and Herbert, 1993). The training can be delivered to parents either individually or in a group, and is typically brief (eight to 12 sessions) with a carefully prepared curriculum for each session. Video clips are used to illustrate common parent-child conflicts, and the emphasis is on structured homework exercises that facilitate the generalisation of skills

learned in therapy to the family environment. Initial sessions focus on positive interactions between the parent and child, particularly those that occur within the context of play. Behavioural principles of selective attention and reinforcement are illustrated and practiced through homework tasks, along with more cognitive components such as problem solving, negotiating turn taking and emotional recognition.

### 1.3.2 Individual Cognitive Behaviour Therapy

The CBT model is based on the proposition that childhood emotional disorders are maintained by cognitive biases which are manifested through fixed core beliefs, dysfunctional assumptions, and automatic thoughts about the world, self, or others and results in dysfunctional mood states, emotion or social interaction.

Typically there are four key components in CBT with children they are engagement, formulation, learning new skills, and applying change strategies. The construction of a shared, comprehensible formulation is central. Problems are defined in terms of a child's thoughts, feelings, and/or behaviour, usually linked to specific situations and rated by frequency and severity. This enables problems to be addressed sequentially and organised in a hierarchical way that allows the child (and parent) to determine what they are able to cope with. The person (child) in a more global sense is not the problem. This definition of the problem allows for explicit understanding about the solution that is being sought and allows the possibility of the child and the parent achieving success by reaching explicit targets of change. Behavioural techniques for noticing and rewarding positive change are usually integrated into this broader CBT approach.

In general, CBT sessions tend to have a more structured curriculum than nondirective therapies. The therapist is active, self-disclosing where appropriate, and adopts a psycho-educational, collaborative approach in which a range of activities within the session may be suggested. Kendall (2000) uses the metaphor of the therapist as being like a sports coach in which concepts of practice, preparation, and training are often referred to. The focus is on creating change both within the session but also more importantly in generalising change to the child's daily life. Practicing anger or anxiety management skills with the therapist in real life situations may be part of the treatment plan, as the intervention is not necessarily confined to the clinic room. In order to support the generalisation of new skills to the home environment, the curriculum often includes homework and record keeping tasks.

Initially activities may focus upon developing core skills such as: emotional recognition; separating thoughts, feelings, and actions; and activity monitoring and diary keeping. For example, poor discrimination between anxiety and anger feeling states may be more common in children with emotional behavioural difficulties. Similarly, improving a child's ability to regulate emotional states is likely to be dependent on their ability to monitor and notice internal states. Activities supporting strategies for change will be adopted depending on the formulation but may include a combination of behavioural and cognitive techniques such as relaxation training, problem solving, role playing, exposure, behavioural experiments, and testing the evidence for beliefs. Perhaps the most widely applied change technique is problem solving, in which children are guided to consider alternative options, to adopt a position of choice rather than powerlessness and to improve social perspective taking.

There are certain limitations to application of this approach. First, in contrast to adults, children are brought to therapy. Children may not collaborate if they perceive the reason for therapy as being critical of them, i.e., having a behaviour problem. Second, compared with adults, children's ability to make changes in their lives is restricted by their dependency on parents/caregivers. Third, children's interests and styles of interaction require that therapeutic methods not rely solely on verbal interaction. Some cognitive techniques for adults may be developmentally inappropriate and ineffective with children. There is a need to incorporate both the form and content of children's thinking for the cognitive components of CBT to become applicable. Thus, for younger children, their thinking and expectations of the world and others may be most readily revealed through symbolic play. Similarly, children may need narratives as a way of developing explanations about the world, rather than abstract ideas. Thus, for example, storytelling may have a greater role in cognitive restructuring than methods of Socratic questioning appropriate for adult CBT work. Finally, CBT interventions partly rely on the patient being able to report cognitive states in order that distortions can be effectively challenged. In general, children may have less practice (and less interest) in the recall of experience and monitoring internal states than adults. That is why such therapeutic tasks need to be carefully constructed to be within their cognitive developmental abilities.

### 1.3.3 Working with Parents

There has been a tendency in the child CBT literature to describe CBT independent of the role and relationship of parents and other family members. For example, Lochman et al. (1991) concluded that the "most striking deficiency in CBT programs has been the neglect of children's caregivers, especially parents". Working with the caregivers can be critical in strengthening treatment effects and in maintaining the generalisation of treatment effects over time. In addition, there is some suggestion that involvement of parents may increase treatment effectiveness.

Different CBT approaches with children have proposed different roles for parents that can be broadly identified as facilitator, co-therapist, or patient. As facilitator, the parent is predominantly involved in supporting the child's individual therapy and may meet with the therapist occasionally. As a co-therapist the parent may be actively involved in supporting the child in learning new skills and may be central to providing behavioural feedback and rewards.

In such instances, the parent is seen as closely collaborating with the therapist using agreed upon CBT technique. Alternatively, parents may be clients receiving treatment to cope with their own difficulties, which may be associated with the child's problem, either as part of a family approach or individually alongside the child's sessions. Typically, parents may be offered CBT to manage their own emotional and behavioural difficulties. In practice, parents may sometimes wish to move between these different roles during a child's treatment and, although some flexibility of relationship with the family is often essential, sudden changes in parental role can be disruptive for the child. In general, much work still needs to be done in developing models of CBT practice that are coherent with family roles, relationships, and individual differences.

## 1.4 FAMILY THERAPY

Family and systemic therapies believe that intervention must address the interactional patterns between people as well as their intra psychic processes. Gurman et al. (1986) have defined family therapy as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family.

The last 10-20 years has seen a major change from individual to family systemic therapeutic approaches to children and families in clinical practice, within both the health and social services. However, it is important to recognise that family therapy is not about the creation, or maintenance, of traditional nuclear families. Family therapists have to recognise the diversity of configurations that families today bring to the task of rearing children and should strive to maintain a respectful and nonjudgmental approach to these differing choices.

### 1.4.1 Children and Young People in Family Therapy

Although family and systemic therapies have become one of the predominant forms of working with children's emotional and behavioural problems, surprisingly little has been written about children's perceptions of family work or about ways in which children might be more fully engaged in the therapeutic process. Most therapeutic models rely heavily on verbal communication and so might be seen to exclude younger children. In the past family therapy has been criticized for ignoring children and, in effect, conducting therapy in their presence without involving them. Children's worlds are often full of play, creativity, and activity and therapy must incorporate these concepts if it is to be meaningful to children.

Different schools of family therapy have addressed these concerns in different ways. These are:

Structural family therapy (Minuchin et al., 1967; Minuchin, 1974) assumes that problems in the child arise from underlying problems in the structure and organisation of the family. The therapist is interested in how the family makes decisions, and how the boundaries between individuals and subsystems within the family lead to relative engagement or distancing.

The therapist is often directive, attending to sequences and patterns of behaviour, and seeking to bring about change using techniques such as enactment and the encouragement of family members to practice new ways of behaving and communication in the session which ensures that all family members, including even quite small children are actively involved in therapy.

### 1.4.2 Brief Solution-Focused Therapy (Berg and de Shazer, 1993)

This therapy assumes that problems are maintained by the way difficulties are viewed and by the repetitive, behavioural sequences surrounding attempts to solve them. Families are seen as constantly changing and it is assumed that families will already have solutions to their own difficulties. The therapist sets clear goals with the family and focuses on solutions not problems. Underlying this emphasis on competence and solutions is a focus on challenging unhelpful

beliefs about the child and the problem as part of the process of generating new solutions. This focus on solutions can be helpful when working with children who are often worried that being brought for therapy is just another context in which they will be blamed for family difficulties. Solution-focused work is often active and, like structural therapies, can involve tasks and between session homework these practical activities provide a further opportunity for children to be actively engaged.

### 1.4.3 Narrative Therapy (White and Epston, 1990)

This therapy draws on the way that we all make sense of our experience by creating personal accounts or narratives. Therapy is a form of conversation that encourages reflection and can transform problem-saturated narratives into more positive accounts. The emphasis on language can be off-putting for children but techniques such as externalisation, which assist in separating the person from the problem, can help the child to feel less blamed and join the child with the family in fighting the problem. Narrative therapists also see those with problems as having expertise in solving them that may help children to feel engaged and less blamed, and the emphasis on narrative suggests the possibility of links with stories and storytelling ideas familiar to children. Narrative therapists also look for unique outcomes and positive exceptions concepts similar to the search for solutions and exceptions by solution-focused therapists, and this too may help children to feel less blamed.

There are a few recent studies looking at children's perspectives on therapy. Stith et al. (1996), for example, explored the experience of 16 children from 12 families in a qualitative study. Children, interviewed alone, wanted to be included in therapy and were keen to know more about their families, be involved in generating solutions and not feel blamed for problems. They did not want to be the sole focus of discussion. Even primary school children understood the purpose of therapy and found talking about problems helpful but their willingness to be involved increased with time and with the amount they knew about why their families were coming to therapy.

There are many important differences between approaches to the treatment of children. Treatments have been extended from traditional inpatient and outpatient settings to community contexts. There is an increased tendency, across orientations, to offer treatment in context: in relation to the family and perhaps the school, rather than focusing on the child alone.

**Self Assessment Questions**

1) Name the predominant approaches to working with children?

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2) What is the aim of psychodynamic child therapy?

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3) What is the goal of parent work in therapy with children?

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## 1.5 PSYCHOTHERAPY WITH ADOLESCENTS

Psychotherapy with adolescents differs in a number of substantive ways from psychotherapy with adults. Adolescence is a time of transition. Processes of cognitive, social, emotional, and physical maturation can affect the nature and course of symptoms. It is necessary to adapt our psychotherapeutic approaches in order to assist adolescents in managing such changes. There is a general consensus that it is important to adopt a contextual and developmental perspective for describing, understanding, and treating adolescents.

### 1.5.1 Developmental Considerations

Early research into the efficacy of psychotherapy for treating youth borrowed heavily from research with adults. Models, methodologies, instruments, and clinical techniques that had been found useful in clinical outcome research with adults were simply applied to a new sample: children and adolescents. It quickly became apparent, however, that processes responsible for the expression of behavioural and emotional difficulties among youth may differ from those of adults. Responding to this challenge, recent research has been more sensitive to developmental differences between children, adolescents, and adults.

A range of physical, social, cognitive, and emotional changes occur over the course of adolescence. These developmental changes and issues must be considered both when developing a clinical treatment plan, and when designing a clinical research project. Developmental changes include puberty, the emergence of formal operational thought, the emergence of an adult identity, increasing emphasis on relationships with peers, decreasing reliance on parents for guidance and support, the establishment of vocational goals, the emergence of sexual interests, and the consolidation of values, standards, and tacit beliefs.

1) **Puberty**

Puberty, for example, is accompanied by a range of changes, both hormonal and physical. The physical transformations that accompany puberty can be confusing,

exciting, and challenging. The effects of physical maturation on adjustment during adolescence, however, are complex. Significant individual differences exist in the age of onset of puberty and in the rate at which physical maturation occurs. Moreover, there can be asynchronies in development across physical, social, and emotional domains.

The effects of physical maturation on psychosocial development and adaptation appear to be mediated by a number of factors including gender, age of onset of puberty, the relative maturity of peers, and cultural, familial, and community beliefs about maturation. That said hormonal changes accompanying puberty appear to have broad effects on adolescent development. They have been associated with changes in expression of anger, oppositionality toward parents and other adults, sexual behaviour, aggression, mood, self-confidence, and level of psychopathology.

It is not clear, however, that relations between physical maturation and adjustment are direct. Rather, the effects of hormonal changes accompanying puberty appear to be mediated and moderated by psychological, familial, and social variables.

The effects of puberty on adjustment are clinically important for a number of reasons. Physical maturation during adolescence has significant effects on the social status of the individual, how they view themselves, how their peers see them, and how they are viewed by their family and the larger community. Others expectations for them will change as they mature. Teenagers who appear mature may not, however, be socially, emotionally, and cognitively mature, leading to confusion and conflict. Moreover, teenagers naturally experience a range of thoughts and feelings about their physical and sexual maturation. Their thoughts, fantasies, and expectations about these changes, and their effects on their life and relationships, are worthy of discussion during psychotherapy. This is particularly important when the teen is dissatisfied with the changes in their appearance or the ways that these changes have affected their relationships with others. Physical maturation and the social changes that accompany it have important effects on adolescent adjustment and can, as a consequence, complicate the practice of psychotherapy with adolescents.

2) **Cognitive Development**

Developmental changes in reasoning also influence emotional and behavioural adaptation during adolescence. As formal operational thought emerges, for example, adolescents may be better able to reflect upon their experiences and motivations, to develop and evaluate alternative interpretations of events, and to examine critically their beliefs and attitudes. As they develop hypothetico-deductive reasoning they will be better able to use insight-oriented and cognitive-behavioural interventions.

As formal operational thought emerges in adolescents, however, it may be applied in an egocentric manner. This may lead adolescents to believe that others are as concerned by their behaviour and appearance as they are (an imaginary audience) or that his or her emotions are both unique and significant (the personal fable). This can be accompanied by fluctuations in affect. Egocentric thought during adolescence can be associated with a tendency to personalise events, to magnify their significance, and to misperceive their consequences. Clinically, this can contribute to emotional lability as adolescents believe their emotional experiences

are more intense than those of their peers. It can also contribute to difficulties trusting others (including the therapist) based on the belief that no one really understands me. A central task in cognitive-behavioural psychotherapy (CBT) with adolescents, then, is to assist the individual to recognise these misperceptions and to develop more mature forms of reasoning.

3) **Autonomy and Independence**

Development of autonomy, a sense of personal efficacy, and an ability to function independently of one's parents and family are central tasks of adolescence. Peer support plays a critical role in accomplishing these tasks. Adolescents' sensitivity to the norms of their peer culture, as well as a desire for acceptance by their peers, can both assist with the process of becoming independent from ones family, and can lead them to become resistant to the authority of their parents and other adults. Moreover, it can lead them to question the beliefs, attitudes, expectations, and values of their families. Clinically disturbed adolescents may, as a result, show little concern for fitting their actions to the norms of adult society. Not surprisingly, such youth can find it difficult to form a trusting relationship with a therapist. This can be exacerbated by a tendency on the part of parents and adolescents to view their problematic behaviour as a normal part of growing up.

