UNIT 1 COUNSELLING: THE ART AND SCIENCE OF HELPING

Structure

1.0 INTRODUCTION

This unit deals with the art and science of counselling. The debate whether counselling is an art or science and whether it can be both has been an important issue in psychology. We start this unit with definitions of counselling and describe the process. Then the characteristics of counselling are taken up and discussed especially in relation to the counselling relationship. Then we discuss the value of therapy and how useful it is and what kind of therapeutic climate should one ensure in order to make the therapy effective. We discuss the barriers to communication which are responsible for the failure of therapeutic sessions. Then we deal with core dimensions of effective counsellor and what are the qualities a counsellor should have and how these are to be ensured in the training. In this we discuss congruence, unconditional positive regard, and empathy as important constituent factors of effective therapist. Then we take up the issue of what is effective therapeutic relationship and in this it is pointed out the genuineness of therapeutic relationship and shared goals in counselling between the therapist and the client.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define counselling as a helping profession;
- Describe the characteristics of counselling relationship;
- Explain therapeutic value and therapeutic climate;
- Elucidate the barriers to communication which affects therapy adversely; and
- Analyse the core characteristics and dimensions of an effective counsellor.

1.2 DEFINITION OF COUNSELLING

One of the important issues discussed in counseling and psychotherapy is whether counseling is an art or a science. If it is an art, then it becomes part of the counselor's innate affective and relational qualities. If it is a science, then it refers to the skills that the counselor has developed as a result of the training that he or she has taken in counseling. Such a skill seeks to spell out the process in the treatment so that others can utilise the same practices. In order to say that counseling is a science, it needs research based evidence in regard to its effectiveness in treating a client's problem. There are a number of research studies that have shown that the counseling process as is being practiced is effective in treating the client's problem. However there are also research evidences that show the contrary.

Hence the question keeps cropping up whether counseling is an art or a science. The answer is that it is both. Counselors need to have key affective qualities and helping skills, knowledge of and competencies in the 12 core functions, familiarity with legal and ethical issues, and grounding in various theoretical frameworks. Most importantly, they need to be able to establish a helpful therapeutic alliance with clients. Hubble, Duncan and Miller summarise 40 years of outcome research and assert that the single most important aspect of counseling is the alliance. The quality of the therapeutic alliance accounts for 30 percent of the change in counseling. Does the client feel listened to, cared for, supported, a sense of bond with the counselor, warmth, respect, genuineness, not judged? A good working relationship is the heart of effective counseling. The non-specific factors that contribute to this alliance are:

1) having a time/safe place to talk
2) feeling understood
3) a meeting of the minds
4) a sense of encouragement, coaching, teaching

What does not work in counseling is attributing failure to the client, arguing with the client, passivity, hostility, negative confrontations, mechanical responses, and ignoring the client's feelings. Fundamental to the therapeutic relationship is the client's perception of that relationship. It is not how the counselor sees it, but how the client sees it. Is the counselor meeting the client at their stage of readiness? In what ways does the client gain hope of recovery from the counselor?

Counseling is an art and science, relationship and action. Academic programs want to focus on both aspects, but the nature of academics leads to a greater emphasis on knowledge and less on interpersonal process. Frankly, it is easier to grade tests of knowledge and harder to grade interpersonal process. Further, we outsource the practice part of the program to supervisors that may not be capable of providing the same kind of detailed assessment that we do in our classes. Most students seeking to learn the art of counseling focus on knowledge and interventions

But the art of counseling trumps knowledge and intervention. Knowing what to do is of little value if trust has not been fully formed. There is no substitute from having repeated interactions with another and getting detailed feedback related to one's relational habits and idiosyncrasies. Jay Adams once said that teaching counseling should be like teaching art. You do not have a lecture on colours and shades and expect them to know how to use them well. Instead, you give them a brush and you expect them to do trial and error while providing good feedback. This means we really have to focus not just on what we counselors intend to communicate when respond to client content, but what they actually hear and take away from us.

Pepinsky and Pepinsky (1954) defined the relationship "as a hypothetical construct to designate the inferred character of the observable interaction between the two individuals".

Shertzer and Stone (1971) have described the helping relationship as "the endeavor, by interaction with another person to contribute in a facilitating positive way to his improvement".

Rogers (1961) defines the helping relationship as one "in which at least one of the parties has the intent of promoting the growth, the development, maturity, improved functioning, and improved coping with life of the other".

1.3 CHARACTERISTICS OF A COUNSELING RELATIONSHIP

Various interpersonal relationships, including that between parent and child or teacher and student, but the helping relationship established between the client and counselor is unique. A number of specific characteristics contribute to its uniqueness.

1) **Affectiveness:** The relationship established between counselor and client is more affective than cognitive. It involves the exploration of the client's feelings and perceptions. Because of the highly personal content of the discussions, the relationship can be comforting and anxiety producing, intense and humorous, frightening and exhilarating.

2) **Intensity:** Since it is based on open, direct and honest communication, the relationship can be intense. Counselor and client are expected to share openly their perceptions and reactions to each other and to the process. This can result in intense communication.

3) **Growth and change:** the relationship is dynamic, it is constantly changing as the counselor and client interacts. As the client grows and changes, so do the relationship.

4) **Privacy:** All clients' disclosures are confidential and counselors are obligated not to share what is being spoken in the interviews with others unless the client has given permission to do so. This protective aspect of the relationship is unique and frequently encourages client self disclosure.

5) **Support:** counselors through the relationship, offer clients a system of support that often provides the necessary stability for taking risks and changing behaviour.

6) **Honesty:** The helping relationships is based on honesty and open, direct communication between counselor and client.

1.4 THERAPEUTIC VALUE

The effectiveness of the helping relationship in the remediation of emotional and psychological problems and in the growth, maturation, and self-actualisation of individuals can be attributed to many factors.

One important factor is that the relationship established between the client and counselor is a microcosm of the client's world, it mirrors the client's patterns of relating to others. The relationship enables the counselor to observe the clients interpersonal style and also provides a vehicle for changing ineffective communication patterns. From this perspective the relationship is therapeutic since the client and counselor encounter each other as two individuals working out the complexities of an intimate relationship.

1.5 THERAPEUTIC CLIMATE

A therapeutic climate is specially created by the counsellor so that the client feels comfortable to express himself and communicate problems without any inhibition. To create a climate of this type, the therapist must ensure the following, viz., (i) Trust (ii) Acceptance

i) **Trust:** A prerequisite for establishing a therapeutic climate is trust. Clients entering the counseling relationship are often anxious and afraid. Their expectations from counseling sessions may be unclear. They are seeking help with personal concerns and hope the counselor will respond with understanding. If, in the initial contact, they perceive the counselor as trustworthy, they will take increasingly greater emotional risks, sharing thoughts, feelings, anxieties, and fears that are difficult to discuss and that have sometimes been denied. As clients realise that the counselor is not finding fault with those aspects of them they dislike, they will become more accepting of themselves. As trust grows, so does the potential for growth and change. From initial contact then, the counselor must be perceived as trustworthy. Roger's emphasises the importance of trust in establishing a helping relationship.

ii) **Acceptance:** The relationship between trust and acceptance has been alluded to in the above discussion of trust. An accepting attitude implies that the counselor can listen to the clients concerns without making judgments and can appreciate the client as a person regardless of clients of the client's views, attitudes and values. This accepting attitude communicates respect for the client as a person of dignity and worth. The client feels that he has been understood by the counsellor, and valued in a very real sense.

1.6 BARRIERS TO COMMUNICATION

i) **Giving advice:** Some counselors are anxious to help their clients by offering advice. They assume that it is their responsibility to guide clients in the right direction and to solve their problems. Because of their expertise in the areas of human development and behaviour, they expect to help clients by instructing them regarding the right course of action.

ii) **Offering solutions:** The difficulties with counselors offering solutions to client problems are several. First the clients present in the initial interview may not be the concerns for which they need counseling. If the client begins solving these, the more basic problem may never surface. It is unrealistic and pretentious for counselors to assume they have solutions to the various concerns that the client faces. This problem solving approach reduces the complexities of living to simple problems that have solutions.

iii) **Moralising and preaching:** When counselors moralise or preach they evaluate the client's behaviour and indicate what the clients ought to do or how the client should feel. This type of response induces guilt, is judgmental, and attempts to change the client's behaviour in the direction of the counselor's value system. Such counselors do not attempt to understand the client's world from the client's perspective.

iv) **Analysing and diagnosing:** Analysing and diagnosing client's problem is an example of ineffective and unaccepting communication because it puts the counselor in the position of viewing the client's problem from an external frame of reference. In other words, the counselor is removed and objective, seeking to identify the maladaptive behaviours and to put them into a clinical framework.

v) **Judging or criticising:** When a counselor judges or criticises a client's response, the client typically withdraws and withholds further information or feelings. Like moralising or preaching, this response does not facilitate client self disclosure but instead induces guilt.

vi) **Praising and agreeing and giving positive evaluations:** The two responses of praising or agreeing and giving positive evaluations are somewhat more difficult to view in terms of their negative impact on the client. Acceptance implies a neutral stand towards the client's attitudes, values and behaviours. At times it is appropriate for the counselor to respond to the clients growth or behaviour change with genuine enthusiasm, however, the counselor must be careful that the seemingly positive response does not communicate a superficial attempt to make the client feel better, make the problem disappear, or to deny that the client really has a problem.

viii) **Reassuring:** Reassurance helps the client only on a superficial level. It stops interaction between the counselor and client and communicates to the client that many others have felt the same way. This type of statement prevents further discussion of the client's fears, anxieties or concerns about particular issues.

Self Assessment Questions

1) Define counselling.

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2) What are the characteristics of counselling relationship?

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3) What is meant by therapeutic value?

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4) What kind of a therapeutic climate is required and how can it be ensured for effective counselling?

