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# UNIT 1 PSYCHOANALYSIS, PSYCHOANALYTIC/ PSYCHODYNAMIC THERAPY

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## 1.0 INTRODUCTION

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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.

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## 1.1 OBJECTIVES

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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.

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## 1.2 PSYCHOANALYSIS

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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.

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## 1.3 FREUDIAN PSYCHOANALYTICAL THEORY

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

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

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

### 1.3.1 Basic Human Drives

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

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

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

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

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

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

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

### 1.3.2 Structural and Topographical Models of Personality

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

#### **Structural Model (id, ego, superego)**

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

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

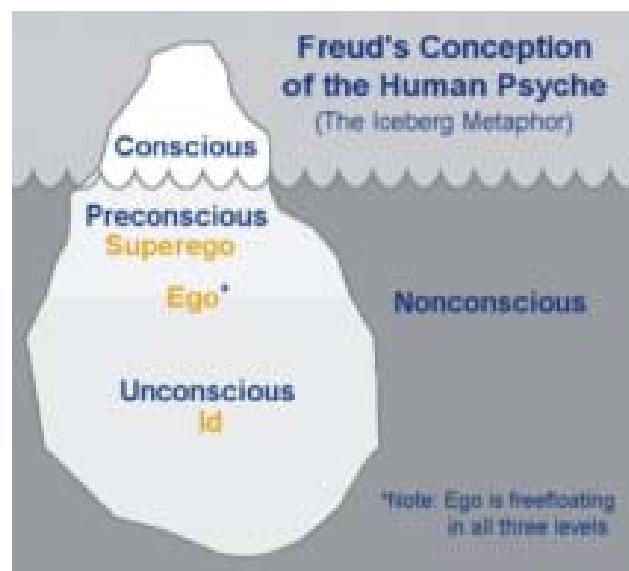
Within the next three years, as the child interacts more and more with the world, the second part of the personality begins to develop. Freud called this part as the Ego. The Ego is based on the reality principle. The ego understands that other people have needs and desires and that sometimes being impulsive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

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

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

### Topographical Model

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



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

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

### 1.3.3 Stages of Psychosexual Development

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

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

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

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

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

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

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

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

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

### 1.3.4 Ego Defense Mechanisms

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

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

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

**Table: 1.4: Defense Mechanisms**

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

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

Ego defenses are not necessarily unhealthy as you can see by the examples above. In fact, 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.

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## 1.4 OBJECT RELATIONS THEORY

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### 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”.

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## 1.5 SELF PSYCHOLOGY

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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.

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## 1.6 ATTACHMENT THEORY

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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.

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## 1.7 LACANIAN PSYCHOANALYSIS

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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.

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## 1.8 POSTMODERN SCHOOLS

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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

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

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

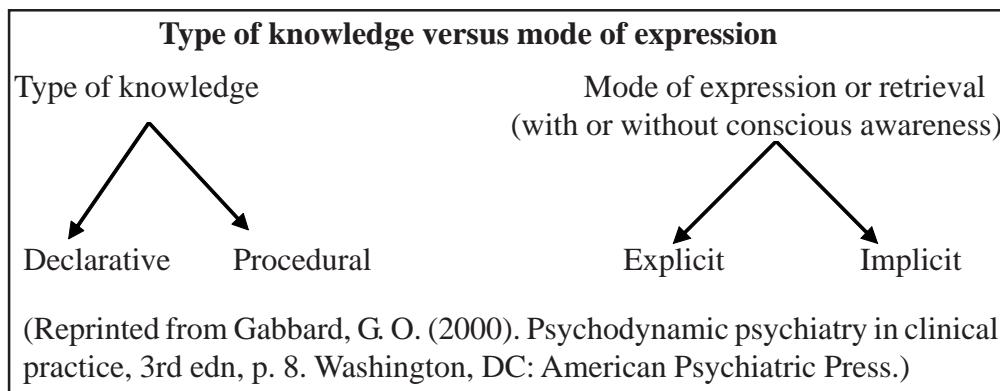
### 1.9.1 Basic Tenets and Concepts of Psychoanalytic Therapy

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

#### The Unconscious

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

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



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

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

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

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

### **The Developmental Perspective**

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

### **Subjectivity**

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

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

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

### **Transference**

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

### **Resistance**

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

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

### **Countertransference**

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

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

### **Psychic determinism**

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

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

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

### 1.9.2 Components of Psychoanalytic and Psychodynamic Psychotherapy

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

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

These three aspects are dealt with in detail below:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 1.9.3 Distinctive Features of Psychodynamic Technique

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

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

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

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



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

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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.

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## 1.11 UNIT END QUESTIONS

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- 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?

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## 1.12 SUGGESTED READINGS

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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.

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## 1.13 ANSWERS TO SELF ASSESSMENT QUESTIONS

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### 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.