Adolescent oppositionality, resistance, and identification with negative aspects of their peer culture may be understood, then, within a developmental context. Difficulties becoming independent from one's parents can also be problematic. Insofar as anxieties and ambivalence about autonomy from one's parents, oppositionality, fluctuating self-image, and challenging of accepted beliefs are, in many ways, normal and adaptive parts of the adolescent experience, it can be difficult for clinicians to discriminate normal, healthy adaptation and problematic behaviour. The line between normative development and clinical disturbance is often a thin one.

Not all adolescents experience turmoil (most, in fact, are reasonably well-adjusted socially and emotionally), and not all turmoil is maladaptive. How therapists conceptualise turmoil can have important effects on how they develop clinical formulations and on how they approach treatment.

## 1.5.2 Depression

Studies suggest that several forms of psychotherapy can be helpful in treating clinical depression among adolescents. Two approaches that have received the largest amount of empirical interest and enjoy the strongest support are CBT and interpersonal psychotherapy for adolescents (also referred to as IPT-A).

A substantial body of research indicates that CBT can be effective for treating depression among adolescents. Although differences exist between cognitive-behavioural protocols, they tend to emphasise the development of specific skills that can be helpful for managing depressed mood. Skills addressed include developing a goal list, monitoring one's mood, engaging in pleasant activities, development of social skills, engaging in activities that provide a sense of accomplishment or mastery, relaxation, conflict resolution and negotiation, identification of cognitive distortions or biases, identification of maladaptive thoughts, rational disputation of maladaptive thoughts, and developing realistic counter-thoughts. Recently developed approaches to CBT tailor therapeutic

techniques to the specific needs of individual patients (Curry and Reinecke, 2003). A list of the specific cognitive-behavioural tasks used in CBT is presented in Table below

**Table 1.1: Cognitive Behavioural Interventions for Depression**

- Development of therapeutic rapport. Make adolescent and parents feel understood
- Develop shared problem list
- Develop and share rationale with adolescent and parents
- Mood monitoring
- Pleasurable events scheduling
- Mastery activities scheduling
- Rational problem-solving
- Realistic counter-thoughts (rational responding)
- Social skills/address social withdrawal
- Family communication (encourage expression of emotions, compromise)
- Assertiveness training (to address passivity)
- Review and consolidation of gains/relapse prevention
- Booster/follow-up sessions

### 1.5.3 Interpersonal Therapy

IPT, a form of psychotherapy developed by Gerald Klerman et al. (1984) for treating depressed adults, has been adapted for use with adolescents (Mufson et al., 1993). The approach focuses on addressing common interpersonal difficulties experienced by adolescents, including challenges associated with autonomy from parents, relationships with peers, and managing the loss of significant relationships. Explicit attempts are made to identify interpersonal factors that are associated with the cause and maintenance of the depressive episode. Information is gathered about the nature and quality of the adolescent's relationships, their expectations for the relationships, whether these expectations are being met, goals for their relationships, and how they have attempted to accomplish these goals. Particular attention is given to separations and losses, conflict, changes in roles, interpersonal deficits (including social withdrawal or isolation, social skills deficits, and social anxiety), and difficulties encountered in single family homes. Active attempts are then made to address difficulties identified in these domains.

To date, research on ITP-A has been positive. Completion of a 12-week ITP-A program has been associated with a significant reduction in symptoms of depression, improved social functioning, and an increased rate of remission from the depressive episode. Moreover, gains appear to be maintained over time. Although research is limited, ITP-A is a promising approach for understanding and treating depressed youth.

Apart from the above approaches, psychodynamic psychotherapy endeavors to treat depression by providing adolescents with insight into defenses used in coping

with the expression of drives, by identifying and rectifying recurrent relationships issues, by addressing feelings of narcissistic injury, or by establishing a more coherent, integrated, and authentic sense of self. Psychodynamic psychotherapy typically is nondirective, long term, and focuses upon the expression and interpretation of events within the therapeutic relationship as a means of bringing about clinical improvement.

Although it is widely used, little systematic research has been conducted examining the efficacy of psychodynamic psychotherapy with clinically depressed youth. No randomized controlled trials of these forms of psychotherapy have been published. Individual psychodynamic psychotherapy has not, then, been demonstrated to be an effective treatment for depression among adolescents. That said, preliminary evidence indicates that adolescents who receive intensive psychodynamic psychotherapy may benefit over time.

In conclusion, CBT and IPT appear to be effective in alleviating symptoms of depression among youth. Gains achieved appear to be reasonably stable over time. Evidence supporting the efficacy of psychodynamic and psychoanalytic psychotherapy is scant.

### 1.5.4 Anxiety

Several protocols have been developed for treating child and adolescent anxiety disorders. Controlled outcome studies completed over the past 15 years indicate that behavioural psychotherapy and CBT can be useful in treating generalised anxiety, school anxiety, specific phobias, panic, and obsessive-compulsive disorder among youth.

Based upon cognitive and behavioural models, these approaches help to alleviate anxiety by teaching children and adolescents to monitor their moods, anticipate situations in which they are likely to become anxious, identify specific distressing thoughts, and respond to these cues by actively using cognitive and behavioural coping strategies. Exposure and desensitisation, relaxation training, guided imagery, rehearsal of adaptive self-statements, and encouragement of adaptive coping attempts are frequently used.

Parent and family sessions are typically included in these treatment programs, both to address parental behaviours that may be maintaining the child's anxiety and to provide them with strategies for managing their child's anxiety at home. Cognitive strategies (which focus upon reducing cognitive distortions, developing coping skills, and enhancing perceptions of control or efficacy) and behavioural approaches (which emphasise desensitisation to anxiety-provoking stimuli and operant reinforcement of adaptive coping) are typically used together.

Types of anxiety experienced by children and adolescents vary with age. Forms of anxiety that may be normal at one age (such as a fear of separation from parents during the toddler years) may be quite inappropriate at a later age. The most common source of anxiety during adolescence is peer rejection, and the most frequent anxiety disorders are social anxiety, panic, and agoraphobia. As adolescents develop the capacity for hypothetico-deductive reasoning, they become increasingly able to envision a range of potential threats, dangers, and sources of social embarrassment.

Increasing rates of social anxiety among adolescents are due to the central importance given to peer relationships for negotiating independence from one's family and for developing mature sexual relationships. Cognitive-behavioural models suggest that anxiety disorders tend, as a group, to stem from unrealistic appraisals of threats related to normal fears. It is these appraisal processes that are the focus of treatment.

CBT has been found effective for treating school phobia, overanxious disorder, overanxious disorder and specific phobia, panic disorder, social anxiety, generalised anxiety, and obsessive-compulsive disorder. Although few long-term follow-up studies have been completed, those that have been published are promising. Results suggest, for example, that gains achieved in CBT may be maintained for up to 3 years.

Parents of anxious children and adolescents often experience high levels of anxiety themselves, and the possibility exists that this may lead parents to behave in ways that exacerbate and maintain their children's difficulties. At a minimum, clinicians should attend to the moods of their patient's caregivers and the ways in which this may affect the child's adjustment. If appropriate, parents might be referred for treatment to address their feelings of anxiety.

### 1.5.5 Conduct Disorders

Conduct problems, including aggressive behaviour, disobedience and defiance at home and at school, and major rule violations, are among the most persistent and difficult to treat clinical problems in adolescence. They are among the most common reasons for clinical referral, reflecting their high prevalence rates and the fact that they can be quite distressing to parents and school officials. Traditionally, serious conduct problems have been treated with long-term, dynamically informed psychotherapy aimed at low frustration tolerance, limited self-awareness, impaired empathy, compromised interpersonal relations, or a fragmented, non-cohesive sense of self.

Three treatments have been developed for and evaluated with conduct disordered adolescents.

The first is anger control training with stress inoculation (Feindler, 1991). At the core of this intervention is the view that youth with delinquent and aggressive problems have serious difficulties with the expression and regulation of anger. The treatment, then, principally aims at teaching youth a variety of coping strategies for reducing angry arousal. Therapy focuses on helping youth to identify anger provocation cues, to suppress immediate anger responses with self-instructions, to modulate arousal with relaxation or self-instructional techniques, and to consider consequences of aggressive behaviour or explosive anger. In addition, a portion of the treatment is directed toward training individuals to behave in an assertive rather than an aggressive manner. Treatment is offered in both individual and group formats, and typically is time limited (12-25 sessions). Although psychoeducation is given emphasis in this treatment therapists also model the components of anger management, and adolescents are made to role-play skills under varied conditions of anger arousal.

The second promising treatments for adolescent conduct disorder are family-based therapies. A growing body of research suggests that disrupted family

relations, poor parental monitoring, inconsistent discipline, and cross-generational continuities may contribute to aggressive and disruptive behaviour among youth. Based on these findings, family processes have been targeted for intervention.

Functional family therapy draws heavily on social learning formulations of noncompliance and aggressive behaviour. At the core of this intervention is the view that aggressive and disruptive behaviours are maintained through patterns of family interaction that unintentionally reinforce problem behaviours while failing to reward pro social behaviours. One recurrent pattern involves negative reinforcement. An adolescent may, for example, respond to limits or requests with aversive behaviours such as whining, arguing, or threatening.

His or her parent, in order to reduce the aversive interaction, responds by disengaging or withdrawing. The youth's aversive behaviour has been reinforced by the removal of the request, and the parents' disengagement is reinforced by the reduction in aversive interactions. Not surprisingly, over time, families with conduct-disordered youth appear to be quite disengaged and lacking in cohesion. Further, youth fail to comply with parental limits and requests.

## 1.6 FUNCTIONAL FAMILY THERAPY

This attempts to modify such dysfunctional family patterns by altering parental monitoring and disciplinary strategies. Parents are taught to use basic social learning principles for managing youth behaviour. Several additional components complement the core behavioural approach including family sessions designed to improve communication and increase family reciprocity, and sessions aimed at facilitating negotiation among family members.

### 1.6.1 Multisystemic Therapy (MST; Hengeler et al., 1998)

This is an integrative and comprehensive approach to treating youth conduct problems and antisocial behaviour. Unlike traditional, comprehensive treatments that remove the adolescent from his or her social environment through placement in residential treatment settings, MST aims at restructuring multiple levels of the youth's environment in order to promote pro-social functioning. Based on Bronfenbrenner's (1979) ecological model of development, individual behaviour is viewed within the context of multiple, nested contexts. Relevant context is not limited to the family, as in functional family therapy, but extended to the school, neighbourhood, peer group, and broader community, as well as to linkages among these systems.

MST draws upon methods from a number of empirically based treatments. For example, interventions at the family level might include communication training as well as methods from strategic or structural family therapy. Integration of specific interventions is guided by a core set of principles. MST begins with the assumption that the purpose of assessment is to understand the fit between identified problems and the functioning of multiple systems.

Psychiatric diagnosis is not the primary aim, instead MST therapists attempt to identify processes at multiple levels that support or impede adaptive functioning. In turn, therapeutic interventions attempt to use systemic strengths, for example, a committed extended family, as levers for change. All interventions are present

focused and action oriented. Typically, many interventions focus on specific contingencies that sustain problematic behaviours. Therapist and family agree upon specific, well-defined goals, and progress is closely monitoring, including family feedback on treatment fidelity.

**Self Assessment Questions**

1) What is interpersonal psychotherapy with adolescents?

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2) Name the three treatments which have been developed for conduct disordered adolescents?

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3) What is functional family therapy?

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## 1.7 LET US SUM UP

The three of the predominant approaches to working therapeutically with children are psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy.

Psychodynamic child psychotherapy was the first psychosocial treatment specifically developed for mental disorders for children. Its aim is the developmental advancement of children whose symptoms are seen as an indication of a failure to progress socially, cognitively, or emotionally. While interpretation and insight represent an important feature of therapeutic process, more central are becoming able to play, and to establish a relationship with a therapist that is richly imbued with symbolic meaning, and aims to extend the child's capacity coherently to represent mental states. These representations allow the child to understand himself and others better, and to gain more control over what happens in his or her relationships as a result. For most child therapists, work with parents is important for both preschool and school-age children, its primary aim being to help parents understand their child's thoughts and feelings.

CBT with children currently encompasses a wide range of interventions to address childhood disorders and distress. In general, there is some evidence of the usefulness of CBT for a number of childhood disorders. More established behavioural approaches such as behaviour modification and parent training increasingly include cognitive factors for both parents and children, and the child is placed in a more central position in the therapeutic endeavor. This is ideologically welcome as it conveys respect for the child's perspective and experience. However, it remains unclear whether CBT is yet addressing critical cognitive factors that lead to childhood disorders.

There is evidence that family and systemic therapy is an effective treatment for some young people and systemic ideas can contribute to the delivery of other treatment modalities. The theoretical models and practical techniques of the current schools of systemic practice all acknowledge the importance of involving children and have all found creative ways of doing this. There is emerging evidence from qualitative research that even quite young children can understand, make sense of, and participate in systemic work. Careful explanation of the purpose and process of therapy, recognition of the expertise of the child and the provision of environments that are child friendly and promote play and creativity should maximize the involvement of children.

We can be optimistic about the benefits of psychotherapy for treating anxiety and depressive disorders experienced by adolescents. The treatment of conduct disorder remains a vexing problem, but the emergence of comprehensive and systematic interventions, such as MST, hold significant promise. The social environment (both family and peers) is important. It is important to attend to both stressors and social supports. Behavioral, emotional, and social difficulties experienced by adolescents can have pernicious effects that persist into adulthood. It is important, then, to include long-term assessments as a part of both clinical practice and research. We should, at the same time, attempt to insure that our interventions have broad, positive effects on adolescents' development.