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5) What are the various barriers to effective communication in therapy situation?

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1.7 CORE DIMENSIONS OF AN EFFECTIVE COUNSELLOR

The three main core conditions that Carl Rogers considered essential for effective counseling are:

1) Unconditional positive regard
2) Empathy
3) Congruence

However in Roger's paper "*The necessary and sufficient conditions of Therapeutic personality change*" he lists six conditions in total:

1) Two persons are in Psychological contact.
2) The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3) The second person, whom we shall term the therapist is congruent or integrated in the relationship.
4) The therapist experiences unconditional positive regard for the client.
5) The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6) The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist and continue over a period of time, then the therapeutic personality change may occur.

Unconditional Positive Regard, Empathy and Congruence are the counselors or therapists conditions needed to facilitate change. Without these conditions being present, a healing relationship cannot form. In the six conditions above we see that the client also has to 'play ball', Psychological contact is needed. If the client does not want to be there they are free to withdraw and the counseling processes cannot continue. The client too it seems needs to realise that there is something not working for them in their lives.

Roger's three core conditions for therapeutic change as explained by him are:

i) Genuineness, realness or congruence
ii) unconditional positive regard and
iii) empathic understanding. These are explained below.

1.7.1 Genuineness, Realness or Congruence

The first element that is genuineness, realness, or congruence refers to the fact that more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, greater is the likelihood that the client will change and grow in a constructive manner. Rogers discussed the vital importance of the clinician to "freely and deeply" be himself/herself. The counsellor needs to be a "real" human being. Not an all knowing, all powerful, rigid, and controlling figure. A real human being is a person with real thoughts, real feelings, and real

problems. All facades should be left out of the therapeutic environment. The counsellor must be aware and have insight into him or herself. It is important to seek out help from colleagues and appropriate supervision to develop this awareness and insight. This specific characteristic fosters trust in the helping relationship. One of the easiest ways to develop conflict in the relationship is to have a "better than" attitude when working with a particular client.

This means that the therapist is openly exposing the feelings and attitudes that are flowing within him or her at the moment. Thus, there is a close matching, or congruence, between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client.

1.7.2 Unconditional Positive Regard

The second attitude of importance in creating a climate for change is acceptance, or caring. The unconditional positive regard refers to when the therapist is experiencing a positive, acceptant attitude toward whatever the client *is* at that moment when the therapeutic movement or change is more likely to occur. The therapist is willing to accept and understand and recognise whatever immediate feeling is going on in the client. It could be positive such as courage, love or pride, or it could be negative such as confusion, resentment, fear and anger. Such caring on the part of the therapist has an important characteristic that is, it is non possessive. The therapist accepts the client in a total rather than a conditional way.

Unconditional Positive Regard (UPR) means that the counsellor listens in a non-judgmental warm way to the client. There are no conditions put upon the relationship. By taking this position in the relationship the client will be able to talk about what they are thinking and feeling without fearing a judgment or a rejection. This means that whatever the client may say or express or feel the therapist or the counselor does not pass any judgement and takes the statements as being stated. Even if the client makes a derisive remark it is taken as it is without judging as to the remark being wrong or undesirable etc. UPR is one of the bits of magic in the relationship that makes the listening and healing possible. It also ties in nicely or is on a similar continuum to congruence, as again communication occurs only between equals. It is only when UPR is present that the client will trust the therapist enough to be open and honest about their inner world. I have faith in UPR so much so that no matter how much a person feels that they have slipped from society's grace that they will be able to gain UPR for themselves and others and hopefully start anew. Rogers believed that every individual has the potential for change and so counseling would help to help the person change .

1.7.3 Empathic Understanding

The third facilitative aspect of the relationship is empathic understanding. This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. This kind of sensitive, active listening is exceedingly rare in our lives. We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special

kind, is one of the most potent forces for change in the client. Empathy or *empathic understanding* is where the therapist picks up on the feelings of the client and reflects this back to the client. This is the process where the therapist can act as a support to the client by making the client feel 'as if' the therapist is there experiencing the array of emotions that he or she is experiencing.

Other conditions include the following:

1.7.4 Congruence

The first condition is named as congruence, realness, genuineness. That is to say that the counselor is present and aware with the client. If we look back historically to the time Rogers was writing in the 1950's, Rogers was the one who helped change the 'Patient' into a 'Client'.

Once the client is treated as an equal, communication will start. If the therapist comes across as an authority or an expert the client will start to tailor their answers to suit this. According to Rogers, accurate communication is possible only in a non punishing situation. Communication occurs only between equals.

Rogers was also saying that we should be 'real' with who we are as a therapist. If we are only putting on the counselor mask it will be picked up upon, much like when we visit a show room and get greeted by an over-zealous sales person, we can easily sense that they are not genuine or that they are only giving us attention because they are after a sale.

Self Assessment Questions

1) What are the core dimenstions of effective counselor?

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2) Describe genuineness, realness and congruence in therapeutic relationship.

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3) What is unconditional positive regard? How does the therapist ensure this?

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4) What is empathic understanding? Explain with examples

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5) Describe congruence.

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1.8 CHARACTERISTICS OF AN EFFECTIVE THERAPEUTIC RELATIONSHIP

What are the skills required by the practitioner to instill a strong therapeutic relationship that can give great benefit to the client? The therapeutic skills needed for this purpose are the following:

The therapeutic skills looked at will be:

- Unconditional Acceptance
- Empathy
- Attending & Listening
- Open Questioning
- Reflection
- Silence
- Physical and Behavioural Techniques
- Concreteness
- Professionalism
- Warmth and Being Genuine

In the earlier sections we have already discussed quite in detail the unconditional acceptance, enmpathy, warmth and being genuine etc. Thus here we will deal with the remaining concepts.

Let us take up attending and listening.

Listening and paying full attention to the patient is possibly the single most important skill that must be honed by the counselor. Attending actually means focusing on the other person, consciously making ourselves aware of what they are saying and what they are trying to communicate. By fully concentrating on

the client, the counselor will not be distracted by own thoughts or by getting caught up in trying to interpret what the client is saying.

Listening refers to more than simply hearing what the client says. The counsellor must be aware of three aspects; linguistic, paralinguistic and non-verbal. The linguistic aspect refers to what the client says and the ways in which the client chooses to express it. Paralinguistic refers to the aspects of speech such as timing, volume and fluency. Non-verbal aspects mainly refer to the client's body language and facial expressions that occur during the dialogue. By doing so the counselor is able to direct the counselors questioning to tose areas that have not been touched upon.

In regard to open questioning, the counselor must refrain from 'over-talking' and asking too many questions. Instead the counselor must use open ended questions. Such questions encourage the clients to talk openly and unrestricted. This may have the benefit of revealing a deeper understanding of the client and new levels to their personality.

Reflection is also used by the counselors for the same purpose. Here the counselor picks up the last few words spoken by the client in order to encourage them to expand on the point. However, closed questions are sometimes necessary when looking into specific manifestations of illness but in general open ended questions will go further to empowering the client.

Silence is another important tool of the counselor. It is not always necessary one or the other person in the therapy situation should be talking. Sometimes silence says many things that are not told. Silence can give the clinet time to think about what they want to say and the best way to express themselves. At the same time it gives the practitioner time to collect his thoughts and assimilate what the patient has been expressing. It must be remembered not to allow the silence to last too long, as it may become uncomfortable and if silences occurs too often, it could cause the patient to question the practitioner's ability.

To encourage the patient to continue their elucidations, the counselor must maintain concentration on what they are saying while at the same time clearly conveying this fact. Several skills can be employed by the counselor to indicate to the client that he is following what they are saying. Minimal prompts such as head nods, 'yes's' and 'mm's' can be used to this end.

The counselor can use certain behavioural techniques to show that they are interested in what the patient has to say. Different seating arrangements can lead to subtle changes in the communication process. Sitting directly across a desk from the client, the counsellor creates an authoritative setting. However, if the client only sits across the corner of the desk from the counsellor this authoritative barrier is reduced, allowing up to six times more interaction to be obtained.

In all seating scenarios, the counselor should always sit squarely to the client so as to be in a position to clearly observe all aspects of the client's communication. If the counselor leans toward the client slightly, it can again 'physically embody' interest. Reasonable eye contact is an important tool to convey that the counsellor is listening and understanding the client. Finally the counsellor should be relaxed when listening to the client and fully devote to the tasks of listening and attending.

Another tool of the counselor is the Concreteness which refers to clarity both in the counsellor's dealings with the client and also in helping the clients to express themselves. The counsellor can greatly empower the therapeutic relationship by clearly explaining how he views the client's illness, what steps he will take and what steps he would like the client to take. When these explanations are given, technical language should be avoided. The practitioner must also try to make sure they are understanding what the patient is explaining and can occasionally summarise in order to clarify what has been said.

Thus the therapeutic relationship has several characteristics. Though these may appear to be simple and basic knowledge, the constant practice and integration of these characteristics need to be the focus of every client that enters therapy. The therapeutic relationship forms the foundation for treatment as well as large part of successful outcome. Without the helping relationship being the number one priority in the treatment process, clinicians are doing a great disservice to clients as well as to the field of therapy as a whole.

Carl Roger defined a helping relationship as , " a relationship in which one of the participants intends that there should come about , in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual ."

There are three characteristics that will be presented that Rogers's states are essential and sufficient for therapeutic change as well as being vital aspects of the therapeutic relationship . In addition to these three characteristics, this author has added two final characteristic that appear to be effective in a helping relationship.

