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Psychotherapeutic Methods

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By: *Anand Prakash Srivastava*

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Sample Preview of the Solved Sample Question Papers

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QUESTION PAPER

June – 2023

(Solved)

PSYCHOTHERAPEUTIC METHODS

M.P.C.E.-013

Time: 2 Hours] ***[Maximum Marks : 50***

Note: *All sections are* ***compulsory****.*

SECTION-A

Q. 1. Critically discuss the solution focused therapy.

Ans. Ref.: See Chapter-7, Page No. 64, 'Solution Focused Therapy (SFT)', 'Ingredients of Solution Focused Therapy' and 'The Practice of Solution Focused Therapy'.

Q. 2. Describe the characteristics of behaviour modification and provide its historical overview.

Ans. Ref.: See Chapter-5, Page No. 44, 'Characteristics of Behaviour Modification' and 'Historical Overview of Behaviour Modification'.

Q. 3. Explain the distinctive features of psychodynamic therapy.

Ans. Ref.: See Chapter-1, Page No. 12, Q. No. 5.

Q. 4. Discuss psychotherapy for adolescents.

Ans. Ref.: See Chapter-14, Page No. 129, 'Psychotheraphy with Fledgling Adults' and Page No. 130, 'Psychotherapy with Young Adults'.

SECTION-B

Q. 5. Explain psychotherapy for cancer patients.

Ans. Ref.: See Chapter-16, Page No. 146, 'Cancer, Problem Focused Psychotherapies' and Page No. 147, Integrated Approaches to Psychotherapy in Cancer'.

Q. 6. Elucidate the use of transference in couples therapy.

Ans. Ref.: See Chapter-11, Page No. 101, 'Use of Transference in Couple's Therapy'.

Q. 7. Discuss various cognitive techniques in cognitive behaviour therapy.

Ans. Ref.: See Chapter-6, Page No. 56, 'Cognitive Behavioural Techniques'.

Q. 8. Discuss the features of short-term therapies.

Ans. Ref.: See Chapter-3, Page No. 26, 'Defining Features of Short-Term Theories'.

Q. 9. Discuss the concept and practice of multi-modal therapy.

Ans. Ref.: See Chapter-8, Page No. 71, 'Multi-modal Therapy', 'Development of Multi-modal Therapy' and Page No. 72, 'Practice of Multi-modal Therapy'.

Note: Write short notes on the following:

Q. 10. Psychotherapy in dementia

Ans. Ref.: See Chapter-15, Page No. 137, 'Psychotherapy in Dementia'.

Q. 11. Multiple-family group therapy

Ans. Ref.: See Chapter-10, Page No. 89, 'Multiple-Family Group Therapy'.

Q. 12. Variables of reinforcement

Ans. Ref.: See Chapter-5, Page No. 46, 'Variables of Reinforcement'.

QUESTION PAPER

December – 2022

(Solved)

PSYCHOTHERAPEUTIC METHODS

M.P.C.E.-013

Time: 2 Hours] ***[Maximum Marks : 50***

Note: *All sections are* ***compulsory****.*

SECTION – A

Note: Answer the following questions:

Q. 1. Discuss the various techniques of cognitive behaviour therapy.

Ans. Ref: See Chapter-6, Page No. 61, Q. No. 5.

Q. 2. Explain the attachment-based interventions.

Ans. Ref: See Chapter-4, Page No. 36, 'Attachment-based Interventions'.

Q. 3. Describe the components of psychodynamic psychotherapy.

Ans. Ref: See Chapter-1, Page No. 5, 'Components of Psychoanalytic and Psychodynamic Psychotherapy'.

Q. 4. Discuss the goals and process of client-centered therapy.

Ans. Ref: See Chapter-9, Page No. 86, Q. No. 2 and Q. No. 3.

SECTION – B

Note: Answer the following questions:

Q. 5. Define terminal illness. Describe the goals of therapy with dying persons.

Ans. Ref: See Chapter-16, Page No. 144, 'Terminal Illness and Psychotherapy" and Page No. 148, Q. No. 3.

Q. 6. Discuss therapies for specific problems in older adults.

Ans. Ref: See Chapter-15, Page No. 137-138, 'Therapies for Specific Problems'.