## 1.8 UNIT END QUESTIONS

1) Describe the different psychotherapy approaches in treatment with children?
2) Discuss in detail the different developmental changes during adolescence?
3) Write about the psychotherapeutic approaches used for treating depression in adolescents?
4) What are the ways in which anxiety could be treated in adolescentgs?
5) Describe the different approaches used for treatment of conduct disordered adolescents?

## 1.9 SUGGESTED READINGS

Friedberg, R. D. and McClure, J. M. (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: the Muts and Bolts.* New York: Guilford Press.

Plante, Thomas G. (2005). *Contemporary Clinical Psychology.* New Jersey: John Wiley & Sons, Inc.

# UNIT 2 PSYCHOTHERAPY WITH ADULTS AND MIDDLE AGED PERSONS

**Structure**

2.0 Introduction
2.1 Objectives
2.2 Psychotherapy with Fledgling Adults
 2.2.1 Life Stage Issues with Fledgeling Adults
 2.2.2 Psychosocial Tasks of Middle Adulthood
2.3 Psychotherapy with Young Adults
2.4 Overview of Young Adult Issues
 2.4.1 The Psychotherapy Model and Young Adult Issues
 2.4.2 The Medical Model and Young Adult Issues
 2.4.3 Therapy for Young Adult Issues
2.5 Psychotherapy with People in Middle Adulthood
2.6 Parallels and Distinctions
2.7 Let Us Sum Up
2.8 Unit End Questions
2.9 Suggested Readings

## 2.0 INTRODUCTION

Many micro skills are common to counseling or therapy with clients of all agesand many significant life events that might bring clients into therapy such as bereavement, illness, traumaticstress, for example have no special or very clear association with age or life stage. Nonetheless, if the differences between counseling children, adolescents and adults are ignored, the outcomes may be disappointing. The present block, therefore, addresses some of the specific issues concerned with counseling clients at different life stages. This unit will describe the issues and concerns related to psychotherapy in fledgling (18-25 years), young (25-40 years) and middle adulthood (40-65 years). Separated out for reasons of convenience and manageability, it needs to be remembered that these stages overlap chronologically and, to an even greater extent, psychologically and developmentally.

Many people feel themselves 'betwixt and between' different life stages, having a foot in two camps as it were. It must be remembered that while life stage labels have their use and their importance is overshadowed by the need to keep to the fore the individuality and uniqueness of each particular client. The goal is to help clients 'be themselves' rather than 'act their age'.

## 2.1 OBJECTIVES

After completing this unit, you should be able to:

- Describe the issues and life stage problems with fledgling adults;

- Discuss the typical issues and areas relevant for therapy with young adults; and
- Describe middle adulthood and issues important for counselling.

## 2.2 PSYCHOTHERAPY WITH FLEDGLING ADULTS

Although those between the ages of 18 and 25 are often referred to as young adults by implying that the status of adulthood has been reached but this may be somewhat misleading. If you think of the range of different minimum age legislation that exists (across countries) for voting, for criminal responsibility, for marriage, for joining the armed forces, for the age of consent, for obtaining a driving license etc., it is hardly surprising that the onset of adulthood is beset with confusion. It is a status acquired haphazardly and little by little. To be sure, young people in the 18–25-year age band are legally adults, but this does not mean that they feel 'grown up'. They move towards adulthood in the context of a diminishing support network, and this can leave them feeling isolated and vulnerable. Contact with parents and other relatives may diminish or be lost as family ties weaken or disintegrate through divorce, geographic dispersion and social diversity. Friendship networks may be unstable. They are less likely to have strong religious affiliation. Universities no longer operate *in loco parentis*.

The dynamic, fluid and transitional quality of this period is captured in such terms as emerging, threshold or fledgling adulthood. Like adolescence, it is a stage that is culturally constructed and during the last three decades of the twentieth century it became a period of increasing demographic diversity and instability. There are now no certainties, and ever fewer probabilities, in relation to likely occupational, residential, marital or parental status.

Thus, for example, while many 18–22 year olds are in fulltime higher education (allowing student counseling to become a distinct and well defined area of work) many others are not.

### 2.2.1 Life Stage Issues with Fledgling Adults

Life stage issues that fledgling adults may bring to psychotherapy or counseling (Thomas, 1990; Cooper, 2003) include:

- Difficulties occurring in relation to family and friends;
- Issues of sexual identity and development;
- Questions of morality in the face of an imperfect self and a flawedsociety;
- Problems of planning a career, finding satisfactory employmentand adjusting to job conditions;
- Financial difficulties.

While these difficulties and their manifestations are by no means unique to the period of fledgling adulthood, the developmental status and social demands of this stage lend them a particular quality and form. The shift in gaze from family to peers offers freedom, but can also create anxiety if such distancing from parents is perceived as risking the loss of their love and support. Furthermore, the independence that a job or full-time education away from home can bestow may

be compromised by continued financial dependence on parents, and by the need to return to the family fold if subsequent occupational opportunities fail to materialise, or the cost of housing outstrips their income.

This is the 'boomerang' generation which leaves home but (sometimes to the discomfiture of their parents) keep coming back. If, in contrast, their professional and/or financial success seems set to outstrip that of their parents, they may feel they are in some way being disloyal and be unable to grasp the opportunities before them.

Fledgling adults will often be concerned with establishing a workable and acceptable system of values. It is a time for putting into practice (or not) the idealism of adolescence. Awareness of the discrepancies between their own pretensions and performances can be acute, with assessment of their own and other people's moral standards being largely grounded in the quality of personal relationships.

The fledgling adult anticipates that, largely through various social and sexual experiences, the unstable and ill defined self concept of adolescence will become more clear and consolidated, and that a specific and fixed sexual identity will be established. While this may be true to some degree, the plasticity of human development including sexual orientation is easily underestimated. The myth of adulthood as a fixed and stable state is pervasive, and distorts both expectations and self-evaluations of personal success and failure.

As fledgling adults strive towards adulthood, the ripples of their struggle disturb the equanimity and sense of being 'in charge' of the generation ahead of them. It emphasises to parents that they are growing older, and that the society they created will eventually be supplanted and overtaken by this new generation. The majority of therapists will still be a good many years older than their fledgling adult clients, and so intergenerational dynamics will again be an issue in the client– therapist relationship. Therapists may at times find that their worldview more closely approximates that of the parents than of the fledgling adults themselves.

### 2.2.2 Psychosocial Tasks of Middle Adulthood

Erikson stated that the primary psychosocial task of middle adult hood ages 45 to 65 is to develop generatively, or the desire to expand one's influence and commitment to family, society, and future generations. In other words, the middle adult is concerned with forming and guiding the next generation. The middle adult who fails to develop generatively experiences stagnation, or self-absorption, with its associated self-indulgence and invalidism.

Perhaps middle adulthood is best known for its infamous midlife crisis: a time of reevaluation that leads to questioning long-held beliefs and values. The midlife crisis may also result in a person divorcing his or her spouse, changing jobs, or moving from the city to the suburbs. Typically beginning in the early- or mid-40s, the crisis often occurs in response to a sense of mortality, as middle adults realise that their youth is limited and that they have not accomplished all of their desired goals in life. Of course, not everyone experiences stress or upset during middle age; instead they may simply undergo a midlife transition, or change, rather than the emotional upheaval of a midlife crisis. Other middle adults prefer to reframe their experience by thinking of themselves as being in the prime of their lives rather than in their declining years.

During the male midlife crisis, men may try to reassert their masculinity by engaging in more youthful male behaviours, such as dressing in trendy clothes, taking up activities like scuba diving, motorcycling, or skydiving.

During the female midlife crisis, women may try to reassert their femininity by dressing in youthful styles, having cosmetic surgery, or becoming more socially active. Some middle adult women try to look as young as their young adult children by dying their hair and wearing more youthful clothing. Such actions may be a response to feelings of isolation, loneliness, inferiority, uselessness, non assertion, or unattractiveness.

Middle-aged men may experience a declining interest in sexuality during and following their male climacteric (male menopause). Fears of losing their sexual ability have led many men to leave their wives for younger women to prove to others (and to themselves) that they are still sexually capable and desirable. In contrast, middle-aged women may experience an increasing interest in sexuality, which can cause problems in their primary relationship if their significant other loses interest in sexual activity. This leads some middle aged women to have extramarital affairs, sometimes with younger sexual partners.

Happiness follows a U-shaped curve during a person's lifetime, according to research showing that middle-aged people are the unhappiest. Satisfaction with life starts to drop as early as a person's late 20s and does not begin to recover until well past 50, says Bert van Landeghem, an economist at Maastricht University in Belgium. While young adults are carefree and full of hope for the future and the over-50s have come to terms with the trials of life, the research indicates that those in the middle feel weighed down by the demands on them.

Studies around the world have shown that happiness tends to dip in midlife, van Landeghem said, and that this was not just a phenomenon confined to the Western world. Last month Lewis Wolpert, emeritus professor of biology at University College London, said happiness could peak as late as 80. In a book called *You're Looking Very Well*, Prof Wolpert said most people were 'averagely happy' in their teens and 20s, but this declined until early middle age as they attempted to support a family and career. He added: 'From the mid 40s, people tend to become ever more cheerful and optimistic, perhaps reaching a maximum in their late 70s or 80s.' An easing of the responsibilities of middle age, maturity and an increased focus on things we enjoy contributed to the trend, he said.

### Timing of Events Model

The field of life span development seems to be moving away from a normative crisis model to a timing of events model to explain such events as the midlife transition and the midlife crisis. The former model describes psychosocial tasks as occurring in a definite age related sequence, while the latter describes tasks as occurring in response to particular life events and their timing. In other words, whereas the normative crisis model defines the midlife transition as occurring exactly between ages 40 and 45, the timing of events model defines it as occurring when the person begins the process of questioning life desires, values, goals, and accomplishments.

A long term study of over 3,500 adults revealed that self esteem ramps up as young adults progress to middle age, and then begins to decline around retirement

age. Researchers studied men and women ranging in age from 25 to 104. The study took place during the period 1986 - 2002 with researchers assessing self-esteem on four occasions. “Self-esteem is related to better health, less criminal behaviour, lower levels of depression and, overall, greater success in life,” said the study’s lead author, Ulrich Orth, PhD. “Therefore, it’s important to learn more about how the average person’s self-esteem changes over time.” Self-esteem was lowest among young adults but increased throughout adulthood, peaking at age 60, before it started to decline.

## 2.3 PSYCHOTHERAPY WITH YOUNG ADULTS

By their mid twenties, most fledgling adults will have largely achieved the outer trappings of separation from their family of origin. Life will have lost some of its ‘provisional’ character and things are now seen as being ‘for real’.

Occupation, lifestyle, friendships and relationships may all seem to be ‘settling down’, with young adults glimpsing a plateau ahead that is reminiscent of the growth, stability, decline model. After the turbulence of adolescence and fledgling adulthood, the period of early adulthood may seem more concerned with consolidation and incremental growth a structure building phase which is less demanding of the need for counselling or psychotherapy.

The losses of this life stage i.e. loss of youthful freedom from responsibilities and loss of such entwined relationships with parents and siblings may pass unrecognised by the young people themselves, by their families, by friends and even by therapists.

Normative pressures to establish an independent ‘adult’ lifestyle may encourage a denial of the importance of continued relationships with one’s family of origin. Because leaving home is regarded as a ritual proof of achieving adult autonomy, we may underestimate the significance of what is lost. Young adults themselves may question and doubt any continuing attachments, accepting the dictum that by now they should have untied themselves from the apron strings of their childhood home. There is, however, evidence (Troll, 1989) that young adults typically keep in close contact with their parents, although this does not mean that things remain the same.

Intergenerational relationships within the family must shift from an adult child relationship involving dependency and control, towards a more equal relationship between adults. It is especially in families where relationships have been particularly close or characterised by intense conflict, that fear of sliding back into a previous dependency may lead young adults to severe, at least temporarily, all links with their family of origin. However, generally a state of ‘intimacy at a distance’ (Troll, 1989) is ultimately attained. While not many young adults live together with their parents, many do live fairly close and will visit frequently. If the distances are too great, then they will generally talk regularly on the phone, and undertake longer visits at less frequent intervals.

The paucity of attention given to the therapy needs of young adults may stem in part from wrongful assumptions about the nature of this life stage, but also from the fact that no longer are large numbers of the age group sharing similar educational experiences, as has been the case from entry into primary school

until graduation from higher education. Members of this age group are more widely dispersed across different institutions than has been the case in their lives till now. Lifestyles are becoming increasingly diverse. However, the boundaries between different life stages are blurred and over lapping, and the problems associated with employment, relationships and money that were identified as characteristic of fledgling adulthood may persist into this life stage. In addition, young adults may find themselves reluctant and hesitant to take on the responsibilities of adult life, wondering, perhaps, if they want to or are capable of really 'standing on their own two feet'.

## 2.4 OVERVIEW OF YOUNG ADULT ISSUES

Erik Erickson, noted developmental psychologist, described the period of young adulthood as being from age 20-45, and the task of the stage to be "intimacy vs. isolation". This seems too broad and simplistic in today's society. In 1970, Kenneth Keniston, a Yale Psychologist, described characteristics of youth as "pervasive ambivalence toward self and society", "having a feeling of absolute freedom, of living in a world of pure possibilities". He proposed that they have not settled the questions of relationship to existing society, vocation, social role and lifestyle.

A young adult in today's society faces issues and challenges that did not exist, or were unacknowledged, in previous generations. In 2000, Jeffrey Arnett coined the term "Emergent Adult" and identified changes that have occurred over the last several decades: more education is needed to survive in information based economy; fewer entry level jobs are available even after all that schooling; young people are feeling less rush to marry because of the general acceptance of premarital sex, cohabitation and birth control; young women feeling less rush to have babies given their wide range of career options and their access to reproductive technology if pregnancy is delayed beyond most fertile years.