1.8.1 Shared Agreement on Goals in Therapy

Galileo once stated, "You cannot teach a man anything, you can just help him to find it within himself." In therapy clinicians must develop goals that the client would like to work on rather than dictate or impose goals on the client. When clinicians have their own agenda and do not cooperate with the client, this can cause resistance and a separation in the helping relationship (Roes, 2002). The fact is that a client that is forced or mandated to work on something he has no interest in changing, may be compliant for the present time; however these changes will not be internalised. Just think of yourself in your personal life. If you are forced or coerced to work on something you have no interest in, how much passion or energy will you put into it and how much respect will you have for the person doing the coercing. You may complete the goal; however you will not remember or internalise much involved in the process.

1.8.2 Integrate Humour in Relationship

The counselors own clinical experience throughout the years that have helped to establish a strong therapeutic relationship with clients is the integration of humor in the therapy process. It appears to teach clients to laugh at themselves without taking life and themselves too serious. It also allows them to see the therapist as a down to earth human being with a sense of humor. Humor is an excellent coping skill and is extremely healthy to the mind, body, and spirit. Try laughing with the clients. It will have a profound effect on the relationship as well as in your own personal life.

Self Assessment Questions

1) Elucidate the characteristics of effective therapeutic relationship.

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2) What do you understand by the term shared agreements on goals in tehrapy? Hw is this ensured?

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3) Explain why there is a need to integrate humour in the therapeutic relationship? Give examples.

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1.9 EMPIRICAL LITERATURE

There are obviously too many empirical studies in this area to discuss in this unit. However, a summary of the studies throughout the years and what has been concluded are stated below:

Horvath and Symonds (1991) conducted a Meta analysis of 24 studies which maintained high design standards, experienced therapists, and clinically valid settings. They found an effect size of .26 and concluded that the working alliance was a relatively robust variable linking therapy process to outcomes. The relationship and outcomes did not appear to be a function of type of therapy practiced or length of treatment.

Another review conducted by Lambert and Barley (2001), from Brigham Young University summarised over one hundred studies concerning the therapeutic relationship and psychotherapy outcome. They focused on four areas that influenced client outcome; these were extra therapeutic factors, expectancy effects, specific therapy techniques, and common factors/therapeutic relationship factors. Within these 100 studies they averaged the size of contribution that each predictor

made to outcome. They found that 40% of the variance was due to outside factors, 15% to expectancy effects, 15% to specific therapy techniques, and 30% of variance was predicted by the therapeutic relationship/common factors. Lambert and Barley (2001) concluded that, "Improvement in psychotherapy may best be accomplished by learning to improve ones ability to relate to clients and tailoring that relationship to individual clients."

One more important addition to these studies is a review of over 2000 process outcomes studies conducted by Orlinsky, Grave, and Parks (1994), which identified several therapist variables and behaviours that consistently demonstrated to have a positive impact on treatment outcome. These variables included therapist credibility, skill, empathic understanding, affirmation of the client, as well as the ability to engage the client and focus on the client's issues and emotions.

To conclude, this empirical literature, we can state what Constaquay, Goldfried, Wiser, Raue, and Hayes (1996) stated, " It is imperative that clinicians remember that decades of research consistently demonstrates that relationship factors correlate more highly with client outcome than do specialised treatment techniques."

1.10 ART AND SCIENCE OF THE COUNSELING PROCESS

1.10.1 Stages of the Counseling Process

The stages of the counseling process are given below:

Stage 1: Relationship Building: Tasks here include:

- Laying foundations for trust
- Establishing the structure and form the relationship will take
- Informed consent process
- Articulating roles of counselor and client – developing a collaborative working alliance. Consider how do we develop rapport, create relationship with our clients? What is it that we bring to the relationship that helps us create a foundation of trust and willingness to work collaboratively toward goals?

Stage 2: Identifying the nature of the presenting problem:

To understand the kind of change that is sought. Seeing the problem in context to the client's larger world. Keeping an eye on the strengths and resources of the client. Counselor builds hypotheses during this stage and throughout the remaining process.

Stage 3: Formulation of Counseling Goals:

The client articulates where they want their counseling journey to take them.

Client role as one of *driving the bus*

Enhances sense of ownership and motivation – factors important in the change process. Well identified goals help create a roadmap and means to evaluate. Goals may change, evolve as therapy progresses.

Stage 4: Categories: counseling goals:

1) To change an unwanted or unwelcome behaviour.
2) To better cope.
3) To make and implement decisions.
4) To enhance relationships.
5) To help client's journey of growth toward achieving potential (Nystul, 2003)

Stage 5: Intervention and Problem Solving:

Begins as soon as goals are established – this is plan for how to achieve them. Action is directed in accordance with new perspective. Collaboratively established plan works best. Educational information is given to that client is offered regarding options, and advantages/disadvantages for each.

Intervention

- New perspectives on both the way clients have looked at the problem and ways they might approach it:
- Confrontation vs Carefrontation
- Self Disclosure as appropriate
- A clear, simple plan toward goals.

Characteristics of a good treatment plan

- goals are clearly defined and reachable
- plan able to be adapted with time
- positive and action-oriented focus
- Essential to an effective plan is client's motivation and willingness to follow it.

Prochaska's stages of Change

- Pre Contemplation
- Contemplation
- Preparation/Determination Action
- Maintenance
- Relapse

Crafting a Treatment Plan

- Begins with clearly articulated problem and priority from client's perspective of primary (presenting) vs underlying clearly defined, broad goals – global objectives.
- Objectives – behaviourally stated, steps on way to broader goal – mindful of accountability.
- Interventions to be utilised by counselor

Stage 6: Termination and follow up:

Collaboration with client in identifying a date in advance for next follow up session and the role to review progress, create closure in client counselor relationship and plan for future. Think of this as a means of empowering

client. Counselor always is mindful of avoiding fostering dependency for the client only till client is aware of own needs. Preparation for termination begins long before. Open door / plan for possibility of future need are required to be given by the counselor to the client. Termination considered not just at end of successful relationship, but also is considered when it seems that counseling is not being helpful.

Stage 7: Research and Evaluation:

- Throughout the counseling process, towards the end, there is a feedback and the counseling process is reviewed through:
- Generating hypotheses
- Trying intervention strategies
- Determining if/when goal is met and a plan for evaluation is made.

1.11 LET US SUM UP

One of the important issues discussed in this unit is whether counseling / psychotherapy is an art or a science. If it is an art, then it becomes part of the counselor's innate affective and relational qualities. If it is a science, then it refers to the skills that the counselor has developed as a result of the training that he or she has taken in counseling. Such a skill seeks to spell out the process in the treatment so that others can utilise the same practices. In order to say that counseling is a science, it needs research based evidence in regard to its effectiveness in treating a client's problem. There are a number of research studies that have shown that the counseling process as is being practiced is effective in treating the client's problem. However there are also research evidences that show the contrary.

But the art of counseling trumps knowledge and intervention. Knowing what to do is of little value if trust has not been fully formed. There is no substitute from having repeated interactions with another and getting detailed feedback related to one's relational habits and idiosyncrasies. Jay Adams once said that teaching counseling should be like teaching art. You do not have a lecture on colours and shades and expect them to know how to use them well. Instead, you give them a brush and you expect them to do trial and error while providing good feedback. This means we really have to focus not just on what we counselors intend to communicate when respond to client content, but what they actually hear and take away from us.

Various interpersonal relationships, including that between parent and child or teacher and student, but the helping relationship established between the client and counselor is unique. A number of specific characteristics, such as affectiveness, intensity, growth and change, privacy, support etc. contribute to its uniqueness.

The effectiveness of the helping relationship in the remediation of emotional and psychological problems and in the growth, maturation, and self-actualisation of individuals can be attributed to many factors. A therapeutic climate is specially created by the counsellor so that the client feels comfortable to express himself and communicate problems without any inhibition. To create a climate of this type, the therapist must ensure the following, viz., (i) Trust (ii) Acceptance

The barriers to effective communication are giving advice, offering solutions, moralising and preaching, analysisng and diagnosing.

The three main core conditions that Carl Rogers considered essential for effective counseling are: 1) Unconditional positive regard, 2) Empathy, 3) Congruence.

The skills required by the practitioner to instill a strong therapeutic relationship that can give great benefit to the client are : Unconditional Acceptance, Empathy, Attending and Listening, Open Questioning, Reflection, Silence, Physical and Behavioural Techniques, Concreteness, Professionalism.

The counselors own clinical experience throughout the years that have helped to establish a strong therapeutic relationship with clients is the integration of humor in the therapy process. It appears to teach clients to laugh at themselves without taking life and themselves too serious. It also allows them to see the therapist as a down to earth human being with a sense of humor. Humor is an excellent coping skill and is extremely healthy to the mind, body, and spirit. Try laughing with the clients. It will have a profound effect on the relationship as well as in your own personal life.

The stages of the counseling process are given below:

Stage 1: Relationship Building

Stage 2: Identifying the nature of the presenting problem

Stage 3: Formulation of Counseling Goals

Stage 4: Categories: counseling goals

Stage 5: Intervention and Problem Solving

Stage 6: Termination and follow up

Stage 7: Research and Evaluation

Our purpose as clinicians is to help other human beings enjoy this journey of life and if this field isn't the most important field on earth I don't know what is. We help determine and create the future of human beings.

1.12 UNIT END QUESTIONS

1) Define counselling and indicate the characteristic features of therapeutic relationship.
2) How does the counsellor ensure therapeutic value and therapeutic climate to make counselling effective?
3) What are the barriers to communication and how can the same be overcome?
4) Discuss the core dimensions of effective counsellor.
5) Describe the characteristics of effective therapeutic relationship.
6) Give the various research studies conducted in regard to therapeutic relationship and its effectiveness.
7) Discuss the art and science of the counselling process.
8) What are the various stages in the counselling process?