Q. 7. Elucidate contingency contracting.

Ans. Ref: See Chapter-5, Page No. 46, 'Contingency Contracting'.

Q. 8. Describe psychotherapy for people in middle adulthood stage.

Ans. Ref: See Chapter-14, Page No. 131, 'Psychotherapy with People in Middle Adulthood'.

Q. 9. Explain the concept and therapeutic principles of group psychotherapy.

Ans. Ref: See Chapter-10, Page No. 92-93, 'History of Group Psychotherapy'.

SECTION – C

Note: Write short notes on the following:

Q. 10. ABC model

Ans. Ref: See Chapter-6, Page No. 54, 'ABC Model'.

Q. 11. Psychosexual stages of development.

Ans. Ref: See Chapter-1, Page No. 2, 'Stages of Psychosexual Development'.

Q. 12. Transference and counter-transference.

Ans. Ref: See Chapter-1, Page No. 4-5, 'Transference and Counter-transference'.

Sample Preview of The Chapter

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PSYCHOTHERAPEUTIC METHODS

BLOCK-1: PSYCHOLOGICAL TREATMENT OF MENTAL DISORDERS : MAJOR MODALITIES

Psychoanalysis, Psychoanalytic/ Psychodynamic Therapy

1

INTRODUCTION

Psychotherapy and psychoanalysis are often used interchangeably. This might be the case because psychoanalysis is the most widely used form of psychotherapy. Additionally, the majority of psychiatrists and psychologists are still only seen as psychoanalysts in popular media like television and movies. Most individuals are shocked to find that clinicians currently employ a variety of treatment modalities in addition to psychoanalysis. Surprisingly, Sigmund Freud was not the first person to employ psychotherapy concepts.

Historically, one of the most effective forms of psychotherapy has been psychoanalysis, which was of course created by Freud. Psychoanalysis has made significant contributions to the ideas and practices of both psychotherapy and counseling. The foundational principles of psychoanalysis played a significant role in the advancement of other therapeutic approaches that came after. Many clinicians who do not identify as psychoanalysts yet place a high priority on ideas like the unconscious, transference, and dream analysis.

CHAPTER AT A GLANCE

PSYCHOANALYSIS

Psychoanalysis consists of three key parts:

- A technique for studying the mind and how people think.
- A formalized collection of hypotheses explaining how people behave.
- A technique for treating mental or emotional disorders.

There are at least 22 theoretical approaches about human mentation and development that fall under the wide definition of psychoanalysis. As with the theories, there are many different "psychoanalytical" therapeutic modalities. The phrase also describes a technique for researching child development.

Theoretical Models

Psychoanalytic theories can be grouped into "schools." Despite their differences, most theoretical "schools" stress the importance of unconscious variables on mental health. Unifying theoretical components has also been a priority. As in many medical fields, debates persist concerning disease causes and treatment methods. List of some influential theories is given below.

FREUDIAN PSYCHOANALYTICAL THEORY

Sigmund Freud was the first prominent theorist to focus on nonbiological ways to understanding and treating mental diseases. His thoughts transformed medical disorders including hysteria.

After receiving a hypnosis grant, Freud produced his first book, '*The Interpretation of Dreams*,' which sold barely 600 copies but became one of the most influential and controversial personality theory works. He introduced the unconscious to medicine in this work about the human psyche. Many biological theorists rejected this idea.

Basic Human Drives

Sigmund Freud believed all thoughts, feelings, and behaviours stem from two basic drives. These include sex and aggression. Life and death or Eros and Thanatos they drive all human motivation.

Sex drives humans, according to Freud. Even though it may appear excessive, sexual interaction creates life and preserves the human bloodline. Even in other animals, sex ensures species survival.

Aggression or the killing instinct, does the opposite. Aggression protects us from damage. The aggressiveness drive helps us live and defeat enemies.

Though primitive, it's more than sexuality and violence. One drive covers the complete survival instinct:

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

These forces affect most animal behaviour, which is easy to comprehend.

Some examples are as follow: Why would adults attend college? Freud believed we change to attract opposite sex persons and find a better companion. Better matches increase our chances of having children and passing on our genes. College graduates earn more, providing them an edge over competition.