Choices for both genders are more numerous. Expectations are less clear about what is one's next step after finishing school (whether it be high school, college, or graduate school). In times past, young adults' paths were more predetermined by role expectations, family expectations, and clearer gender expectations. The traditional cycle seems to have gone "off course". Young people remain unattached to romantic partners or permanent homes, are going back to school for lack of better options, traveling, avoiding commitments, competing for unpaid internships or temporary public service volunteer jobs. In other words, forestalling the beginning of adult life. Sociologists call it "the changing timetable for adulthood."

### 2.4.1 The Psychotherapy Model and Young Adult Issues

Psychotherapy with young adults may help the client explore their identity, including values, interests, and questions of who the person is in the world. Instability is addressed as clients deal with a feeling of being "in between" one stage of life and the next, often striving for independence from parents, but needing to depend on them for financial or emotional support. Clients are naturally very self focused at this time of their life, but may need help in seeing a bigger picture in terms of how they fit into the world and their relationship with others. Young adults' sense of possibilities can help to establish hope for the future, but can also hinder progress if the client is overwhelmed by possibilities and may need

assistance narrowing down choices. Some of these characteristics are part of adolescence but they take on new depth and urgency in the 20's.

### 2.4.2 The Medical Model and Young Adult Issues

A NIMH longitudinal study found that children's brains were not fully mature until at least age 25. Most significant changes after puberty were in prefrontal cortex and cerebellum, the regions involved in emotional control and higher-order cognitive functioning.

The limbic system explodes during puberty, but the prefrontal cortex keeps maturing for another 10 years. This is the part that allows you to control your impulses, come up with a long-range strategy and answer the question, "What am I going to do with my life?"

Many serious mental illnesses tend to appear in the late teens or early 20's *(bipolar, schizophrenia).* Other common problems may include *substance abuse, eating disorders, depression* and *anxiety*. These illnesses and issues complicate the already complex question of life choices and direction.

### 2.4.3 Therapy for Young Adult Issues

Clients of this population are frequently looking for an encouraging parental figure in a therapist, particularly if they were or are not so well supported by their own parents. Other times they are looking for the opposite of a parental figure, that is someone who sees them as capable and adult. Not an authority, just an older, wiser guide. If they come in with their parents, or are living with their parents, they are sometimes ambivalent about separation from them, and may need some help being launched. Therapy helps to establish where a young adult is in the separation process and how much autonomy he or she is feeling. What is keeping someone tied to his or her parents? Is it okay to be different from parents? What are fears/anxieties about independence?

Therapy also helps young adult clients to explore their identity or how well they know him or herself? What is one's personality type, one's values and goals, one's sense of him or herself in the world? Group therapy is a powerful intervention for this cohort, as many young adults are feeling isolated and alone, as if everyone else "has it together" except for them. Group therapy helps them to see that this is not the case, and gives them a place to feel less isolated and more supported, as they grapple with issues of what their life will be about.

At this stage they experience anxiety and uncertainty over child bearing decisions, or difficulties in relation to child rearing including problems of raising children as lone parents.

In previous generations, and especially for women, the prospect of reaching the age of 30 often signaled an increase in awareness of the ticking of the 'biological clock'. Twenty years ago, young women frequently wished, and believed it was necessary, either to have had their first child by the time they were 30, or, at least, to have clear plans about whether and when they would do so. However, demographics change, and the birth rate among women in their 20s continues to fall. It is predicted that the birth rate among women aged 25 to 29 years will soon be lower than the birth rate among women aged 30 to 33, meaning that the age 30 transition has largely lost its significance as a 'last chance saloon' for

motherhood. Nonetheless, miscarriage, stillbirth, abortion and infertility are losses that affect a significant number of women and couples, and issues around fertility and the transition to parenthood can be highly emotive concerns of clients at this stage.

By the end of their 30s, however, most young adults who are to become parents will have done so. A developmental task for this decade is frequently, therefore, the adjustment to parenthood, or, for those who, whether out of choice or not, do not become parents, managing the consequences of deviating from this social norm.

With the arrival of children, parents' developmental tasks become joined to those of their children, and the couple relationship has to be renegotiated. Parenthood frequently exacerbates the difficulties of achieving a satisfactory work home balance. Former leisure activities may be squeezed out, and friendships, particularly with friends who do not themselves have children, may fall by the wayside.

Stereotyping, and what Huyuk and Guttman (1999) describe as the 'parental emergency' of the child-rearing years, may increase pressure for couples to adopt role specialisation during the woman's 'window of fertility'. It is still mothers who overwhelmingly assume greater responsibility than fathers for childcare. Therapists may find themselves working with clients to help them prioritize roles, activities and relationships, and to find ways of responding to multiple, pressing demands. For some, coming to terms with 'non-events' may be an issue, that is the career path that did not materialise or proved disappointing, or the stable relationship that did not develop or did not last or the baby that was not conceived. In each case, assumptions, expectations and hopes largely socially constructed may be dashed.

## 2.5 PSYCHOTHERAPY WITH PEOPLE IN MIDDLE ADULTHOOD

For most clients, middle adulthood is a time of multiple and sometimes conflicting roles, demands and opportunities, making the resources a person has available for dealing with this complexity one of the key therapeutic issues of this life stage (Biggs, 2003). There have, historically, been several different interpretations of midlife as:

- **a*plateau* –** with, for example, mid career being seen as a time of 'maintenance';
- an overwhelming crisis, whereby a person's coping resources are severely stretched;
- a period of challenging change and transition, although not necessarily crisis; and
- a period of continuity involving more incremental than dramatic change.

Furthermore, midlife may be present either in positive fashion as 'the peak period of life', where people are 'wise and powerful that is, in charge of themselves and others or more negatively, as the herald of 'a downhill slide in energy, attractiveness, occupational performance, and happiness at home'.

These different interpretations will influence, perhaps unknowingly, both clients' and therapists' expectations about midlife and this may lead to difficulties in the therapeutic situation (Biggs, 2003). Seeing midlife issues as depressing and without solution may lead therapists to resist confronting issues of ageing. Seeing age as irrelevant i.e. being 'age blind' may create false expectations of what is possible, ignoring the need for developing resilience to the inevitable losses that accompany passage through the life course and the need to adapt to forms of decline.

Seeing midlife as inevitably a time of crisis may result in an exaggeration of the significance of everyday issues and problems, or by way of contrast ignoring them as intractable and unavoidable.

Life adjustment problems that clients in middle adulthood may typically bring to counselling coalesce around concerns regarding work and career, family commitments and health (including sexual potency). Specific concerns include (Thomas, 1990) the following:

- the need to change career or to retire, either because skills no longer fit the needs of a changing job market, or because the ability to cope with the demands of the job has diminished with age;
- stress at work, and the desire to resolve job dissatisfaction and/or conflict between job responsibilities, family commitments and diminishing energies;
- the need to renegotiate relationships with partner, with children (as they move towards and achieve independent adulthood) and with parents (who may be becoming increasingly dependent, vulnerable and demanding);
- the wish to find meaningful occupation and purpose, either within or beyond the workplace, as children grow up and leave home;
- concern about the physical changes often associated with midlife in terms of physical appearance, diminishing sexual desire and potency, and, for women, the approach, occurrence and implication of the menopause.

Grief following the death of a child, parent, partner or close friend.

These issues are often interrelated, rarely arising in isolation. Thus, middle adulthood is the life stage during which demands of both career and family may be at their peak. In the family arena, midlife often coincides with children's long passage from adolescence to adulthood. Not only does this serve as a reminder to the midlife adult of their own ageing, but also requires that the parent, as well as the child, is involved in the renegotiation of relationships that characterises this transition. Powerful feelings around autonomy and encroaching dependency may arise (Biggs, 2003). Furthermore, once children have left home, parents can no longer use their children to mask problems in their relationship with each other and this can lead them to seek help of a therapist.

Seeing offspring successfully take on the mantle of adulthood may lead parents to reflect on, and perhaps regret, the choices they have made in their own lives (Cooper, 2003). At work, the increasingly apparent presence and advancement of 'the younger generation 'serves' as another reminder of the passage of time. As a result of increasing life expectancy, midlife adults may also find themselves implicated in the transitions of their parents through late adulthood.

As children become more independent, so parents may become more dependent and needy. For much of middle adulthood the 'midlifer' may be part of a 'sandwich' generation that is caught it might sometimes feel, between the demands and needs of both those ahead and those following on behind in the human race.

While there are clear and observable physiological changes in both men and women during the middle years, it is the awareness and perception of these changes that is of prime importance. Thus, the menopause is a socially constructed as well as a physiological transition that, in contrast to its image as crisis, leaves many women feeling freer, more in control of their lives and enjoying improved communication (including sexual).

However, health problems or at least the possibility of them may become more apparent during middle adulthood, exacerbated by the illness or death of contemporaries. This can lead to an increased sense of physical vulnerability in men and preparations for widowhood in women, leading to a restructuring of life in terms of 'time left to live' rather than 'time since birth'. The awareness of mortality that this denotes is seen as the basis of the apocryphal midlife crisis.

## 2.6 PARALLELS AND DISTINCTIONS

The present unit has focused on the dissimilarities of different lifestages. However, while each life stage is *distinctive*, it is also true that life stages are not *distinct* in the sense of being separate and isolated. While it is important, when working with any age group, to be aware of their particular qualities and vulnerabilities, it is equally important to be aware of the connection between different life stages.

Although people of different ages differ, their concerns and preoccupations are not as different as perhaps they might appear. There are wide ranging and fundamental psychological themes that may appear in varying forms at any phase of life. These include attachment, loss, separation, hope, fear, anger, hostility and love. Many writers focusing on clients of a particular age or life stage reiterate this point.

There is interplay and interaction between the concerns and developmental tasks characteristic of different life stages. For example, the social network of parents with young children frequently comprises the parents of other children of a similar age to their own, irrespective of the age of the parents. Thus, the 20-year-old parent of a toddler and the 45-year-old parent of a toddler may see themselves at a broadly similar life stage – even though, by the framework adopted in the present unit, they would have been identified as being nonfledgling adulthood and middle adulthood, respectively. Another example is the interplay between the developmental preoccupations of adolescents and their parents. It is often the timing of the departure of adolescents or fledgling adults from their childhood home that determines to a significant extent when parents reevaluate their own future and confront issues in their relationship that have been masked by child rearing responsibilities.

While being of different ages, life stages and generations sometimes separates and distinguishes us, our position on this dimension of difference is continually changing. Although we may choose not to dwell on it, we either were or can anticipate reaching the age and life stage of those many years our junior or senior.

This points to a key distinction between ageism, on the one hand, and sexism and racismon the other.

Although sex change and skin pigmentation operations do exist, for most people the categories of sex and race are constants. Our age classification, however, is not static. While people who behave in a racist or sexist manner are unlikely ever to be members of the group that is the target of their discrimination, ageism is unique in that those who practice it were once a member of, or will one day join (if longevity is granted them), the group they presently discriminate against. Ageism identifies those of different ages as 'the other', and creates an artificial 'them' and 'us' divide between different life stages.

**Self Assessment Questions**

1) What are the life stage issues that fledgling adults may bring to therapy?

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2) Write about the problems which young adults are prone to bring to therapy?

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3) What is midlife?

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## 2.7 LET US SUM UP

Although those between the ages of 18 and 25 are often referred to as young adults, the dynamic, fluid and transitional quality of this period is better captured in such terms as emerging, threshold, or fledgling adulthood. Life stage issues that fledgling adults may bring to counseling include:

- difficulties occurring in relation to family and friends;
- issues of sexual identity and development;

- questions of morality in the face of an imperfect self and
- a flawed society;
- problems of planning a career,
- finding satisfactory employment and
- adjusting to job conditions and financial difficulties.

Persons belonging to 25-40 age range can be termed as young adults. This is characterised feeling of settling down in terms of occupation, lifestyle, friendships and relationships.

The mid-life paradox is that of entering the prime of life, the stage of fulfillment, but at the same time the prime and fulfillment are dated. Death lies beyond. Somewhere between 35 and 45 most of us begin to realise that half of life is over. Points of reference change with the individual's realisation that s/he has stopped growing up, and has begun to grow old. Taking stock we register unachieved youthful dreams and the unlikelihood of our anticipated outstanding contribution.

Mid-life reevaluation is precipitated by changing relationships to elderly or dead parents, to childlessness or self-reliant children. Shocked by illness or unexpected deaths we register signs of the biological clock's slowing down in our own bodies. Memory loss, discovery of one's ineffectuality at work or elsewhere, lack of influence over colleagues, politicians, or family members accompany growing awareness of one's own mortality.

## 2.8 UNIT END QUESTIONS

1) Describe and discuss the issues and life stage problems related to fledgling adults?
2) After the turbulence of adolescence and fledgling adulthood, the period of early adulthood may seem more concerned with consolidation and incremental growth. Discuss?
3) Write about middle adulthood in terms of issues relevant in psychotherapy?

## 2.9 SUGGESTED READINGS

Woolfe. R., Dryden. W., Strawbridge.S (2003). *Handbook of Counselling Psychology* (2nd edn). London: Sage.

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# UNIT 3 PSYCHOTHERAPY WITH OLDER ADULTS

**Structure**

3.0 Introduction
3.1 Objectives
3.2 Background
3.3 Cognitive Behavioural Therapy
3.4 Cognitive Analytical Therapy
3.5 Psychodynamic Therapy
3.6 Interpersonal Therapy
3.7 Systemic (Family) Therapy
3.8 Reminiscence/ Life Review Therapy
3.9 Psychotherapy in Dementia
3.10 Therapies for Specific Problems
    3.10.1 Uncomplicated Depressive Illness
    3.10.2 Depressive Illness and Borderline or Narcissistic Personality Trait
    3.10.3 Depressive Illness in Dysfunctional Family Systems
    3.10.4 Somatisation Disorder
    3.10.5 Psychological Approaches to Dementia Care
3.11 Modification or Adaptation of Treatment
3.12 Let Us Sum Up
3.13 Unit End Questions
3.14 Suggested Readings

## 3.0 INTRODUCTION

Psychological therapies with older people have traditionally held a lowly position in old age psychiatry and in psychotherapy generally. This is due to a number of reasons, particularly ageism, which has been a great hindrance to development of expertise and services in this area. Negative stereotypes about the treatability of older people and a lack of psychotherapy theory that can speak to later life still have a pervasive negative effect on expectations and expertise. With the current high demand on old age psychiatry services for the assessment and treatment of early dementia, developments in services are focusing on biological models of illness and pharmacological treatments, again at the expense of psychological therapies.