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UNIT 2 PROFESSIONAL ISSUES, ETHICS, EDUCATION AND TRAINING IN COUNSELLING

Structure

2.0 INTRODUCTION

In this unit we will be dealing with ethical issues in counseling. Ethical Responsibilities and Regulations are then considered under which nature of ethics, code of ethics, and confidentiality. Then we deal with privileged communication and privacy. This is followed by a section on respecting clients rights in the various exceptions in this regard are also discussed. The importance of sharing client information with others is another important aspect which is dealt with in the next section. When to interview groups and families of the client is taken up in the next section and what all should be done when the client is unable to give informed consent or is incapable of doing so because of the person being a child and cannot really understand anything. The next section deals with the maintenance of records of whatever the client says and the do's and dont's in this regard are discussed. Research, training and consultation are discussed in the

next units to be followed and the role of Rehabilitation Council of India in ensuring ethical standards in India especially in counseling and psychotherapy are discussed in the next section. Amongst the ethical issues, competence and confidentiality are discussed followed by education and training in counseling.

2.1 OBJECTIVES

After reading this unit you, will be able to:

- Define and describe ethical responsibilities;
- List out the regulations covering ethical issues in counseling;
- Elucidate the exceptions to the rules;
- Explain how to keep records of the client's statements;
- Describe the ACA rules and regulations;
- Describe the RCI ethical guidelines;
- Elucidate the ethical issues such as competence and confidentiality;
- Explain the qualification for counseling courses; and
- Analyse the scope of counseling in India and abroad based on the qualifications.

2.2 ETHICAL RESPONSIBILITIES AND OBLIGATIONS

Counselors like all other professionals have ethical responsibilities and obligations. There are many ethical and legal considerations that need to be looked in to by the counselors as helping professionals. At the same time considerable measures have to be taken to make these ethical guidelines more comprehensive, specific and related to different situations. For instance the following needs to be kept in mind:

1) First, clear cut, specific ethical codes that provide adequate guidelines for the ethical behaviour in the very wide range of situations encountered in counseling relationships have yet to be evolved.

2) Second, most counseling professionals work within the context of institutions such as schools, colleges, hospitals, churches and private agencies whose institutional value systems are quite different from those of counseling profession itself.

3) Finally, counselors are particularly likely to encounter situations where their ethical obligations overlap or conflict. Often a counselor is simultaneously working with several people who are involved in their own close interpersonal relationships, whether in the family, school or other institutions. In such situations, ethical obligations become exceedingly complex.

The principle rule supporting ethical obligations is that the counselor must act with full recognition of the importance of client's rights, the ethics of the profession, and the relationship of moral standards and values, individual or cultural, in the life of that client.

The emphasis here is on the importance of practicing within the ethical guidelines established by ones professional associations and guidelines established by law. In fact, the very labeling of counseling as a helping profession suggests that we have assumed responsibilities of our profession in providing professional counseling services for our clientele and serving the public. These responsibilities include acceptable standards of performance or competence, an accepted code of personal conduct in relationships with clients and the public, and a commitment to contribute to the public well being that transcends monetary gain.

2.2.1 Nature of Ethics

A code of ethics represents the values of a profession translated into standards of conduct. A code of ethics provides structure to guidelines for a profession's membership to follow in professional practice and also for the public to anticipate in interactions with the profession and its membership. It is important to differentiate professional ethics and legally mandated ethics.

For counselors at least two basic statements of ethical practice and behaviour apply to work in the profession

a) ACA code of ethics (2005), and

b) Ethical principles of psychologists and code of conduct of American Psychological Association (2002).

The members of these associations are expected to follow these codes of ethics and professional standards. Failure to abide by these standards may result in expulsion from the profession.

2.2.2 American Counselling Association (ACA) Code of Ethics

The American Counseling Association (ACA) describes itself as an educational, scientific, and professional organisation whose members work in a variety of settings and serve in multiple capacities. The association has adopted a Code of Ethics that provides guidelines to ACA members around issues of responsible and ethical decision making.

Five Purposes

According to its Introduction, the ACA Code of Ethics serves five purposes:

1) Clarifying members' ethical responsibilities;

2) Supporting the ACA mission;

3) Establishing principles for behaviour and best practices of ACA members;

4) Serving as an ethical guide promoting the counseling profession's values; and

5) Providing a basis for processing ethical complaints.

Eight Sections

The ACA Code of Ethics address ethical principles required of counselors who subscribe to the organisation's purposes.

There are in all 8 sections

Section A : Deals with the counsellor's encouragement of client growth.

Section B : This deals with professional responsibility.

Section C : This deals with professional relationships.

Section D : This section addresses client rights, building trust and boundary setting between client and the counselor.

Section E : This describes requirements for counselor, which includes knowledge of and familiarity with counseling tools, supervision and teaching.

Section F : This provides guidelines for training counselors.

Section G : This is also called as the research and publication section. This encourages counsellors to add to the knowledge base of the profession and describes the proper steps that need to be taken.

Section H : This is called the ethical issues section and describes how to determine and respond to ethical dilemmas and offences. This section discusses what counselors should aspire with regard to ethical behaviour and responsibility.

Standards of practice : This sets forth the minimal behavioural standards set in the Code of Ethics. The eight sections given above describe the information contained in the Code of Ethics in more detail, breaking them down into 51 practice standards.

2.2.3 Confidentiality, Privileged Communication, and Privacy

Confidentiality

Confidentiality is an ethical concept which states that what ever is said between two persons will remain secret and will not be shared without consent. The ethical standards state that the counselors should keep information confidential unless disclosure is required to prevent clear and imminent danger to the client and others when legal requirements demand that confidential information be revealed. The ethical standards also state that while the counsellor's primary obligation for confidentiality is to the client, the counselor should balance that obligation with an understanding of the legal and inherent rights of the client. Counsellors are advised to explain the limits of confidentiality to clients so that they do not feel betrayed if confidentiality is broken. .

Privileged communication

In law, communication between parties to a confidential relation such that the communication's recipient is exempted from disclosing it as a witness. Communications between attorney and client are privileged and do not have to be disclosed to the court. The right to privileged communication also exists between husbands and wives, as neither is required to testify against the other in court, and between physicians and patients, though doctors may be required to disclose such information if the right of the defendant to receive a fair trial outweighs the patient's right to confidentiality. Members of the clergy have limited rights to refuse to testify in court, and reporters have been accorded a limited right to privileged communication concerning the sources of their information, though they can be ordered to divulge information in certain circumstances.

Certain classes of communications between persons who stand in a confidential or fiduciary relationship to each other that the law will not permit to be divulged in court. Examples of confidential relationships are those of psychiatrist and

patient and attorney and client. Confidentiality of communications depends on the law in each state.

A privileged communication is a private statement that must be kept in confidence by the recipient for the benefit of the communicator. Even if it is relevant to a case, a privileged communication cannot be used as evidence in court. Privileged communications are controversial because they exclude relevant facts from the truth seeking process.

Privileged communications exist because society values the privacy or purpose of certain relationships. The established privileged communications are those between wife and husband, clergy and communicant, psychotherapist and patient, physician and patient, and attorney and client.

These relationships are protected for various reasons. The wife-husband and clergy-communicant privileges protect the general sanctity of marriage and religion. The Counsellor and client privilege promotes full disclosure in the interests of the client's welfare.

A communication is not confidential, and therefore not privileged, if it is overheard by a third party who is not an agent of the listener. Agents include secretaries and other employees of the listener. For example, a communication between a counselor and client would be privileged even if the counsellor's secretary happened to overhear it.

Privileged communications are not always absolute. For instance, a criminal defendant may be able to access communications between an accuser and the accuser's doctor if the defendant's interest in the disclosure, in the opinion of the court, outweighs the interest in confidentiality. The court will consider such a request only if the defendant can establish a reasonable probability that important information exists in the communication that will be relevant to the case.

Privacy

In general, the right to be free from secret surveillance and to determine whether, when, how, and to whom, one's personal or organisational information is to be revealed. In specific, privacy may be divided into four categories:

1) Physical: restriction on others to experience a person or situation through one or more of the human senses;

2) Informational: restriction on searching for or revealing facts that are unknown or unknowable to others;

3) Decisional: restriction on interfering in decisions that are exclusive to an entity;

4) Dispositional: restriction on attempts to know an individual's state of mind.

2.2.4 Respecting Client Rights

a) **Multicultural/Diversity Considerations:** Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

b) **Respect for Privacy:** Counselors respect client rights to privacy. Counselors solicit private in- formation from clients only when it is beneficial to the counseling process.

c) **Respect for Confidentiality:** Counselors do not share confidential information without client consent or without sound legal or ethical justification.

d) **Explanation of Limitations:** At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breached.

2.2.5 Exceptions

a) **Danger and Legal Requirements:** The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end of life issues.

b) **Contagious, Life Threatening Diseases:** When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if they are known to be at demonstrable and high risk of contracting the disease. Prior to making a disclosure, counselors confirm that there is such a diagnosis and assess the intent of clients to inform the third parties about their disease or to engage in any behaviours that may be harmful to an identifiable third party.

c) **Court Ordered Disclosure:** When subpoenaed to release confidential or privileged information without a client's permission, counselors obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible due to potential harm to the client or counseling relationship.

d) **Minimal Disclosure:** To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

2.2.6 Information Shared with Others

a) **Treatment Teams:** When client treatment involves a continued review or participation by a treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

b) **Confidential Settings:** Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

c) **Third-Party Payers:** Counselors disclose information to third party payers only when clients have authorised such disclosure.

d) **Transmitting Confidential Information**: Counselors take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, telephones, voicemail, answering machines, and other electronic or computer technology

e) **Deceased Clients:** Counselors protect the confidentiality of deceased clients, consistent with legal requirements and agency or setting policies.

2.2.7 Groups and Families

a) **Group Work:** In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group being entered.

b) **Couples and Family Counseling:** In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties having capacity to give consent concerning each individual's right to confidentiality and any obligation to preserve the confidentiality of information known.