Structural and Topographical Models of Personality

Psychosexual development was simply one part of Sigmund Freud's personality theory. His theory's complicated. He believed that many important driving elements emerge during these times.

Structural Model (id, ego, superego)

Freud believed the Id was innate. The Id meets our needs as newborns. Freud considered the Id pleasurable. The Id always wants what feels nice. Child screams because Id needs food. The Id wants the crying baby changed immediately. When the child is uncomfortable, in pain, too hot, too cold, or seeks attention, the Id demands attention. The Id is self-centered. Parents rarely influence babies. They don't mind when their parents rest, eat, or wash. When the Id wants something, nothing else in important

The next three years shape the child's second personality. Freud called this part as the Ego. Realistic ego. The ego realises others have needs and that being impulsive or selfish may hurt ourselves. Egos reconcile desires with reality.

At five, the Superego forms. Caregiver's morality and ethics shape the Superego, the moral part of the personality. The conscience, or Superego, directs morality.

Freud believed a healthy Ego could satisfy the Id, calm the Superego, and evaluate every situation. Too much Id leads to impulses and self-gratification. A person with a prominent Superego is judgemental and moralistic.

Topographical Model

Freud believed most emotions, thoughts, and impulses are unconscious. Their subconscious drives them. Fear pushed same-sex parent sentiments and thoughts into the unconscious in Oedipus and Electra complex. Freud felt they still influenced us while buried.

The model just includes the unconscious. Freud felt our conscious remembers everything. Our conscience is little. Thus, much of our individuality is always veiled.

Subconsciousness concludes. If asked, we can see this. It's hidden until we locate it. The preconscious remembers childhood, phone numbers, and best buddies. Because the unconscious is so large and we only know a small fraction of it, this hypothesis has been called an iceberg. The nonconscious—water, represents all we don't know, haven't experienced, or haven't assimilated into our psyche.

Stages of Psychosexual Development

Freud (1856-1939) is the best-known personality theorist. 'Freud's Stages of Psychosexual Development', like other stage theories, follow a fixed order and can lead to healthy or ill personalities. Freud's erogenous zone theory is the most disputed.

Failure means a child remains fixated on that erogenous zone and either over- or under-indulges as an adult.

1. Oral Stage (Birth to 18 months): During oral development, the child enjoys oral pleasures (sucking). Oral Fixation or Oral Personality can result from excessive or insufficient enjoyment. This person may smoke, drink, eat, or bite their nails more. Gullible, dependent, and followers. Resisting these urges may make them pessimistic and hostile.

2. Anal Stage (18 months to three years): The child enjoys pooping during this time. Parents and society pressure kids to control anal stimulation. Anal concern at this period can lead to cleanliness, perfection, and control obsessions (anal retentive). They can also get messy (anal expulsive).

3. Phallic Stage (Ages three to six): Genital joy reigns. Freud believed boys in this age had unconscious sexual urges towards their mothers. This rivals his father for his mother's devotion. Boys worry their fathers will castrate them for these impulses. Oedipus complex describes these feelings (after the Greek Mythology figure, who accidentally killed his father and married his mother).

4. Latency Stage (Age six to puberty): Sexual impulses are still suppressed throughout this time, and kids generally socialise and play with their own sex's peers.

5. Genital Stage (Puberty on): At the onset of puberty, when sexual desires are reawakened, the final stage of psychosexual development begins. Adolescents focus their sexual impulses on their opposite sex peers, with the primary focus of pleasure being the genitalia, according to the lessons learnt throughout the earlier stages.

Ego Defense Mechanisms

The Ego's role was to gratify the lurges d's without offending the Superego's morality while considering the scenario. This was a difficult job, too. Id is the "devil on your shoulder" and Superego is the "angel on your shoulder." We talk to both of them, hear their perspectives, and then decide. Ego, seeking equilibrium, made this choice.