The aim of this unit is to give students an overview of the psychological therapies that have been applied to work with older people, in order to inform clinical work in old age psychiatry and to encourage interest, training and referral where resources and practitioners are available.

## 3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the background and different therapeutic approaches for older adults;

- Describe psychotherapy with dementia;
- Discuss the types of therapies used with specific problems; and
- Discuss the modification and adaptation of therapies for treatment with older adults.

## 3.2 BACKGROUND

Ageism, or the discrimination against people on the grounds of age alone, has been slow to gain public awareness in society. Although racism, casteism and sexism, for example, have been tackled in statute law around the world, ageism is just surfacing in the collective consciousness of policy makers and clinicians. It is interesting to consider the paradox that discrimination based on a universal experience(ageing and death) has been relatively slow to achieve public awareness compared with 'isms' that oppress minority groups in society. There may be many reasons for this: the prevalence of age is among older people themselves (discouraging the formation of a 'minority group'); our need for robust denial based defenses to protect against frightening existential uncertainties (death, meaninglessness); and the notion of the demise of 'elder hood' in Western society in the 20th century.

Even at the age of 49 himself, Freud considered older people (the over-50s by his reckoning) ineducable (Freud, 1905). This therapeutic nihilism has had a profound effect on the development of both psychotherapy theory and services for older people. Psychotherapy theory has tended to focus on childhood development and the developmental stages of infant, child and early-adult life, with later life being neglected as a developmental phase.

An exception to this has been the work of Erikson (1966),who identified 'eight ages of man' in terms of dichotomies, with 'generality *v*. stagnation' and 'ego integrity *vs*. despair' describing the developmental challenges of later life. The apparent linearity of this model, however, and the lack of elaboration of the nature of psychological development in later life over the 30 years since Erikson proposed it have left old age psychotherapy detached from the mainstream and without a firm theoretical base. In addition, the dominance of the biological or organic model in old age psychiatry and neuropsychology has tended towards 'brain-based' rather than 'psyche based' explanations for all illness and distress in later life, where the imaging and charting of deficits takes priority over any meaningful dialogue about shared existential fears between professional and patient.

Despite all these problems, many psychotherapists, psychologists and psychiatrists have used various psychotherapies with older people with success and enthusiasm. Of particular note is the work of Martin (1944) and Hildebrand(e.g. Hildebrand, 1990), who can be seen as pioneers in this field. Many others, who will be mentioned in the sections below, covering individual psychotherapies, have been determined to apply and develop different theoretical approaches in their work with older people and to share their experience and positivity. In contrast to the pessimistic starting point that psychotherapy with older people is 'too late' there is hope not only that it is not too late, but that for many it can be just in time.

## 3.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

Cognitive Behavioural Therapy (CBT) is the form of psychotherapy most often used with older people. In controlled clinical studies it has been shown to be efficacious in the treatment of depression, anxiety and problematic behaviours in the context of dementia. In a series of studies with older people in the USA by Gallagher-Thompson and colleagues (reviewed by Teri *et al*,1994) CBT has been shown to be highly effective with depressed patients in both hospital and community settings as well as in individual and group formats. A more recent trial (Barrowclough *et al.*, 2001) of the effectiveness of CBT *v.* supportive counselling on anxiety symptoms in older adults showed CBT to be both effective and superior to supportive counselling in terms of improvement in anxiety symptoms and self rating of anxiety and depression over a 12-month period.

Cognitive behavioural therapy focuses on negative thoughts and their reinforcing behaviours, attempting to identify dysfunctional cycles and to intervene with challenges to unhelpful thinking, the reduction of negative and avoidant behaviours and the introduction of positive behaviour patterns. Negative thoughts can be challenged by techniques that assess the evidence behind the thoug ht, the 'thinking errors' that are present, the pragmatic effect of negative thoughts on overall well being and the consideration of alternative viewpoints. The intensity with which thoughts are held can be rated and monitored through treatment, and the reinforcing avoidant behaviours can be tackled using a graded exposure model. In work with older people, writers in the field suggest some adaptations to CBT technique, including increased emphasis on maintaining the focus on the work, acknowledgement of feelings of guilt and helplessness following the onset of disability and other life events and an awareness of the interaction of somatisation and the physical symptoms of organic disease. Cognitive behaviouraltherapy offers a structured, collaborative, and brief and client centered approach.

## 3.4 COGNITIVE ANALYTIC THERAPY

Cognitive analytic therapy (CAT) represents a modern integration of analytic (object relations theory) and cognitive psychotherapy traditions to provide a brief, structured and collaborative therapeutic journey from past trauma into reconnection with dialogue and meaning. In existence for less than 20 years, the evidence base, although in progress, is yet to be established, but there is interest in applying the model to older people because of its emphasis on shared meaning in the context of the client's life story and the importance it gives to 'dialogue', both cathartic and reparative, in the therapeutic relationship. Traditional concepts from psychoanalytic theory and psychiatry (such as narcissism, borderline personality traits and post-traumatic syndromes) have recently been applied to later life from a CAT perspective.

Later life can be a time when coping mechanisms are challenged by losses, disability and changes insocial role. It is then that pre-existing trauma and low self-esteem can resurface to produce anxiety,depression and self-destructive behaviours, which need to be understood in terms of the person's wholelife story. Cognitive analytic therapy can offer a coherent way of linking past and present, and maybe well suited to work in later life because of its emphasis on the interpersonal and the need to find shared meaning and understanding in therapy across generational and cultural boundaries.

**Self Assessment Questions**

1) Discuss psychotherapy in regard to older persons. Give a background of the old persons.

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2) What is Cognitive Behavioural Therapy (CBT)?

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3) Discuss cognitive analytic therapy and bring out the difference between cognitive behaviour and cognitive analytic therapies.

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## 3.5 PSYCHODYNAMIC THERAPY

This broad range of therapies, stemming largely from the work of Freud, Klein and Jung, has been discussed widely in relation to later life. Some empirical evidence exists to suggest that psychodynamic work with older people is at least as effective as CBT in dealing with depression (Thompson *et al*, 1987).

Psychodynamic approaches often center on the development of insight into repressed unconscious material from earlier life experience and on the working through of this material in the therapeutic relationship. Experience has shown that the client's age can be an important factor in the nature of the transference and counter transference aspects of the therapy.

Therapists may be reluctant to acknowledge the infantile needs of an elderly client because of a subconscious fear of the perceived dependence and helplessness that they might themselves experience in old age. Erotic transference may be ignored or ridiculed in the counter transference, and the client's situation may elicit in the therapist idealised care fantasies resulting from the therapist's unconscious fears and concerns about their own older family members. The psychodynamic model, however, is likely to be well suited to working with

material derived from the client's 'feelings of abandonment and despair, intimacy and isolation, arrogance and disdain, stagnation and creativity as each of us struggles with the developmental task of "the third age" '.

## 3.6 INTERPERSONAL THERAPY

Interpersonal therapy is a practical, focused, brief, manual-based therapy that can be applied by arrange of professionals after a period of basic training. Its accessibility has generated considerable interest in its use with older people, and a reasonable evidence base exists to support its efficacy in the treatment of depression in older people, both in the acute phase and in relapse prevention (Reynolds *et. al*, 1999).

Interpersonal therapy focuses on disturbances relationships, categorized into four domains:

i) role transition,

ii) role dispute,

iii) abnormal grief and

iv) interpersonal deficit.

A range of therapeutic interventions aim to improve communication, express affect and support renegotiated role relationships, with the result of symptom reduction and improvement in functionality. Experience in applying interpersonal therapy to work with older people has suggested that it is directly applicable to the relationship and developmental issues relevant to people in later life.

## 3.7 SYSTEMIC (FAMILY) THERAPY

Although the evidence base for the use of systemic approaches in work with older people is sparse, a model that looks at individuals in the context of their wider family and social system seems to have wide applicability. A systemic approach may be particularly helpful in the context of communicating and processing the diagnosis of dementia in a family setting and also in unraveling the reinforcing factors in dysfunctional somatizing and sick role behaviour in older adults. Systemic approaches can be used pragmatically both in one time therapeutic assessments andin more formal therapy sessions following an established family therapy model.

The systemic approach recognises that presenting symptoms in the patient may result from dysfunctional dynamics in the wider matrix of relationships surrounding the individual. By using techniques such as circular questioning (e.g. 'what do you think X would say to that?'), positive connotation (e.g. 'you are such a close family that sometimes you care too much'), paradoxical intervention (e.g. 'So it seems that you have solved all your difficulties and don't need our help any longer'), reframing (e.g. 'It seems as if X is flagging up the distress on behalf of the whole family') and exploration of the shared genogram (family tree),therapy may tip the system into positive change. The availability of professionals skilled in system approaches is likely to be highly beneficial as a consultative tool for those working directly with clients in old age, who are well aware of the challenging family dynamics often uncovered by mental illness in late life.

## 3.8 REMINISCENCE / LIFE REVIEW THERAPY

Reminiscence Therapy (RT) involves recalling the past as a way to increase self-esteem and social connection. RT typically occurs in a group format in which individuals are encouraged to remember and share memories of the past, with personal artifacts, newspapers, and/or music often used to stimulate memories. These sessions are frequently structured with the therapist picking the topic. This very popular counseling tool is regularly used with elderly to gain perspective on their lives and thus is popular in senior centers, residential settings, and retirement communities rather than as clinical intervention for those older adults with major mental health or personality disorders (Thorton and Brotchie, 1987).

Life review therapy (LRT: Butler, 1963), a more intense type of RT, involves the reworking of past conflicts in order to gain a better understanding and acceptance of the past. These types of therapies are based on the work of Erik Erikson (1966) and his eight-stage model of psychosocial development. The underlying premise is that an older adult can be helped through the last stage of Erikson's model, ego integrity versus despair. It is thought that if older adults can satisfactorily formulate and accept personalised answers to existential questions such as, 'Who am I?' and 'How did I live my life? Etc., they may be able to achieve integrity.

**Self Assessment Questions**

1) Define and describe psychodynamic therapy.

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2) Discuss interpersonal therapy and how is it applicable in the adults group.

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3) What is systemic (family) therapy? Elucidate

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4) Put forward the reminiscence life review therapy.

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## 3.9 PSYCHOTHERAPY IN DEMENTIA

An important area in need of further investigation is the application and provision of psychotherapeutic services to those with cognitive impairment. A significant minority of the elderly population experience limitations in their cognitive abilities due to progressive dementia, and many of these individuals also experience co morbid emotional distress. Owing to their cognitive deficits, such as memory loss or decreased capacity for judgment and problem solving, persons with dementia are usually not considered to be good candidates for traditional psychotherapy. However, the symptoms and behaviours of persons with dementia should not be viewed solely as manifestations of biology, but rather, as being affected by social, psychological, and environmental contexts as well. Thus, patients with dementia are able to derive some benefit from psychological interventions. Various CBT, environmental, and supportive interventions may help cognitively impaired older adults reduce disruptive behaviours and excess disabilities, increase or maintain positive behaviours, improve memory or learn coping skills to manage loss of cognitive skills, increase quality of life, reduce excessive burden on health-care delivery systems, alleviate symptoms of depression or anxiety, or help adjustment to multiple losses.

Many psychosocial interventions currently in use with older adults with dementia are based on uncontrolled case studies and anecdotal reports. However, there are some studies examining the feasibility of conducting therapy or the effectiveness of therapy for particular purposes with older adults. Use of behavioural and environmental treatments for behaviour problems and memory and cognitive retraining for some forms of late-life cognitive impairment may be effective. However, there is much dispute about cognitive training, in particular. Support groups and CBT can assist those with early-stage dementia to foster coping strategies and reduce distress. RT may provide mild to moderate stage individuals with interpersonal connections. Behavioral approaches and memory training target specific cognitive and behavioural impairments and help to optimise remaining abilities.

## 3.10 THERAPIES FOR SPECIFIC PROBLEMS

The choice of psychological approach will largely depend on availability of expertise, which is often sadly lacking because psychotherapies are still regarded as being unnecessary or ineffective for older people. In an ideal world, however, a range of therapies would be available, and given that some require considerably more time and resources than others, the following is a guide to deciding what might be best for whom.

### 3.10.1 'Uncomplicated' Depressive Illness

Cognitive–behavioural or interpersonal therapy maybe offered in the first instance with or without pharmacological treatment. Both therapies may be useful in relapse prevention in those with recurrent depression. Interpersonal therapy may take preference where obvious tensions exist in current relationships, whereas CBT may suit a more cognitively minded patient. Cognitive behavioural therapy should also be the first line approach for pronounced anxiety symptoms and panic with avoidant behaviours.

### 3.10.2 Depressive Illness and Borderline or Narcissistic Personality Traits

Patients with depressive illness complicated by borderline or narcissistic personality traits often have a history of traumatic experience in childhood or earlier in their adult lives and exist either in a highly dysfunctional systemic context or in relative isolation following severing of close interpersonal links. Cognitive analytic therapy or psychodynamic therapy is the treatment of choice.

### 3.10.3 Depressive Illness in Dysfunctional Family Systems

Depressive illness in late life is sometimes complicatedby enmeshed and 'high expressed emotion'family or systemic relationships. Systemic (family)therapy is indicated if at least some of the systemcan be engaged in it.

### 3.10.4 Somatisation Disorders

Cognitive behavioural therapy is probably the first line approach, but if the somatic or dissociativesymptoms can be traced to earlier trauma a moreexploratory therapy such as CAT or psychodynamictherapy may be needed.