2.2.8 Clients Lacking Capacity to Give Informed Consent

a) **Responsibility to Clients:** When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received in the counseling relationship as specified by state laws, written policies, and applicable ethical standards.

b) **Responsibility to Parents and Legal Guardians:** Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

c) **Release of Confidential Information:** When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take culturally appropriate measures to safeguard client confidentiality.

2.2.9 Records

a) **Confidentiality of Records:** Counselors ensure that records are kept in a secure location and that only authorised persons have access to records.

b) **Permission to Record:** Counselors obtain permission from clients prior to recording sessions through electronic or other means.

c) **Permission to Observe:** Counselors obtain permission from clients prior to observing counseling sessions, reviewing session transcripts, or viewing recordings of sessions with supervisors, faculty, peers, or others within the training environment.

d) **Client Access:** Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the record in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that related directly to them and do not include confidential information related to any other client.

e) **Assistance With Records:** When clients request access to their records,counselors provide assistance and consultation in interpreting counseling records.

f) **Disclosure or Transfer:** Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

g) **Storage and Disposal after Termination:** Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with state and federal statutes governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. When records are of an artistic nature, counselors obtain client (or guardian) consent with regards to handling of such records or documents.

h) **Reasonable Precautions:** Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death.

2.2.10 Research and Training

a) **Institutional Approval:** When institutional approval is required, counselors provide accurate information about their research proposals and obtain approval prior to conducting their research. They conduct research in accordance with the approved research protocol.

b) **Adherence to Guidelines:** Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

c) **Confidentiality of Information Obtained in Research:** Violations of participant privacy and confidentiality are risks of participation in research involving human participants. Investigators maintain all research records in a secure manner.They explain to participants the risks of violations of privacy and confidentiality and disclose to participants any limits of confidentiality that reasonably can be expected. Regardless of the degree to which confidentiality will be maintained, investigators must disclose to participants any limits of confidentiality that reasonably can be expected.

d) **Disclosure of Research Information:** Counselors do not disclose confidential information that reasonably could lead to the identification of

a research participant unless they have obtained the prior consent of the person. Use of data derived from counseling relationships for purposes of training, research, or publication is confined to content that is disguised to ensure the anonymity of the individuals involved.

e) **Agreement for Identification:** Identification of clients, students, or supervisees in a presentation or publication is permissible only when they have reviewed the material and agreed to its presentation or publication.

2.2.11 Consultation

a) **Agreements:** When acting as consultants, counselors seek agreements among all parties involved concerning each individual's rights to confidentiality, the obligation of each individual to preserve confidential information, and the limits of confidentiality of information shared by others.

b) **Respect for Privacy:** Information obtained in a consulting relationship is discussed for professional purposes only with persons directly involved with the case. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

c) **Disclosure of Confidential Information:** When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organisation with whom they have a confidential relationship unless they have obtained the prior consent of the person or organisation or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation.

Self Assessment Questions

1) Discuss nature of ethics.

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2) What are the important componenets of ACA code of ethics?

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3) Discuss in detail the privileged communicaqtion, confidentiality and privacy.

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4) Describe the conditions under which one finds exceptions to the ethical rules.

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5) Discuss maintaining of records of clients cases.

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2.3 REHABILITATION COUNCIL OF INDIA (RCI)

In India the counseling, psychotherapy, psychological treatments, social work interventions, rehabilitation counseling etc. are all monitored by the apex agency Rehabilitation Council of India. Not only they monitor the training institutitons and ensure that the counselors get the proper training, but they also make sure that the counselors are updated on the latest techniques available once license is given, by organising refresher courses for the practicing counselors. They also have worked out certain ethical guidelines which are given below.

"RCI Code of Ethics Adopted July 17, 2001 Revised March 28, 2006

Introduction

The standards contained in this Code of Ethics are statements of ethical principles having broad applicability to members and registrants of RCI. However, the enumeration of particular duties and the proscription of certain conduct do not negate the existence of other obligations logically flowing from such principles. Conduct deemed unethical may be construed to include lesser offenses, such as aiding and abetting.

Members and registrants of RCI should also recognise that their profession and their practice may be governed by various laws and regulations regarding professional registration and the conduct of trade. It is their responsibility, therefore, to be familiar with those laws and regulations and to conduct themselves accordingly.

General Obligations Members and registrants shall maintain and further their knowledge of the science and profession of roofing, waterproofing, and the building envelope, and shall maintain the highest possible standard of professional judgment and conduct.

Obligations to the Public

Members and registrants should uphold the letter and spirit of the ethical standards governing their professional affairs and should consider the full impact of their actions on the community at large.

Thus, a member or registrant shall: I) Engage only in accurate, appropriate and truthful promotion of his/her practice; II) Be respectful of the rights of others in obtaining professional work or employment; and III) Make only accurate, truthful and appropriate statements or claims about his/her professional qualifications, experiences or performance.

Obligations to the Client

Members and registrants shall conduct themselves in a fashion which brings credit to themselves, their employers and their profession. In addition to upholding the behavioural standards described above, a member or registrant:

I) Shall preserve the confidence of his/her client or employer and serve each in a professional and competent manner.

II) Shall exercise unprejudiced and unbiased judgment and conduct when performing all professional services;

III) Shall practice only in his/her area of competence;

IV) Shall decline any activity or employment, avoid any significant financial or other interest, and decline any contribution if it would reasonably appear that such activity, employment, interest, or contribution could compromise his or her professional judgment or conduct, or prevent him/her from serving the best interest of his/her client or employer, without making full disclosure to the client and obtaining the client's consent thereto;

V) Shall neither offer nor make any payment or gift to any public official, private client or industry representative with the intent of influencing that person's judgment or decision in connection with an existing or prospective project in which the member/registrant is interested; and

VI) May contribute his services or anything of value to those endeavors which the member deems worthy. Further, a member or registrant has the right to participate in the political process and to contribute time and money to political campaigns.

Obligations to the Profession and Building Industry

Members and registrants shall:

I) Recognise the value and contributions of others engaged in the design and construction process, and refrain from making false statements about the work of others, and shall not maliciously injure or attempt to injure the prospects, practice, or employment position of others; and

II) Encourage professional education and research, as well as the development and dissemination of information relating to the design and construction of roofing, waterproofing, and building envelope systems.

Further, the following practices are not in themselves unethical, unprofessional, or contrary to any policy of RCI, and RCI members and registrants are free to decide for themselves whether to engage in any of these practices:

I) Submitting competitive bids or price quotations, including in circumstances where price is the sole or principle consideration in the selection of a consultant;

II) Providing discounts; or

III) Providing free services.

2.4 ETHICAL ISSUES

2.4.1 Competence

The ethical issue of competence begins when the counselor accepts a position as a professional counselor. The counselor must determine, along with the potential employer, whether he or she is qualified by virtue of training and, where appropriate, experience for the position. The counselor applicant must possess qualifications for certification or licensure when appropriate and also special interests and or values that might influence on the job functioning. The counselors should not apply for positions in which they are not interested or for which they re not qualified.

On the job the counselor is responsible professionally to practice within his or her limitations. Although competence is often difficult to determine, training and experience can provide useful guidelines in indicating what we are qualified to do. Consultation with supervisors and or more experienced professional colleagues can help identify the limits of ones professional competence.

Degrees, licenses and certificates may convey levels of competence to the public, yet in actuality, we must recognise variations in the competencies among practitioners with the same credentials. It is the responsibility of the counselor to keep updating their skills, competence and expertise through participation in various educational and professional opportunities, reading professional literature and attending professional meetings, seminars and conferences.

When the counselors determine that the client's needs may be beyond their competencies, they should promptly arrange for an appropriate referral. Thus responsibility includes helping the client identify a suitable professional.

2.4.2 Confidentiality

Trust is an essential cornerstone in the counseling relationship and central to the development and maintenance of trust is the principle of confidentiality. The obligation of counselors to maintain confidentiality in their relationships with their clients is not absolute; however, counselors need to be aware of both ethical and legal guidelines that apply.

Principles of Confidentiality

1) The obligation of confidentiality is relative rather than absolute since there are conditions that can alter it.

2) Confidentiality depends on the nature of the material, so that the material which is already public or can easily become so is not bound by confidentiality in the same way as the entrusted secret.

3) Material that is harmless does not bind the counselor to confidentiality.

4) The material that is necessary for a counselor or an agency to function effectively is often released from the bounds of confidentiality.

5) Confidentiality is always conditioned by the intrinsic right of the counselee to his integrity and reputation, to the secret, and to resist aggression. Such rights can be protected by the counselor even against the law.

6) Confidentiality is limited to also by the rights of the counselor to preserve his own reputation and integrity, to resist harm or aggression, and to preserve privileged communication.

7) Confidentiality is determined and limited by the rights of an innocent third party and by the rights of the community.

Three Levels of Confidentiality

1) Professional use of information. Every counselor is obligated to handle information about clients or potential clients only in professional ways.

2) Confidentiality refers to information that arises out of the counseling relationship.

3) This level of confidentiality occurs when it is obvious that the client will not communicate to complete confidence except in cases of clear and immediate danger to human life.

In distinguishing between confidentiality and privileged communication, it is important to remember that confidentiality is primarily an ethical concept whereas privileged communication is a legal concept. Confidentiality may be viewed as an ethical responsibility that requires the professional counselor to protect and withhold from others information shared with the assumption of privacy by the client during the counseling process.

Arthur & Swanson (1993), note exemptions cited Bissel and Royce (1992), the ethical principles of confidentiality are:

1) The client is a danger to self and others. The law places physical safety above considerations of confidentiality for the right of privacy. Protection of the person takes precedence and includes the duty to warn.

2) The client requests the release of the principle and privacy remains with the client and maybe waved. The counselor should release information as requested by the client.

3) A court orders a release of information. The responsibility under the law for the counselor to maintain confidentiality is overridden when the court determines that the information is needed to serve the cause of justice.

