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?

....

....

....

....

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

....

....

....

....

....

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

....

....

....

....

4) What are the goals of Gestalt therapy?

....

....

....

....

....

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

....

....

....

....

....

6) What is communication analysis?

....

....

....

....

....

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.