### 3.10.5 Psychological Approaches to Dementia Care

Insights from psychodynamic theory and CAT can contribute to an understanding of the role-play between the care giver and the person with dementia and help prevent interaction that reinforces the isolation and alienation experienced. Behavioural approaches may be helpful for clusters of repetitive behavioural disturbances in more severe dementia. Family and systemic approaches can be useful in exploring a diagnosis of early dementia. A general approach based loosely on the principles of validation therapy (Feil, 1982), with time for reminiscence and life review, is likely to provide a humane theoretical backdrop to dementia care in many settings.

**Self Assessment Questions**

1) Discuss the therapies suited to the following specific problems

   a) Dementia

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   b) Uncomplicated depressive illness

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   c) Depressive illness borderline disorder

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   d) Depression in dysfunctional family system

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## 3.11 MODIFICATIONS OR ADAPTATIONS OF TREATMENT

There are numerous physical, psychological, cognitive, social, developmental, and environmental factors that can impact the choice and delivery of psychotherapy to older adults. Older adults have at least one chronic medical illness, some degree of functional impairment/disability, an increasing frequency of loss events, and a decrease in controllability of these losses (e.g., financial limitations, diminished sensory capacities, decreased mobility, retirement, widowhood, and change in residence). The complexity of these intermingling influences often merit special therapeutic consideration.

Although some mental health interventions are comparable with those used with younger individuals, it is often necessary to adapt therapies to address special considerations unique to older adults. For example, psychotherapy with older adults often occurs at a slower pace due to possible sensory problems and slower learning rates. This means that repetition is very important in the learning process, and information should be presented in both verbal and visual modalities (i.e., on chalk boards and hand-outs) in order to help older patients encode and retain information. Older clients should also be encouraged to take notes to help aid memory retention and thus increase efficacy of therapy. Assignments may need to be in bold print or sessions tape-recorded for review. Additionally, psychotherapy with older adults often requires a collaborative style with few clearly outlined goals and a more active or task-focused approach.

The goals of psychotherapy with older adults should be continually highlighted to reinforce the purpose and facilitate the direction of treatment. It may also be necessary to facilitate therapy for those with sensory problems, particularly hearing and vision impairments. Thus, adaptations such as pocket talkers to assist in hearing or eliminating glare for the sight impaired should be made available. Rather than giving suggestions or expecting the client to infer answers, Knight and Satre (1999) suggest that as there is a normal age decline in fluid intelligence, therapists may need to lead the older adult to conclusions.

When determining if and which modifications are needed, it is important to separate the effects of maturation from the effects of cohort. Maturational effects include similarities that are developmentally common or specific to older adulthood, such as adjusting to chronic illness and disability, or loss of friends and family due to death. Cohort effects are specific to a certain birth-year-defined group. For example, in the USA, early-born cohorts have lower educational levels and less exposure to psychological concepts. Psychotherapists working with older people need to be aware of maturational and cohort differences in the expression and treatment of psychological problems. Additionally, therapists working with older adults should learn about chronic illness and its psychosocial impact, management of chronic pain, factors influencing adherence to medical treatment, rehabilitation methods, and assessment of behavioural signs of negative medication effects.

Assessment should always include current mental and cognitive status. A brief screen of cognitive functioning, such as the Mini-Mental State Exam (MMSE; Folstein et al., 1975), can measure suitability for treatment, as well as identify

patients in need of more extensive neuropsychological testing. It is also imperative to consider the medical status of and social support available to older adults, as these may affect presentation and treatment of pathology. Formal testing, such as the MMSE, requires normative data specific to older adults in the reference group of the person being tested (e.g., education, race, gender). Without such normative data, 'normal' aging processes are impossible to distinguish from pathology or impairment.

Providing psychological services to older adults often requires flexibility in scheduling, location and collaboration. Older adults often have a greater chance of hospitalisation or reduced mobility, responsibility to care for infirm relatives, or reluctance to travel in bad weather conditions, all of which may necessitate missed therapy session. Thus, brief, occasional hospital visits, telephone sessions, or letters may need to be made at times to maintain contact.

At times, when an older adult becomes temporarily dependent upon a caregiver for assistance, it may be crucial to engage the caregiver in aspects of the treatment. An example of this is the pivotal work by Teri et al. (1997) of treating depression in older dementia patients via training caregivers in behavioural interventions. Goals of that treatment, not uncommon to other caregiver stress experiences, included setting limits and making time for personal needs. Treating the caregiver in individual or group, dyadic or brief educational sessions can be directly beneficial to the caregiver and indirectly helpful to the care recipient. If a caregiver is taught to understand and more effectively cope with emotions such as frustration and anger, they may be less distressed and better able to provide effective care.

Because many older adults have experienced increased loss of family members or friends compared with younger individuals, clinical lore suggests that the therapeutic relationship becomes a vital source of support as well as information. For this reason, it has been suggested that rather than traditional termination, ending sessions be spread out and booster sessions be offered.

A suggested acronym to help therapists working with older adults provides respectful and appropriate therapy is MICKS:

a) use Multimodal teaching,

b) maintain Interdisciplinary awareness,

c) present information more clearly,

d) develop Knowledge of aging challenges and strengths, and

e) present therapy material more slowly.

Clinical findings also suggest that many older adults hold negative stereotypes about mental health and psychotherapy, which may result in reluctance to accept or engage in therapy, limitations in self-disclosure and endorsement of symptoms. Some of these myths follow: only crazy people seek mental health treatment; psychological problems indicate moral weakness; therapy constitutes an invasion of privacy; adults, especially men do not share their feelings or show weakness to strangers; adults do not need to ask for help; and therapy has no relevance. Thus, one additional adaptation for therapy with older adults may be to have an introductory orientation/socialisation into psychotherapy. Here incorrect assumptions or fallacies can be corrected, and roles and expectations established.

It is important to remember that there is much more commonality between the young and the old than there are differences, and that older people have a huge diversity of life experience having matured in a world of unprecedented change, where wars, mass migration, and rapid technological development changed many aspects of life beyond recognition for many individuals. Psychotherapists, although benefiting from the specialised skills and approaches utilised in work with older people, need to bear in mind that what is shared with their older clients is humanity and that what is different may take some understanding.

## 3.12 LET US SUM UP

Psychotherapies with older people have been slow to develop, both theoretically and operationally. This is due to ageism and the predominance of models of psychological development relevant to children and younger adults. Despite this, many have applied their practice and skills to psychological work in old age psychiatry, countering the dominance of the 'organic' model. An evidence and practice base exists to suggest that cognitive behavioural therapy, interpersonal therapy, cognitive analytic therapy, psychodynamic and systemic approaches can help in a range of psychiatric problems in older people, including affective disorders, personality disorders and dementia. The inclusion of older people in existing psychotherapy services and the development of networks of practitioners whose support and supervision are encouraged are likely to be positive ways forward.

## 3.13 UNIT END QUESTIONS

1) Discuss the various therapeutic approaches in therapy with older persons?
2) Write about psychotherapy in dementia?
3) "It is often necessary to adapt therapies to address special considerations unique to older adults". Discuss?
4) What modifications or adaptations do we make in treatment of adults?
5) Multiple Choices Questions
    1) Ageism:
        a) is a psychological disorder
        b) creates negative stereotypes of older people
        c) is mainly found among the young
        d) is an inevitable response to ageing
    2) Psychological therapy services for older people:
        a) are widespread
        b) attract high referral rates
        c) are disconnected from general psychotherapy services
        d) is offered at all clinical settings.
    3) CBT with older people:
        a) is an effective treatment for depression
        b) is an effective treatment for dementia

   c) is an effective treatment for bipolar disorder
   d) focuses on childhood experiences
4) The following are focuses for interpersonal therapy with older people:
   a) role transition
   b) normal grief
   c) reciprocal roles
   d) the 'wise old man'
5) The following have been used in dementia care:
   a) personal construct therapy
   b) behavioural therapy
   c) social role valorisation
   d) Gestalt therapy

## 3.14 SUGGESTED READINGS

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# UNIT 4 PSYCHOTHERAPY IN TERMINAL ILLNESSES (AIDS, CANCER)

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## 4.0 INTRODUCTION

In this unit we are dealing with psychotherapy in terminal illnesses such as cancer and AIDS. We start the unit with an introduction to terminal illnesses and how psychotherapy could be used in a dying person etc. We then discuss the goals of psychotherapy with dying person. Then we take up the different therapeutic approaches and discuss them in terms of their important features and how the same could be used in the cases of dying persons. We discuss under this category the psychodynamic, humanistic, behavioural and family therapy. Then we dealt with the major therapy issues related to dying person. We discuss the psychology of the dying person and follow it up with the four stages of dying put forward by Weisman. Then we take up depression, anxiety and anger and discuss these emotional reactions as part of dying and how to handle the same in therapy. This is followed by psychotherapy for specific illnesses such as cancer and AIDS. Here we present the problem focused psychotherapies, supportive expressive therapies, integrative approaches to psychotherapy and interpersonal psychotherapy etc.

## 4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe terminal illness and psychotherapy in that context;
- Describe the goals of therapy with dying persons;
- Discuss the differences between typical therapy and therapy with dying persons;
- Explain the major therapy issues and the stages of dying and therapy at different stages;
- Elucidate the various psychotherapies for specific illnesses such as cancer AIDs etc.;
- Discuss the psychology and emotional reactions of the dying persons; and
- Analyse the issues and therapy for persons with cancer and AIDS.

## 4.2 TERMINAL ILLNESS AND PSYCHOTHERAPY

Terminal illness is used to describe patients with advanced disease and a drastically reduced lifespan, with perhaps months or weeks to live. Inevitably the range and severity of physical symptoms will have increased, and will be having a profound effect on how the patient lives his life. General symptoms such as fatigue, pain and sleeplessness will all be taking their toll, and even patients who have coped well find the final insidious decline taxing their psychological reserve.

How well a patient copes is dependent on a number of variables, age of patient, level of education, religion, previous experience of illness, social support, personality and medical factors such as pain to name but a few. An optimal adjustment also depends on how bad news is delivered, and how the various reactions to this are managed.

In many cases, but not all, the patient will only have reached the terminal phase of the illness after a period of declining health and failed treatment. Both the patient and his family may well be aware of the possibility that the prognosis is grave, but this is different to being told that death is certain in so many months. There are also cases where the patient may present with metastatic disease, and the diagnosis and prognosis may come as an enormous shock to patient and family alike.

Psychotherapy with dying patients shares many features with all other psychotherapy. However, the unique status of the dying person presents special problems for the mental health professional. Clearly, everyone will die, and in this sense all therapy is done with patients of a limited life span. The labeling of a person as a "dying patient", identifies that person as belonging to a special category of humanity, and creates profound changes in the emotional, social, and spiritual climate of therapy. The dying person is one who is seen to be in a life-threatening condition with relatively little remaining time with little or no hope of recovery. This unique existential position of the dying person necessitates some adaptations of the typical psychotherapeutic attitudes and strategies. The goals, structure, and process of therapy must change to meet the special needs and circumstances of the dying patient.

There are several features which distinguish therapy with a dying person from "typical therapy". They are:

*First,* therapy is more time-limited and time-focused.

The dimension of time takes on special urgency with the dying patient.

While many therapies are time-limited, often they proceed as if time were an inexhaustible resource.

The brief remaining time for the dying patient intensifies the therapy process, and accelerates it.

*Second,* the goals of therapy with dying patients are often more modest.

Recognising the limits of possible change is an essential feature of therapy with the dying.

What can be accomplished is quite restricted by time, disability, and other aspects of the patient's condition.

*Third,* the treatment of the dying patient often requires careful coordination with a variety of medical, nursing, and religious professionals.

The physical condition, medical treatments, and institutional settings of the patient complicate the practical and psychological context of therapy.

## 4.3 GOALS OF THERAPY WITH DYING PERSONS

The major goals of therapy with the dying patient can be summarized in a few simple statements.

- To allow open communication with patients regarding their conditions, and to provide honest, factual information about those conditions.
- To facilitate the expression of important emotions and to help patients learn to manage these emotions as well possible under the circumstances.
- To provide a relationship in which patients can experience support in the confrontation with death.
- To intervene between patients and other significant people such as family, friends, and medical staff.

**Self Assessment Questions**

1) Explain psychotherapy with dying persons.

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2) Differentiate between typical therapy and therapy with dying persons.

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3) What are the goals of therapy with dying persons?

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## 4.4 THERAPEUTIC APPROACHES

Prior to Elisabeth Kubler-Ross' seminal work, "On Death and Dying", very little systematic attention had been given to psychotherapy with dying patients. One important exception to this neglect was the humanistic approach described by Bowers, Jackson, Knight, and LeShan in their book, "Counseling the Dying". The prime impetus, though, was certainly Kubler-Ross, who provided an integrated theoretical and therapeutic perspective for use with the dying patient.

Following her lead, hundreds of books and articles have appeared in the last decade. Reflecting the increased maturity of the field, there are presently many therapists and researchers focusing on this population, and in addition several scholarly journals which devote some attention to the care of the dying person. Psychotherapy is beginning to be incorporated into the more general and growing field of clinical thanatology, which is concerned with the overall care and treatment of the dying person - mind, body, and spirit.

Modern psychotherapies are divided into four main groups – psychodynamic, humanistic, behavioural, and family therapy.

The main features of these therapies as used with all patients are preserved in the treatment of the dying, but each has been modified somewhat to fit the unique needs of dying persons.

### 4.4.1 The Psychodynamic Approach

The psychodynamic approaches are primarily concerned with the emotional conflicts and defense mechanisms of the individual. Special issues of conflict and defense arise in the dying person, and this approach addresses them in the hope of resolving the psychic crisis to the fullest extent possible. Dying is the ultimate crisis of ego development, and as such is associated with intense intra-psychic turmoil. Psychoanalyst Erik Erickson labels the last stage of ego development, "ego integrity versus despair", and identifies it with the crisis

provoked by the confrontation with one's mortality. The fear of death may precipitate a breakdown of previously integrated ego functioning, and result in an attitude of despair and disgust.