4) The counselor is receiving systematic clinical supervision. The client gives the right of confidentiality when it is known that session material will be use during supervision.

5) Clerical assistance process information and papers related to the client. The client should be informed that the office person will have access to the records for routine matters such as billing and record keeping.

6) Legal and clinical consultations are needed; the client should be informed (ethical) rights of the counselor to obtain other professional opinions about progress and the name(s) of those used as consultant (s).

7) Clients raise the issue of their mental health in a legal proceeding. In a custody suit, parents introduce their mental condition into the suit, where upon they authorise the release of the counselor's records.

8) A third party is present in the room, clients are (presumably) aware of person other than the counselor is present and therefore wave their right of privacy in permitting the third person to be present.

9) Clients are below the ager of 18, parents or guardians have the legal rights to communication between the minor and counselor.

10) In intra agency or institutional sharing of information is part of treatment process otherwise confidential material maybe shared among professional staff when it is in the interest of the client to do so, however, the client must be aware that this is being done.

11) Sharing of information is required within a penal system. Information obtained from prisoners that may otherwise be considered confidential maybe shared within the system in the interest of the operation of the system and disposition of the case.

12) The client's purpose in disclosing information was to seek advice in the furtherance of crime and fraud. The obligation here changes from one of maintaining confidentiality to one of preventing society from further criminal activity.

13) The counselor has reason to suspect child abuse. All states now legally require the reporting of suspected abuse.

The counseling process involves the sharing of very personal information. People will not feel safe discussing their situations and feelings with a counselor unless they are confident that their privacy will be respected, and their issues will not

be casually spread around. Nonetheless, there are times when sharing such information is appropriate, or even necessary.

Here are some instances:

- Your client presents an imminent, serious danger to self or others
- Your client requests that you share information with others
- Another person is present in the room, clearly visible to your client (and, most often, at your client's request)
- Here are some borderline situations. You should discuss these with your client before you share their story with others.
- You feel the need to get input from a Craft elder, or from a counselor whose experience or insight you respect, or from another professional whose expertise is relevant to your client's situation (e.g. doctor, lawyer, teacher)
- You are presenting your client's case as part of ongoing supervision
- You normally share Craft concerns with your working partner, particularly when those concerns relate to a student or convener.
- You have someone trustworthy person assisting with your record keeping .
- Finally, there may come times when you are under legal pressure to break your client's confidence. It's very important that you become familiar with applicable law where you live. In situations like these, you must weigh all possible legal and related consequences and make your best conscientious decision:
- a court orders release of information
- your client is a legal minor, and parents demand disclosure
- "mandated reporter" situations, which vary from jurisdiction to jurisdiction. These may include child abuse, suicide risk, drug use or other problems

Our strong suggestion is that you ponder these situations, and any others that you can recall or imagine, before they arise. How do you think you would respond to them? As you understand your own reactions, you can let your clients know where your limits are. This allows them to decide how much personal information they can comfortably share with you.

Self Assessment Questions

1) Delineate the ethical guidelines of the RCI in India

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2) What are the various aspects related to confidentiality?

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3) Discuss competence in clients from the point of view of ethical guidelines.

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4) What are the conditions under which one need not follow the ethical guidelines strictly?

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2.5 EDUCATION AND TRAINING IN COUNSELING

2.5.1 Qualifications for Counseling Courses

Certificate, Diploma and PG Diploma courses on counseling are offered by various institutes all over India. For pursuing a PG Diploma in Clinical and Community psychology, you need to have a graduation in Psychology. For admission to diploma program in Guidance & counseling, some institutes prefer candidates with a Bachelors degree in Home Sc., Education or Arts, whereas others admit candidates with a M.A/M.Ed (psychology) degree.

Counseling courses also include a certificate course in Guidance. Candidates with M.A degree in Psychology can apply for Diploma program in Vocational Rehabilitation and Counseling and PG Diploma course in Rehabilitation Psychology. Postgraduate candidates can also apply for PG Diploma in Counseling.

2.5.2 Benefits of Counseling Courses

More and more people are resorting to counseling to solve various crises of their lives. After pursuing counseling courses, students acquire helping skills to counsel and guide people for coping up with their educational, social or personal crisis.

2.5.3 Scope for Counseling in India

Once you complete counseling courses, you can choose from several job profiles in India. Trained personnel can opt to work in marriage counseling agencies, schools and colleges, old age homes, counseling centers, welfare departments of governments or remain self employed.

2.5.4 Scope for Counseling Abroad

In the countries in the West, counselors are held in the same rank as other medical practitioners. Their remunerations are thus higher than that in India. Counselors can opt for practicing abroad in the same fields offering counseling jobs in this country.

2.6 LET US SUM UP

Counselors like all other professionals have ethical responsibilities and obligations. There are many ethical and legal considerations that need to be looked in to by the counselors as helping professionals. At the same time considerable measures have to be taken to make these ethical guidelines more comprehensive, specific and related to different situations.

The principle rule supporting ethical obligations is that the counselor must act with full recognition of the importance of client's rights, the ethics of the profession, and the relationship of moral standards and values, individual or cultural, in the life of that client.

The emphasis here is on the importance of practicing within the ethical guidelines established by ones professional associations and guidelines established by law. In fact, the very labeling of counseling as a helping profession suggests that we have assumed responsibilities of our profession in providing professional counseling services for our clientele and serving the public. These responsibilities include acceptable standards of performance or competence, an accepted code of personal conduct in relationships with clients and the public, and a commitment to contribute to the public well being that transcends monetary gain.

A code of ethics represents the values of a profession translated into standards of conduct. A code of ethics provides structure to guidelines for a profession's membership to follow in professional practice and also for the public to anticipate in interactions with the profession and its membership. It is important to differentiate professional ethics and legally mandated ethics.

For counselors at least two basic statements of ethical practice and behaviour apply to work in the profession, a) ACA code of ethics (2005), and b) Ethical principles of psychologists and code of conduct of American Psychological Association (2002).

The members of these associations are expected to follow these codes of ethics and professional standards. Failure to abide by these standards may result in expulsion from the profession.

In India the counseling, psychotherapy, psychological treatments, social work interventions, rehabilitation counseling etc are all monitored by the apex agency

Rehabilitation Council of India. Not only they monitor the training institutitons and ensure that the counselors get the proper training, but they also make sure that the counselors are updated on the latest techniques available once license is given, by organising refresher courses for the practicing counselors.

The ethical issue of competence begins when the counselor accepts a position as a professional counselor. The counselor must determine, along with the potential employer, whether he or she is qualified by virtue of training and, where appropriate, experience for the position. The counselor applicant must possess qualifications for certification or licensure when appropriate and also special interests and or values that might influence on the job functioning. The counselors should not apply for positions in which they are not interested or for which they re not qualified.

Trust is an essential cornerstone in the counseling relationship and central to the development and maintenance of trust is the principle of confidentiality. The obligation of counselors to maintain confidentiality in their relationships with their clients is not absolute; however, counselors need to be aware of both ethical and legal guidelines that apply.

In distinguishing between confidentiality and privileged communication, it is important to remember that confidentiality is primarily an ethical concept whereas privileged communication is a legal concept. Confidentiality may be viewed as an ethical responsibility that requires the professional counselor to protect and withhold from others information shared with the assumption of privacy by the client during the counseling process.

The counseling process involves the sharing of very personal information. People will not feel safe discussing their situations and feelings with a counselor unless they are confident that their privacy will be respected, and their issues will not be casually spread around. Nonetheless, there are times when sharing such information is appropriate, or even necessary.

2.7 UNIT END QUESTIONS

1) Define ethical responsibilities and regulations.

2) Discuss nature of ethics

3) What are the ethical guidelines ACA code of ethics?

4) Define and describe the issues concerned with confidentiality, privileged communication and privacy.

5) Discuss respecting client's rights and indicate the exceptions.

6) What are the conditions under which the relatives and families are interviewed?

7) Put forward the ethical guidelines of the Rehabilitation Council of India.

8) What are the ethical issues concerned with competence and confidentiality?

9) Discuss research and training for counseling.

2.8 SUGGESTED READINGS

ACA Code of Ethics (2008). As approved by ACA Governing Council . www.counseling.org

Steven D. Brown and Robert W.Lent (Eds) (2008). *Handbook of Counselling Psychology*. 4th edition. Wiley International Chicago, IL

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UNIT 3 COUNSELLING PROCESS: COUNSELLING INTERVIEW AND COUNSELLING RELATIONSHIP

Structure

3.0 INTRODUCTION

In this unit we will be dealing with counseling process, counseling interview and counseling relationship. In the counseling process we will be presenting the need for counseling, how to prepare oneself for counseling, how to conduct counseling sessions and how to followup after the counseling session has ended.

Then we take up phases of counseling followed by goals of counseling in which we will present the various counseling goals such as the developmental goals, preventive goals, cognitive goals etc. Then we deal with how to start the initial counseling interview in which opening the counseling session will be discussed and what strategies of counseling the counsellor should use etc. will be mentioned. Then we deal with counseling interview process in which we start with establishing relationship to problem identification and exploration and the various methods of problem solving etc. Then we deal with different communication skills needed for interviewing and counseling the client.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Define the counseling process;
- Explain how to identify the need for counseling;
- Explain how to prepare and conduct counseling sessions;
- Elucidate the phases of counseling process;
- Present the goals of counseling;
- Explain how to conduct the initial counselling interview;
- Describe establishing counseling relationship with the client; and
- Analyse the various counseling skills needed to make effective counseling.

3.2 THE COUNSELING PROCESS

Counselling is a process in which the counselor, or therapist, helps the client understand the causes for problems and guides the person through the process of learning to make good life decisions. Initially, counselling can be a bit painful, in that one may be suddenly come face to face with certain unpleasant aspects of one's own self. However, as the person continues on with the counseling sessions, the person will discover that the sessions are easier and easier, and the client will learn to be more positive, and make better decisions. The counselor's role is to guide the client through the process and not tell what the client should do. The clients are helped to help themselves.