Table : Defense Mechanisms

Defense	Description	Example
Denial	arguing against an anxiety provoking stimuli by stating it doesn't exist	denying that your physician's diagnosis of cancer is correct and seeking a second opinion
Displacement	taking out impulses on a less threatening target	slamming a door instead of hitting as person, yelling at your spouse after an argument with your boss
Intellectualisation	avoiding unacceptable emotions by focusing on the intellectual aspects	focusing on the details of a funeral as opposed to the sadness and grief
Projection	placing unacceptable impulses in yourself onto someone else	when losing an argument, you state "You're just stupid;" homophobia

Rationalisation	supplying a logical or rational reason as opposed to the real reason	stating that you were fired because you didn't kiss up the the boss, when the real reason was your poor performance
Reaction Formation	taking the opposite belief because the true belief causes anxiety	having a bias against a particular race or culture and then embracing that race or culture to the extreme
Regression	returning to a previous stage of development	sitting in a corner and crying after hearing bad news; throwing a temper tantrum when you don't get your way
Repression	pulling into the unconscious	forgetting sexual abuse from your childhood due to the trauma and anxiety
Sublimation	acting out unacceptable impulses in a socially acceptable way	sublimating your aggressive impulses toward a career as a boxer; becoming a surgeon because of your desire to cut; lifting weights to release 'pent up' energy
Suppression	pushing into the unconscious	trying to forget something that causes you anxiety

The aforementioned examples show that ego defenses are not always harmful.

Face it, a lack of these safeguards or a failure to employ them properly can frequently result in issues with daily living. But occasionally we overreact or deploy the defenses inappropriately, which can be just as harmful.

Limitations

The following are some of the common objections to Freudian theory:

- Freud's hypotheses cannot be verified or refuted. What would constitute sufficient proof to support or contradict theoretical assertions is unclear.
- The theory is founded on a flawed conceptualization of women's experience.
- The significance of sexuality in the growth and experience of human psychology is overemphasized in this perspective.

OBJECT RELATIONS THEORY

Symbiosis and Separation/ Individuation

The premise behind "object relations theory", a psychoanalytic adaption that builds on this idea, is that a person's psychological life is generated in and through relationships with other people.

The capacity to walk and talk are among the "innate potentials and character features" that are permitted to develop during this period in the presence of "excellent object connections." Language and motor skills are influenced by the quality of these relationships.

The first three years of life are marked by two things:

1. the development of a close, symbiotic relationship with the primary carer, who is typically the mother; and
2. the subsequent severance of that relationship through separation (differentiating oneself from the carer) and individuation (establishing one's own abilities and personality traits).

Self Identity and Gender Identity

The process of becoming a "gendered subject" complicates the child's growth. Since the primary caretaker is usually the mother, the child's gender is the same as the mother's at birth. Boys and girls are born "feminine". To become "masculine", the boy must repress much of his early, symbiotic experience. (Girls repress infantile experience less).

As shown, child development has two crucial elements:

- Self identity and
- Gender identity.

Reproduction of Social Patterns

Finally, object relations theory's central idea is that the developing human subject is substantially shaped by its carers. Since those caretakers are socially determined, they will pass on their race, class, and gender preferences to the child. Thus, social relations define "human essence".

SELF PSYCHOLOGY

Self psychology emphasises empathetic communication with key significant others, called "self objects", to establish a stable and integrated self. Self objects strengthen the developing self by meeting its mirroring, idealisation, and twinship demands. "Transmuting internalisations" help the patient internalise the therapist's self-object functions. Heinz Kohut introduced self psychology, which Arnold Goldberg, Frank Lachmann, Paul and Anna Ornstein, Marian Tolpin, and others have refined.

ATTACHMENT THEORY

John Bowlby developed attachment theory against psychoanalytic beliefs of his time. However, attachment theory has recently been integrated into psychoanalysis pluralistic structure. Bowlby (1988) stressed the child's real experience and the external world's role in healthy development. Bowlby believed attachment behaviours were unrelated to other drives, citing ethology. The infant is not object-seeking, unlike object relational thinking. Instead, the youngster seeks a psychophysiological condition associated with closeness to the mother or provider.

Holmes (2001) indicated that insecurely attached adults may employ "pathological secure base phenomena" like substance misuse, self-harm, or

binge eating when pressured or threatened. These behaviours may mimic the secure base's physiological condition without its psychological or relational aspects.

The Strange Situation study by Ainsworth *et. al*., (1978) refined the attachment notion. In this 20-minute lab test, a kid is briefly separated from its mother. These separations categorised children as securely attached, anxious-avoidantly attached, anxious-ambivalent or resistant, or disorganized/disoriented.