In most people the threat of death generates powerful defensive reactions, and although these defenses provide some limited relief of emotional distress, in the end they prohibit the personfrom effectively coping with the death crisis. Common defenses which are found in the dying person include denial, displacement, projection, and regression. As Kubler-Ross pointed out, denial is a very typical reaction of the dying person. The refusal to accept the reality of death makes it impossible for people to prepare themselves and their families adequately for it.

Through the displacement defense the fear of dying is channeled into other, "substitute" fears. For example, one may become preoccupied with anxiety about family members, personal business, household jobs, or other matters, and, thus, obtain partial release of one's death anxiety. The dying person's projection defense typically expresses itself in hostility and resentment toward others, e.g., doctors, nurses, and family. The person may irrationally blame others for the illness, or accuse them of not doing enough to cure or help. Regression in the dying person is often manifested in increasingly immature, dependent, and occasionally self-threatening behaviours and attitudes. An example is the extremely helpless, "infantilised" position of the person who has completely given up and merely waits for death.

A major goal of dynamic therapy with the dying is to help the person recognise, confront, and replace the defenses which run counter to an emotionally healthy attitude toward death. In the process it may be necessary to try to work through some long-standing problems and fixations which are intensified by the death crisis. For instance, a patient with a history of anxiety over separation from family members may be more distressed over the issue of loss/separation than by other death-related concerns. Dynamic therapy with dying patients is not directed as much toward the goal of insight, as it is with others. Time limits the course of therapy with the dying, and the goals are therefore more short term changes; rather than long-term personality change. The strategy of Kubler-Ross is a good model of a dynamic approach to defenses and emotional conflicts in therapy with the dying.

"On Death and Dying" provides many wonderful examples of a therapeutic approach that begins by accepting the defensive position of the patient, and then proceeds to work with the patient to overcome the self-defeating results of those defenses. Below is an example of one of Kubler-Ross' cases:

Mr. R was a successful businessman dying of Hodgkin's disease. During his stay in the hospital he behaved like a tyrant with his family and the staff. He blamed his cancer on his own "weakness" and claimed that "it was in his own hands to get up and walk out of the hospital the moment he made up his mind to eat more." His wife consulted with Dr. Ross for help in dealing with his domineering behaviour.

"We showed her - in the example of his need to blame himself for 'his weakness' - that he had to be in control of all situations and wondered if she could give him more of a feeling of being in control, at a time when he had lost control of so

much of his environment. She did that by continuing her daily visits but she telephoned him first, asking him each time for the most convenient time and duration of the visit. As soon as it was up to him to set the time and length of the visits, they became brief but pleasant encounters. Also, she stopped giving him advice as to what to eat and how often to get up, but rather rephrased it into statements kike, "I bet only you can decide when to start eating this and that". He was able to eat again, but only after all staff and relatives stopped telling him what to do".

As Mr. R. began to regain a sense of control over his environment and his activities, his anger, guilt, and tyrannical behaviour decreased, and his relationship with his family improved.

Another significant concern which has been addressed by the psychodynamic approach is countertransference, the emotional reactions of the therapist. The therapist must be particularly careful to avoid letting personal fears and conflicts over death interfere with helping the patient.

The three potential negative results of countertransference are:

1) The therapist unwittingly supports the patient's denial of death by avoiding the issue.
2) The therapist regresses to a helpless position in doing therapy with the patient.
3) The therapist engages in an anxious avoidance of the patient and his concerns.

In order to minimize the effects of the therapist's own attitudes toward death on the therapy, the therapist should explore and confront personal death attitudes before initiating treatment.

### 4.4.2 The Humanistic Approach

More than other approaches the humanistic view of therapy clearly integrates a philosophy of human nature in which death plays an essential role. Existentialism is a philosophy which has had a significant effect on the humanistic approach, and in this philosophy living the "good life" demand a confrontation with the reality of death. Death awareness helps us to clarify our values and purpose in life, and motivates us to live our lives with fullness and meaning. Death is the absolute existential threat, and it forces us to acknowledge the limit of our life plans and face "nothingness".

Humanistic therapy aims to help the dying patient live as full a life as possible in the face of death. Without giving false hope or optimism, the therapist attempts to mobilise the patient's will to live, to encourage the expression and growth of the self, and to facilitate the patient's self-actualisation. LeShan, an advocate of this approach, expresses his view of humanistic therapy with the dying in the following remark:

"Help is really needed in terms of how to live, not how to die."

With the dying patient humanistic therapy is more intensely focused than with others. According to LeShan psychotherapy should "move strongly" with the dying patient. An example of his approach is given in this dialogue. (Given in the box)

Patient (P): "I'm afraid of my cancer. I want to live

Therapist (T): "Why? Whose life do you want to live?"

P: "I detest it! I've never lived my own life. There was always so much to do at the moment. So much to ...I never got around to living my life."

T: "You never even were able to find out what it was."

P: "That's why I drink. It makes things look better. Not so dark."

T: "Maybe the better way would be to find out what is your way of life and start living."

P: "How could I do that?"

T: "That's what we are trying to do here."

Feigenberg describes the main features of his humanistic, "patient-centered" approach in the following way:

1) It emphasises building a strong, supportive, and empathic relationship with the client.
2) It allows the client to set the pace of the treatment.
3) It enables the client to actively and positively participate in the process of dying.

### 4.4.3 The Behavioural Approach

The behavioural approach to therapy relies on educating patients about more adequate coping skills to help deal better with the death crisis. Impending death is a terribly stressful situation, and it produces extreme emotional reactions like anxiety and depression, which inhibit patients from living out the remainder of their lives in a satisfactory way. The symptoms of the dying patient are partially manageable through some standard behavioural techniques. For example, relaxation training and desensitisation can help to alleviate excessive fear and tension. Other self-management skills, like biofeedback and self-hypnosis, are also useful in controlling the distressing emotions of the patient.

One example of a valuable behaviour therapy technique is "stress inoculation training". With the dying patient this strategy may be used to help cope with the physical and emotional aspects of pain. In this approach the patient is taught how to employ cognitive and behavioural skills in preparing for pain and managing pain. Some of the "self-statements" learned in this technique for pain control are shown below. (In the box)

**Preparing for Pain:** "What is it I have to do?" "I can develop a plan to handle it." "Just think about what I have to do."

**Confronting and Managing Pain:** "I can meet the challenge." "Just handle it one step at a time." "Just relax, breathe deeply."

**Self-Reinforcing Statements:** "Good, I did it." "I handled that pretty well." "I knew I could get through it."

A basic goal of behaviour therapy is to provide some Coping skills so that the patient can reduce discomfort and gain a measure of control over life. The loss of control over one's body, one's actions, and one's future which is experienced by the dying patient can lead to emotional distress and to feelings of helplessness and passivity. The acquisition of productive coping skills will not only enable

the patient to manage negative feelings better, but can also improve self-esteem by providing a sense of competence and self-efficacy.

The behavioural approach to therapy tends to focus on specific and concrete symptoms. It does not directly attend to the developmental and personality issues which are so important in dynamic or humanistic approaches. The goal of the therapy is primarily to relieve negative emotions and to enable the patient to cope more effectively in the remaining time.

### 4.4.4 Family Approach

The impending death of a family member places the entire family in a state of crisis. Death presents a threatening situation for each member of the dying person's family. The degree of disturbance in the family depends on many factors such as the role of the dying member, the stage of development of the family, and the quality of relationships among family members. A family systems approach conceives of the entire family, not just the dying person, as the recipient of therapy. This approach seeks to provide the family unit the opportunity to learn to deal with the tragedy. Some therapists will continue treatment beyond the death, offering grief counseling for the survivors.

Though family therapy may be integrated into therapies of various types, there are several issues on which family therapists are more likely to focus. Dying patients often experience a need to feel the closeness and support of their families in facing the death crisis. In families where past conflicts have interfered with relationships between the patient and others, family therapy can facilitate more open and productive communication. This can benefit all members concerned in terms of finding closure for "unfinished business". The defenses of family members can make it very difficult for the dying patient to confront death. It often happens that family members share the defensive reactions of the dying person, such as denial of the facts and displaced anger.

An advantage of the family approach to therapy is that it offers an experience that may enable everyone to accept the facts and to work together to enhance the quality of life for the dying person. Families generally experience a range of intense emotions regarding the dying patient, including anger, guilt, fear, and depression. In family therapy members are encouraged to understand and express these feelings in anticipation of the death of their loved one.

As she was in many other areas, Kubler-Ross was a pioneer in involving families in the therapeutic process with the dying. The case below, from Kubler-Ross, illustrates some common emotional dynamics in families with a terminally ill member.

"I am reminded of an old woman who had been hospitalised for several weeks and required extensive and expensive nursing care in a private hospital...

Her daughter was torn between sending her to a nursing home or keeping her in the hospital, where she apparently wanted to stay. Her son-in-law was angry at her for having used up their life savings... When I visited the old woman she looked frightened and weary. I asked her simply what she was so afraid of ... She was afraid of 'being eaten up alive by the worms'. While I was catching my breath and tried to understand the real meaning of this statement, her daughter

blurted out, 'If that's what's keeping you from dying, we can burn you' by which she naturally meant that a cremation would prevent her from having any contact with earthworms. All her suppressed anger was in this statement."

Kubler-Ross encouraged the mother and daughter to communicate honestly for the first time about their individual concerns, and they were able to console each other and make arrangements for the mother's cremation. The mother died the next day.

**Self Assessment Questions**

1) Describe psychodynamic approach with dying persons.

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2) What is humanistic approach? How is used in dying persons?

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3) Describe the behavioural approach with dying persons.

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4) How do we help persons dying with family approach?

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## 4.5 MAJOR THERAPY ISSUES

### 4.5.1 The Psychology of Dying Person

The best known theory of the dying process is that of Kubler-Ross, who proposes that many dying people progress through five stages of dying, described below:

**Stage 1:** **Denial:** Initially the reaction is "No! Not me!" Though the denial is rarely complete, most people respond with disbelief in the seriousness of their illness.

**Stage 2:** **Anger:** In this stage the dying person expresses anger, resentment, and hostility at the "injustice" of dying, and often projects these attitudes onto others.

**Stage 3:** **Bargaining:** The dying person tries to "make deals" to prolong life, e.g., making promises to God.

**Stage 4:** **Depression**: Here the individual may become overwhelmed with feelings of loss, hopelessness, shame and guilt, and may experience "preparatory grief".

**Stage 5:** **Acceptance**: In the final stage one comes to terms with death, not necessarily happily, but with a feeling of readiness to meet it.

Some researchers have questioned the generality of Kubler-Ross' five stages, pointing out that they do not necessarily apply to all dying people and that the therapeutic implications of the theory are not necessarily appropriate for everyone.

An alternate view of the "trajectory" of the dying person is offered by the psychiatrist, Avery Weisman. He believes that Kubler-Ross' theory describes some common reactions to loss, rather than general stages of dying. Weisman proposes four very flexible stages:

### 4.5.2 Weisman's Four Stages of Dying

1) **Existential Plight:** The dying person experiences an extreme emotional shock at the awareness of his/her own mortality.

2) **Mitigation and Accommodation:** The individual attempts to resume a "normal" life after first learning of the terminal nature of the illness.

3) **Decline and Deterioration:** When illness and its treatment begin to take full control over one's life and normal living is no longer possible, this stage begins.

4) **Pre-Terminality and Terminality:** This final stage refers to the very end of life, when treatment is no longer helpful and the "death watch" begins.

Whether they accept stage theories or not, most researchers and practitioners recognise that there are many common features in the emotional reactions of dying people. The core emotions on which therapies focus include depression, anxiety, and anger.

### 4.5.3 Emotional Reactions

1) **Depression:** Depression is perhaps the most typical response of the dying person. Although they are not inevitable, feelings of hopelessness and powerlessness pervade the experience of most dying people. The physical impairments that result from terminal illnesses and the restrictions on hospitalised patients only add to these feelings. The mental and physical condition of the dying person fosters a sense of alienation and withdrawal.

   Patients may slowly become estranged from family and friends, and they begin to disengage from "normal" living at the point where death is the prognosis. Depression is also associated with the loss of control over life events experienced by the patient. As death nears it is easier to slip into a state of passive resignation and despair. The potential of suicide is also a matter of great concern. The demoralisation, hopelessness, and physical pain of the dying patient contribute to a greater risk for suicidal action. The relatively high rates of suicide among the elderly may reflect depression in this group because of the infirmities of old age.

2) **Anxiety:** For most people the thought of death provokes anxiety. In facing death people typically experience a wide range of anxieties and related emotions like fear, dread, and panic. An analysis of the anxiety of the dying person identifies several central concerns. Surely, everyone confronts death in a unique way dependent on one's individual needs, personality, culture, and social situation, but the majority of dying persons experience intense feelings of anxiety and associated emotional stress. Some of the common elements of this anxiety are described below:

   The physical condition of the patient is certainly an obvious and significant source of anxiety. Pain, suffering, and the physical debilitation of the terminally ill person contribute significantly to insecurity, stress and anxiety. In addition terminally ill patients whose medical treatments are painful or aversive, e.g., chemotherapy for cancer victims, may develop conditioned anxiety reactions to the treatment setting and anticipatory anxiety regarding further treatments. Anxiety and shame can also result from the physical changes which occur in the dying person. The patient who insists "I don't want anyone to see me like this!" may be expressing a fear of rejection by others because of unacceptable bodily alterations from the illness.

   The social dimension of anxiety is also an important issue with the dying. Many worry about the effects of their illnesses on family members and friends. For people whose social roles are critical to the well-being of others,this anxietymay be as pronounced as self-concern. For instance, a single mother with two young children is quite likely to experience great fear for the future and safety of her children. Another aspect of social anxiety in the dying - involves the fear of loss and disruption of relationships. As suggested above social anxieties may be due to anticipated rejection because of physical revulsion, or to other factors, e.g., the fear of not being needed or wanted by others.