Let us now look at the processes in the counseling process and these are:

- Identify the need for counseling.
- Prepare for counseling.
- Conduct counseling.
- Follow up.

3.2.1 Identification of the Need for Counseling

It is important first step to identify the need for counseling. Whether the person concerned requires counseling at all and if so what is the reason for the same. Sometimes counseling may be needed by a child in the school who is unable to benefit from the teaching learning process that goes on in the school. In yet another case an adolescent facing self esteem problems or showing aggression

or extreme anger at trivial things may need counseling to overcome the anger and aggression and restore the self esteem. In certain other cases an adult who has gone through a financial crisis in business may need counseling to overcome the depression that the person is facing. In yet other cases, there may be a marital problem or divorce situation which needs to be handled through counseling. In orgnaisations and industries, counseling may be required to motivate the employees to work better and to their full potential or in some cases to overcome the workplace violence etc. Counselling for better interpersonal relationship is very much needed in an organisation where the work and performance of employees are affected due to lack of positive interpersonal relationship amongst various levels of staff.

3.2.2 Preparation for Counselling

Successful counseling requires preparation. To prepare for counseling, the following needs to be done:

- Select a suitable place.
- Schedule the time.
- Notify the person or the client well in advance.
- Organise information.
- Outline the counseling session components.
- Plan the counseling strategy.
- Establish the right atmosphere.

As for selecting a suitable place, counseling should be carried out in an environment that minimises interruptions and is free from distracting sights and sounds.

Regarding the scheduling the time, when possible, the client should be counseled after deciding upon a mutually convenient timing. The length of time required for counseling depends on the complexity of the issue. Generally a counseling session should last less than an hour. If the client needs more time, a second session may be scheduled. Also the counsellor should select a time free from competition with other activities and consider what has been planned after the counseling session. Important events can distract a client from concentrating on the counseling.

For a counseling session to be client centered, the client must have time to prepare for it. The client should know why, where, and when the counseling will take place. Counseling following a specific event should happen as close to the event as possible. However, for performance or professional development counseling, clients may need a week or more to prepare or review specific products, such as support forms or counseling records.

Solid preparation is essential to effective counseling. The counsellor should review all pertinent information. This includes the purpose of the counseling, facts and observations about the client, identification of possible problems, main points of discussion, and the development of a plan of action. Focus on specific and objective behaviours that the client must maintain or improve as well as a plan of action with clear, obtainable goals.

It is important to outline the components of the counseling session. For this, using the information obtained, the counsellor should determine what to discuss during the counseling session. He must note what prompted the counseling, what the counsellor aims to achieve, and what the role of the counselor is. It is important to identify possible comments or questions to help the counsellor keep the counseling session client centered and help the client progress through its stages. Although the counsellor never knows what a client will say or do during counseling, a written outline helps organise the session and enhances the chance of positive results.

Many approaches to counseling exist, such as directive, nondirective, and combined approaches to counseling. The counsellor should use a strategy that suits the clients and the situation.

The counsellor must establish the right atmosphere which promotes two way communication between a counsellor and a client. Some situations make an informal atmosphere inappropriate. For example, during counseling to correct substandard performance of a subordinate, the manager who functions also as a counsellor, may direct the client subordinate to remain standing while he remains seated behind a desk. This formal atmosphere, normally used to give specific guidance, reinforces the manager's rank, position in the chain of command, and authority. But in general counseling session this is not advocated. The counsellor should sit in such a manner that he is able to observe every emotion of the client and note every gesture verbal and nonverbal that the client makes so that the same could be used in counseling and problem solving sessions.

3.2.3 Conduct of Counseling Session

While conducting the counseling session, the counsellor should be flexible. Often counseling for a specific incident occurs spontaneously as counselors encounter clients in their daily activities. Even when the counsellor has not prepared for formal counseling, he should address the four basic components of a counseling session. Their purpose is to guide effective counseling rather than mandate a series of rigid steps. Counseling sessions consist of:

- Opening the session.
- Discussing the issues.
- Developing the plan of action.
- Recording and closing the session.

Ideally, a counseling session results in a client's commitment to a plan of action. Assessment of the plan of action becomes the starting point for follow up counseling.

Open the Session: In the session opening, the counsellor should state the purpose of the session and establish a client centered setting. The best way to open a counseling session is to clearly state its purpose. For example, an appropriate purpose statement might be: "The purpose of this counseling is to discuss your personal relationship problem with your spouse and then to create a plan to enhance the relationship so that you can manage your problem without difficulty. If applicable, the counsellor can start the counseling session by reviewing the status of the previous plan of action.

Discuss the issue: The counsellor and the client should attempt to develop a mutual understanding of the issues. The counsellor can best develop this by letting the client do most of the talking. He can use active listening, respond, and question without dominating the conversation. The aim of the counsellor is to help the client better understand the subject of counseling, for example, interpersonal relationship, a problem situation and its impact on the client's daily routine.

Both the counsellor and the subordinate should provide examples or cite specific observations to reduce the perception that either is unnecessarily biased or judgmental. However, when the issue is poor interpersonal relationship, the counsellor should make clear how the interpersonal relationship is poor. The conversation, which should be two-way, then addresses what the client needs to do to improve the interpersonal relationship. It is important that the counsellor defines the issue as poor interpersonal relationship and does not allow the client to define the issue as one which cannot be set right. The counsellor should help the client consider altering the conditions under which the client may be able to improve the interpersonal relationship. .

Develop a Plan of Action: A plan of action identifies a method for achieving a desired result. It specifies what the subordinate must do to reach the goals set during the counseling session. The plan of action must be specific. It should show the client as to how to modify or maintain his behaviour. It should avoid vague intentions such as "Next month I want you to improve your communication skills with your children. The plan must use concrete and direct terms. For example, the counsellor may state that the client will appreciate his wife's cooking or any room arrangement that she has made. After coming back the next wekk for counseling session, the client will give a feed back to the counsellor and dependin g on what the feed back is the counsellor may be able to suggest certain skills that might work better.

Record and Close the Session: Although requirements to record counseling sessions vary, a counsellor always benefits by documenting the main points of a counseling session. Documentation serves as a reference to the agreed upon plan of action and the client's accomplishments, improvements, personal preferences, or problems. A complete record is made of counseling aids in making recommendations for professional development, schools, promotions, and evaluation reports.

To close the session, the counsellor should summarise its key points and ask if the client understands the plan of action. Invite the client to review the plan of action and what is expected of the counsellor. With the client, the counsellor should establish follow up measures necessary to support the successful implementation of the plan of action. These may include providing the client with resources and time, periodically assessing the plan, and following through on referrals. The counsellor must schedule any needed future meetings, even if only tentatively, before terminating the counseling session.

3.2.4 Follow Up

The counseling process does not end with the counseling session. It continues through implementation of the plan of action and evaluation of results. After counseling, the counsellor must support the clients as they implement their plans

of action. Support may include teaching, coaching, or providing time and resources. The counsellor must observe and assess this process and possibly modify the plan to meet its goals. Appropriate measures after counseling include follow up counseling, making referrals, and taking corrective measures.

3.3 PHASES OF COUNSELLING PROCESS

In addition to this, there are four phases in initial stages of the counseling process and these are: (i) Assess the plan of action (ii) Making an informed assessment (iii) Establish mutually agreed upon goals and objectives and (4) Implementation of the plan. Let us take each of these and discuss.

Phase 1: Assess the Plan of Action

The purpose of counseling is to develop clients who are better able to achieve the purpose for which the counseling session started initially. During the assessment, the counsellor should review the plan of action with the client to determine if the desired results were achieved. The counsellor and the client should determine the date for this assessment during the initial counseling session. The assessment of the plan of action provides useful information for future follow up counseling sessions.

There is a natural progression that takes place within the context of the helping relationship. This process enables the counsellor and the client to build a relationship, assess the situation, set goals and come up with a plan to bring about the desired results. This progression is known as the counseling process.

Phase 2: Make an Informed Assessment

An informed assessment happens when both the counsellor and the client gather information in order to figure out what "really" is going on, so that the counsellor can assess what needs to happen next in order to change the situation for the better or build up the client's coping skills to better deal with a problematic situation. The first step in making an assessment is to find out if change is necessary, and if it is what needs to happen for change to take place. If the counsellor has decided that change is necessary, then the next step is to figure out what needs to change. Is it a behaviour? An attitude? A situation?

A good assessment can provide an opportunity for a client to see how his/her behaviour or attitude might be contributing to an undesirable or unhealthy situation. Assessment is an ongoing process. The counsellor needs to regularly check in with the client to see how things are going. Reassessments enable the counsellor to ensure that the counsellor and the client are on the right track.

The counsellor gathers information in a number of ways: talking with the client, observing the client's behaviour and interactions, discussions with other people who are involved in the client's life, and reading any documented information on the client. The counsellor should keep in mind that when utilising client's information given by some one else, he must make sure that there is no bias or assumptions.

Phase 3: Establish Mutually agreed upon Goals and Objectives

Why is it important to establish "mutually agreed" upon goals and objectives? Because if a client is in agreement with the goals then he/she is more likely to

follow through on them. When a client is actively involved in the goal setting process and is in agreement with the goals, then he/she is more inclined to take ownership of the goals, which have to be accomplished.

The counsellor must think of goals as the end result that he is trying to achieve. While goals are broad statements that identify what the counsellor wants to accomplish overall, objectives are the measurable steps that the counsellor takes to achieve the goals. For example if the counsellor has a goal that states that the client will be better able to manage her anger, one of the objectives of the counsellor might be, that the client will recognise emotional triggers that lead to angry outbursts and use positive, self-talk to calm herself down. Thus the objectives of the counsellor should always be concrete and measurable. They should also be derived from the overall goal.