Attachment theorists have found it clinically useful to think of adults in four somewhat analogous attachment categories: secure/autonomous individuals who value attachment relationships; insecure/dismissing individuals who deny, devalue, idealise, or denigrate both current and past attachments; and preoccupied adults who are overwhelmed, disorganised or unreasoned individuals who have often sufficed neglect or trauma. Attachment theory has more empirical research than other psychoanalytic schools.

LACANIAN PSYCHOANALYSIS

French and Latin American psychoanalysts prefer Lacanian psychoanalysis with semiotics and Hegelian philosophy. Ego psychology based British and American psychoanalysis differs from Lacanian psychoanalysis. Jacques Lacan regularly used "retourner à Freud" ("return to Freud") in his seminars and writings to emphasise that his views were an extension of Freud's, opposed to Anna Freud's Ego Psychology, Object Relations, and "self" theories, and that Freud's entire works should be read. "Mirror image", "Real", "Imaginary", and "Symbolic" are Lacan's concepts. In literary theory, Lacan's views have had little impact on psychoanalysis or psychotherapy in the English-speaking world. Lacan was expelled from the International Psychoanalytic Association for his irrational, inconsistent, and pseudoscientific views.

POSTMODERN SCHOOLS

Recent theoretical models emphasise psychoanalysis treatment's two-person aspect. Intersubjectivity, relational theory, constructivism, and interpersonal psychoanalysis all promote scepticism about any underlying truth in the patient or analyst. Therapist and patient contact co-constructs truth. They doubt objective reality and are postmodernists.

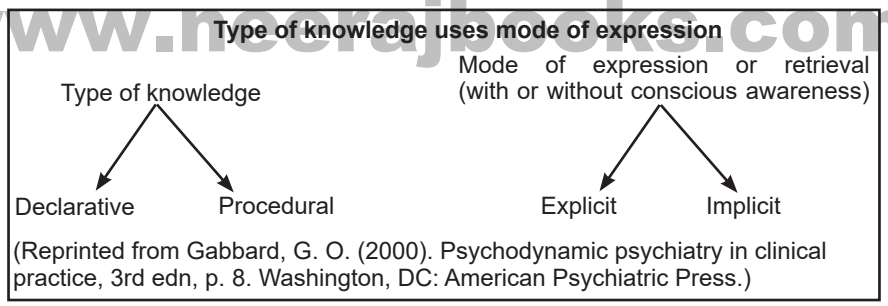
PSYCHOANALYTIC/PSYCHODYNAMIC THERAPY

Psychodynamic and psychoanalytic are interchangeable. Psychoanalysis refers to a psychological treatment in which a psychoanalyst or analyst uses established techniques to understand transference and gain insight. Psychoanalysis involves three to five weekly for 45- to 50-minute sessions. The analyst sits behind the patient while they free associate on a couch. Psychodynamic psychotherapy uses the same procedures as psychoanalysis but is shorter and less demanding.

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: Experimental psychology has supported Freud's idea that most mental life is unconscious. Psychoanalytic psychotherapists use unconscious representations or mental functioning rather than the unconscious. Neuroscience no longer views "the unconscious" as a reservoir.



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

Current psychodynamic and neuroscience thinking classifies procedural and declarative memories as conscious or unconscious. Whether knowledge is stated or recalled consciously distinguishes explicit from implicit memory. Thus, the explicit-implicit dichotomy is analogous to conscious-unconscious.

The Developmental Perspective: Psychoanalysis uses a developmental model of behaviour. Assumption: Childhood events shape adults. Childhood intrapsychic difficulties cause repeated interpersonal problems. We now know that a child's genetic disposition affects much of their connection with their parents. Thus, hereditary traits elicit parental responses that shape the child's personality. Psychoanalytic therapists do not blame parents. They believe the patient's issues stem from the child's, parents, and their "fit."

Subjectivity: Psychodynamic subjectivity emphasises personal meaning. Psychodynamic physicians focus on the patient's phenomenological experience, i.e., how they see themselves, others, the world, etc.

Transference: Psychotherapists become like old friends to patients. We now know that the therapist's personality and behaviour shape transference, contrary to Freud's view. The patient's perception of the therapist depends on the therapist's gender, age, appearance, and approach.