   The spiritual and existential aspects of death anxiety are also part of the psychology of dying. Questions about the meaning of one's life and the possibilities of life after death are common concerns of the dying person. It

is not unusual for people to show sudden increases in religious feelings when facing the prospect of personal annihilation. In dealing effectively with these concerns psychotherapists do well to cooperate with the priests or clergy and pastoral counselors, who are proficient in helping people through religious crises.

3) **Anger:** In Kubler-Ross' model anger is an essential stage of dying. The disorganisation of and threat to life felt by the dying person generates frustration, resentment, and hostility. These emotions can easily be turned against others or turned in on the self. Family members, friends, hospital staff, and therapists are likely to bear the brunt of this anger. The reactions of the recipients of anger may include withdrawal, anxiety, defensiveness, and anger in return. This will only complicate an already tension-filled situation. When the patient's anger is internalised, it leads to self-recrimination, self-blame, guilt, and lower self-esteem. As many psychologists have pointed out, anger turned on the self often fuels depression. The anger of the dying person is not always focused on others or the self, but is for many a diffuse, untargeted feeling. The pain, injustice and absurdity of dying cannot always be blamed on anyone or anything but the human condition, and that cannot be changed.

A case reported by Kubler-Ross illustrates some of the common features of a patient's anger.

Bob, a 21 year old cancer victim, was troublesome with the staff and other patients. His intense hostility prompted Kubler-Ross' consultation with him. On seeing his collection of "Get Well" cards she asked him, "Bob, doesn't that make you mad? You lie on your back in this room for six weeks staring at this wall with these pink, green, and blue get well cards?"

"He turned around abruptly, pouring out his rage, anger, envy, directly at all the people who could be outside enjoying the sunshine, going shopping, and picking a fancy get-well-soon card. And then he continued to talk about his mother who spends the night here on the couch.

Big deal! Big sacrifice! Every morning when she leaves, she makes the same statements - "I better get home now, I have to take a shower!" 'And he went on, looking at me, most full of hate, saying, 'and you too, doctor, you are no good! You, too, are going to walk out of here again.'

What counsel and advice can be offered to the dying person who experiences these intense emotions, and the many associated problems accompanying them? Often, the answer depends on the theoretical orientation of the therapist. As discussed earlier, different theories recommend different strategies for treating emotional distress. Behavioral therapies can assist the patient to take some control over these feelings through techniques like desensitisation, stress management, and relaxation training. Even a small measure of control can improve the condition of the patient. Humanistic therapists seek to help the patient confront death in as active and positive a way as possible, relying on an exploration of the individual's values, goals and self understanding. Dynamic therapy attends to the defensive reactions of the patient, and attempts to overcome self defeating defenses in order to help the patient through the dying process.

Despite considerable diversity in theory, the practical demands on counselors of the dying have led to some common concerns. As a rule therapists working with dying people take an "eclectic" approach. That is they choose from various theories those ideas which are most applicable to the individual needs of their patients.

If there is one fundamental principle of therapy with the dying person, it is to facilitate communication about the person's needs. A primary task of therapists is to assist patients in meeting their individual needs in their remaining time. Of course, each one has different needs, depending on life history, personality, and many other factors, but there are some common needs shared by most dying people. These needs include, but are not necessarily limited to, security, affection, support, dignity, and self-expression.

**Self Assessment Questions**

1) What are the five stages of dying?

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2) What are the four stages of dying according to Weisman?

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3) Describe the three emotional reactions to dying.

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## 4.6 SPECIFIC ILLNESSES AND PSYCHOTHERAPY

In considering the treatment context of the dying person one factor of fundamental importance is the specific disease from which the patient suffers. Specific terminal illnesses create unique medical, psychological, and social problems for patients. Though there are obviously many diseases which kill people, only a few have

received special attention by those working with the dying. Two diseases and their implications for psychotherapy will be discussed here: cancer and AIDS.

### 4.6.1 Cancer

Therapists have attended to cancer victims more than any other terminally ill group. Some of the features of terminal cancer which set it apart from other illnesses are its prolonged course, periods of remission, and its stigma. Because cancer may be a progressively debilitating disease, the cancer victim can anticipate a long and often painful struggle, associated with aversive medical treatments. For many cancer patients the disease involves a rollercoaster ride from remission to relapse, which is enormously stressful.

i) **Cancer-Related Psychosocial Morbidity**

Faulkner and Maguire (1994) have suggested that psychosocial adjustment to cancer is associated with six hurdles: (1) managing uncertainty about the future; (2) searching for meaning; (3) dealing with a loss of control; (4) having a need for openness; (5) needs for emotional support; and (6) needs for medical support. They suggest that a failure to deal with these results in psychosocial problems. Increasing medical advances have meant that people with cancer are now tending to live longer than used to the case, a factor that means that cancer is increasingly being conceptualised as a chronic illness. Patients who are told that they havecancer experience distress, but some have a normal adjustment reaction with limited distress that does not cause lasting psychological problems. Others experience psychological problems that significantly interfere with their quality of life; some of these will develop symptoms of an adjustment disorder, major depressive disorder, or an anxiety disorder.

ii) **Cancer Treatment**

Cancer treatment is also associated with a number of psychosocial concerns, some of which comprise quality of life and contribute to anxiety or depression. Nonphysical treatment side-effects such as anger, anxiety, or apprehension are often rated by patients as being more severe than physical side-effects such as nausea or hair loss. Indeed, some patients drop out of chemotherapy because of psychological problems.

Some treatment procedures (e.g., bone marrow transplantation) result in psychological problems because of the particular demands that accompany them. Many patients have to face treatment regimens that are difficult to tolerate, may involve behavioural demands such as frequent hospital visits and levels of motivation that may be difficult to generate or sustain.

Advances in drug therapies have resulted in a reduction in the incidence of nausea and vomiting associated with chemotherapy. However, conditioned nausea and vomiting do still occur and aversions to food can also develop. Even after the end of treatment, patients' lives may be affected throughout the follow up period, as they attend appointments to determine whether the cancer has returned.

Some psychological problems are more commonly experienced at particular times during the patient's 'cancer journey': at diagnosis, during the early months of treatment, at the end of treatment, at the discovery that the cancer has spread, or at recurrence. Some patients find that they notice persistent negative psychological

consequences only at the end of treatment. Most, however, do not experience any lasting negative psychological consequences. Others develop an increased vulnerability to future psychosocial problems as a result of the impact of an episode of cancer and cancer treatments. Some become more avoidant in their thinking about illness, having greater illness concerns and diminished capacity to work.

### 4.6.2 Problem-Focused Psychotherapies

Psychoeducational and cognitive-behavioural interventions are the most commonly problem-focused therapies for cancer patients. Psychoeducational interventions are typically of short duration and concentrate on didactic teaching of skills and strategies. This is in contrast to cognitive behaviourally based therapies that include instruction in specific skills and strategies but that are based on a cognitive and behavioural conceptualisation of the individual patient.

These therapies typically seek to help patients reduce their emotional distress by fostering control and regulating affective responses via the application of behavioural strategies (e.g., activity scheduling) or cognitive strategies that address distortion in thinking and/or enable people to test and develop more helpful alternatives to their dysfunctional ideas.

### 4.6.3 Supportive Expressive Psychotherapies

Supportive-expressive therapy has been traditionally delivered in a group and in the context of research activity that has sought to evaluate the impact of participation in such groups on survival. One of the major goals of this modality is to enable individuals to express all emotions (negative and positive). Based on the premise that most people tend to avoid the fear and anxiety associated with the possibility of death, supportive expressive therapy enables someone to express and tolerate the affect associated with thoughts of death and dying. This has been referred to as ‘detoxifying death’. It has been suggested that therapy with this focus may be more appropriate for patients with advanced cancer.

### 4.6.4 Integrative Approaches to Psychotherapy in Cancer

Kissane et al. (1997) have integrated elements of cognitive, supportive, and existential therapies in group therapy, including elements of Spiegel’s work (i.e., the development of a supportive network and addressing issues of death) with an existential focus on the management of uncertainty and awareness of one’s own mortality.

Supportive expressive work shares some similarities with other modalities. The ‘detoxification’ of death, for example, enables patients to express their feelings about death. It can also, from a cognitive perspective, provide patients with evidence about the impact and consequences of the expression of emotion. In practice, most clinicians tailor therapy to the individual, taking account of the presenting problems, and emphasise particular educational, supportive, expressive, or existential elements.

In conclusion, therapists working with cancer patients will focus on the cycle of optimism and despair which accompanies changes in the symptoms of the disease. In addition there are stress and pain management techniques that are helpful in enabling patients to get through the more noxious periods of medical treatment,

e.g., chemotherapy. Behavioral therapy techniques such as desensitisation and relaxation training have been useful to help cancer patients learn to control the anticipatory stress and nausea related to chemotherapy.

**Self Assessment Questions**

1) Name the six hurdles which are associated with psychosocial adjustment to cancer?

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2) What are three potential negative results of countertransference in therapy with a dying person?

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### 4.6.5 Aids

The past few years have seen an enormous amount of interest in AIDS (acquired immune deficiency syndrome). Some predictions indicate that AIDS will reach epidemic proportions in the next 20 years. For now though mental health professionals have begun to examine the specific therapeutic needs of AIDS victims. As great as the stigma of cancer may be, it pales in comparison with the stigma of AIDS. Several reasons for this stigmatisation are apparent. It is primarily transmitted through intimate sexual contact and sharing of needles by intravenous drug users. The prevalence of AIDS in homosexuals, prostitutes, and drug abusers gives it an association with "deviant" sexuality and antisocial behaviour.

Aside from its association with groups who are negatively perceived, the disease is typically fatal, thus allowing little or no hope for recovery on the part of victims. For now at least, a diagnosis of AIDS is equivalent to a death sentence, and the fear generated by this disease among the public has often been turned against its victims and those in high AIDS-risk groups.

Where most other terminally ill patients are pitied, AIDS victims are often shunned, rejected, and met with open hostility, even by those family members and friends who are most needed by the patient.

Psychotherapy with people with AIDS who are at the end stage of their illness generally occurs in one of two clinical situations. The first is where the individual has been in some form of on-going counselling prior to entering the final phase of life. In the other case, a client seeks out a mental health professional as a direct result of being diagnosed as HIV positive or as a result of having deteriorated

due to wasting or an opportunistic infection. AIDS has challenged psychologists in private practice as well as those who are employed in hospitals, nursing homes, hospices, community based AIDS organisation, and other home health care agencies to become prepared for working with people who are dying and their loved ones.

As people develop symptoms of advanced AIDS they increasingly lose control over their bodies and lives. One task of counselling is to help people living with HIV and AIDS recognise what they can control. An individual's physical and mental deterioration has an impact on his/herself as well as the people he or she lives with. Family therapy can be a valuable tool to help family members adjust to the changes that the progression of a loved one's illness has on the family structure and dynamics.

Clients living with a progressive disease like HIV/AIDS require help in planning for hospitalisations and debilitating illnesses. It is best for the clinician to raise the difficult and painful issues such as hospitalisation, care of dependent children, living will, medical proxy and issues to be taken care of after their death etc., long before there is any apparent need for them. The rationale for this is that when the client is still well he or she is more likely to have the necessary physical and psychic energy to plan for the ensuing difficult realities.

Therapists need to question and often challenge clients' unwillingness to discuss concrete plans or desires for a living will or treatment options. It is helpful to stress to the clients that by addressing these issues now they can insure that they will have a measure of control over what happens to them later. Obviously this has the potential to confront a client's denial, and thus the clinician must be prepared to be the target of the client's anger in response to initiating such necessary queries.

Negative core beliefs about the 'self' such as an HIV-positive patient's conception of himself as defective and unlovable can usefully be targets of cognitive approaches to case conceptualisation and treatment. The labeling of inaccurate inferences or distortions may help the patient become aware of the unreasonableness of such automatic patterns of thought.

Cognitive probes and questioning may be used to elicit automatic thoughts. Such automatic thoughts can then be tested with the therapist who carefully attends to the possibility of exaggeration and catastrophizing. Relaxation techniques can also be useful with patients who are anxiously worried about the impact of their diagnosis on various aspects of their lives.

### 4.6.6 Interpersonal Psychotherapy

Interpersonal psychotherapy has been shown to have particular advantages for HIV patients (Markowitz et al., 1998). Interpersonal therapy relates mood changes to environmental events and resultant changes in social roles. For example, the interpersonal therapist defines depression as a medical illness and then assigns the patient both the diagnosis and the sick role. She then engages the patient on affectively laden current life issues, and frames the patient's difficulties within an interpersonal problem area: grief, role dispute, role transition, or interpersonal deficits. Strategies then address these problem areas, focusing in the present on what the patients want and what options exist to achieve this.

### 4.6.7 Exploratory Psychodynamic Treatments

These treatments including psychoanalysis may be usefully employed with the HIV positive patient grappling with these issues. In patients with AIDS, evaluation and treatment should focus on helping patients receive life-enhancing medical care, resolving troubling psychological issues and making the best use of whatever time is left.

## 4.7 LET US SUM UP

Psychotherapy basically offers the dying person much the same that it offers anyone – a supportive relationship in which the individual has opportunities to work on significant personal concerns. The unique life situation of the dying person places limits on the process of therapy and demands greater modesty on the part of therapists regarding possible outcomes. Regardless of theoretical orientations therapists working with dying patients rely first and foremost on communication. Therapy is best used as a forum for exchanging information, educating, expressing fears, and discussing needs.

## 4.8 UNIT END QUESTIONS

1) Discuss in detail how the major therapeutic approaches have been modified to the unique needs of dying persons?
2) Discuss the psychology of the dying person?
3) Describe the core emotional reactions of a dying person?
4) Write about the psychosocial morbidity related to cancer? Discuss the therapy approaches with cancer patients?
5) Write about the issues and therapy with persons with AIDS?

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