Phase 4: Implementation Plan

The implementation plan is a plan that the counsellor and the client work on together. It is designed to prevent, intervene, or address unhealthy behaviours and practices. The implementation plan identifies who will perform the activities, where the activities will occur, how frequently they will occur, how they will be carried out and when they will be carried out. Implementation activities are designed to help clients rethink risky behaviour, work through problematic issues, address unhealthy lifestyle practices, learn new skills and build strengths. Implementation activities can include: counseling, crisis intervention, training and education, supportive services, concrete services and constructive use of free time.

As the counsellor can understand, each stage of the counseling process builds upon the former. As the counsellor moves through each stage, he will come to realise that it takes patience and practice to counsel the client effectively, but if the counsellor is committed to the goal he will be able to achieve and implement successfully. The counsellor may not feel completely confident in their ability as a counselor, but as he expands his knowledge base, he would gain more experience and strengthen his helping skills, and thus he will become a more effective counselor.

3.4 GOALS OF COUNSELLING

The counseling process is a very specific step by step process. There are important steps that must be adhered to if one wants to maximise positive outcomes in the client's therapy treatment of resolving various psychological, social, emotional and developmental issues. The counseling process has some major goals through which the entire treatment and positive outcomes the treatment rests on. Verbal and non verbal cues of ones body language play an important role in the counselors counseling process to bring out the best solutions for client issues and for the clients comfort level to be established for a positive and healthy counselor client helping relationship.

The goals of counseling are:

3.4.1 Developmental Goals

These are goals wherein the clients are assisted in meeting or advancing their anticipated growth and potential development (that is socially, personally, emotionally, cognitively, physical wellness and so on).

3.4.2 Preventive Goals

Prevention is a goal in which the counselor helps the client avoid some undesired outcomes.

3.4.3 Enhancement Goals

If the client possesses special skills and abilities, enhancement means they can be identified and/or further developed through assistance of a counselor.

3.4.4 Remedial Goals

Remediation involves assisting a client to overcome and/or treat an undesirable development.

3.4.5 Exploratory Goals

Exploration represents goals appropriate to the examining of options, testing of skills, and trying of different and new activities, environments, relationships and so on.

3.4.6 Reinforcement Goals

Reinforcement is used when clients need help in recognising that what they are doing, thinking or feeling is right and okay.

3.4.7 Cognitive Goals

Cognition involves acquiring the basic foundations of learning and cognitive skills.

3.4.8 Physiological Goals

Physiology involves acquiring the basic understandings and habits for good health.

3.4.9 Psychological Goals

Psychology helps in developing good social interaction skills, learning emotional control, developing a positive self concept, and so on.

Hackney and Cormier (1996), talk about 3 goals that are important for the counseling process.

1) Goals serve as a motivational function in the counseling process.

2) The goals can also have educational function in counseling, in that they can help clients acquire and learn new responses and behaviours and

3) The goals can also meet an evaluative function in the counseling whereby the clients goals help the counselor to choose and evaluate various counseling strategies appropriate to the client's goals.

3.5 INITIAL COUNSELING INTERVIEW

3.5.1 Opening the Counseling Session

There is no doubt that the initial interview puts maximum demands upon the counselor's skill, knowledge, and abilities. How the initial interview is structured

and developed will have a strong influence upon the subsequent developments and outcomes of a counseling relationship. Errors made in the first session are usually much more costly than those made after a good working relationship has been established. If the initial interview has developed toward goals as outlined herein, then the counselee will find he has been able to express and explore some of life's difficulties which have been bothersome or disturbing to him. He is likely to feel some progress has been made. The counselor should recognise that a major counseling goal has been achieved when, at the end of the initial interview, he feels he has established a helping or working relationship with the counselee.

3.5.2 Counseling Interview: Strategies

The counseling interview is a very common type of communication situation. In fact, we are all called upon to offer advice to others on a daily basis. These suggestions identify some of the skills necessary for effective counseling interviews:

- The counsellor performs the counseling role whenever called upon to offer advice on emotional, financial, academic, or personal problems. These situations are very important since they directly influence sensitive aspects of others' lives.
- Effective counseling skills begin with a thoughtful self analysis including an assessment of counsellor's own feelings and communication skills. Based upon this analysis, the counsellor must be realistic about his own counseling skills and not try to solve every problem encountered .
- The counsellor must also carefully consider the background of the client so that the counsellor's advice can meet that person's needs.
- Based on the counsellor's analysis of own skills as well as the needs of the other person, the counsellor must decide whether to use the directive or nondirective approach. The directive approach is best when it is necessary for the counsellor to control the interview situation and the nondirective approach is best when the interviewee would best control the situation.
- Although the structure of the interview can vary, four stages are typically followed. First, the counsellor should establish rapport and create a helpful climate. Second, he should thoroughly assess the crisis/problem faced by the client. Third, the counsellor should probe more deeply into the client's feelings. Finally, the counsellor should come to some decision and offer potential solutions.
- A conductive interview climate must allow for trust, openness, and rapport between the client and the counsellor. The counsellor must also be an effective listener to truly understand the feelings of the client. When appropriate, the counsellor must ask probing questions to gather more information.
- The counsellor should use a client centered approach and provide either highly directive or highly nondirective responses. Highly nondirective responses encourage the interviewee to continue analysing and communicating ideas. Highly directive responses provide the interviewee with directives and ultimatums. These forms of responses are two ends of a continuum, and can be thought of as extremes.

- After effective closure of the interview, the counsellor should carefully evaluate the interview so that he can further refine his skills.

3.6 COUNSELING INTERVIEW PROCESS

The counseling process is usually specified by a sequence of interactions or steps. The counseling process is concerned with relationship establishment, followed by a method to identify the client's problem and patterns of exploration, leading to planning for a solution to a problem and radiation and concluding with action and termination. A brief description of each of these stages is provided in the following subsections.

3.6.1 Establish Relationship

Counseling is a relationship. It is further defined as a helping relationship. It therefore, follows that if it is to be a relationship that is helpful, the counselor must take the initiative in the initial interview to establish a climate built on trust, mutual respect,, free and open communication, and understanding in general of what the counseling process involves.

Though the responsibility shifts increasingly to the client, at this stage the responsibility for the counseling process rests on the counselor primarily. The counselor uses techniques designed to relieve tension, anxiety, stress and open up communication. Both the counselor's attitude and verbal communications are significant to the development of a satisfactory relationship. All the counselors' verbal communication skills are brought into play. These include attentive listening, understanding and feeling with the client. The quality of the counselor client relationship influences the counseling process outcomes.

The various factors that are important in the establishment of this counselor client relationship are positive regard, respect, accurate empathy and genuineness. These conditions imply the counselor's openness, that is an ability to understand and feel with the client, as well as a valuing of the client. The counselor client relationship serves not only to increase the opportunity for clients to attain their goals but also to be a potential model of a good interpersonal relationship, one that clients can use to improve the quality of their other relationships outside the therapy setting.

Counselors must keep in mind that the purpose of a counseling relationship is to meet as much as possible the clients needs and not the counselor's needs. The counseling process within this relationship seeks to assist the client in assuming the responsibilities for his or her problem and its solution. This will be facilitated by the counselor's communication skills, the ability to identify and reflect client's feelings, and the ability to identify and gain insights into the clients concerns and needs.

Establishing a relationship with the client must be achieved early in the counseling process, in as much as this will often determine whether or not the client will continue. The initial counseling process has a goal and so has the client a goal. Let us see what these are.

The goals of the initial counseling process are as follows:

1) Establish a comfortable and positive relationship.
2) Explain the counseling process and mutual responsibilities to the client.
3) Facilitate communications.
4) Identify and verify the clients concerns that brought her or him to seek counseling assistance.
5) Plan, with the client, to obtain assessment data needed to proceed with the counseling process.

Understand the counseling process and his or her responsibilities in this process.

Share and amplify reasons for seeking counseling.

Cooperate in the assessment of both the problem and self.

3.6.2 Problem Identification and Exploration

Once an adequate relationship has been established, clients will be more receptive to the in depth discussion and exploration of their concerns. At this stage, clients must assume more responsibility because it is their problem, and therefore, it is their responsibility to communicate the details of the problem to the counselor and respond to any questions the counselor may have in order to maximise counselors assistance and help.

During this phase, the counselor continues to exhibit attending behaviour and may place particular emphasis on such communication skills as paraphrasing, clarifying doubts, perception, checking or giving feedback. The counselor may question the client, but questions are stated in such a way as to help the client to continue exploring client's problem area. Questions that can embarrass clients are avoided. Throughout this phase the counsellor has to be very conscious about knowing the cultural difference and culturally specific behaviours and responses.

Here, the counsellor seeks to distinguish between the surface problems and the problems that are deeper and more complex. The counsellor tries to identify that the problem stated initially is the actual problem or that there could be another more important underlying issue that needs to be attended to and dealt with to the client. This may be a time for information gathering. The more usable information the counselor has, the greater are the prospects of accurate assessment of the clients needs.

The information is gathered under three headings: the time dimension, the feeling dimension and cognitive dimension are as follows:

i) **The time dimension:** This includes the clients past experiences, especially those which he or she may view as influencing experiences of their lives.

ii) **The feeling dimension**: This includes the emotions and feelings of the client towards himself and herself, as well as significant others, including groups, attitudes, values, and self concept.

iii) **The cognitive dimension**: This includes how the client solves problems, the coping styles that she or he employs, the rationality used in making daily decisions and the clients capacity and readiness for learning.

The goals of this stage are for counselors to seek and integrate as much information as possible from the client. The counselor also shares these perceptions with the client. A goal of this stage is for both the counselor and the client to perceive the problem and its resolution. One of the counselor's goals during this stage is to help the client develop a self understanding that recognises the need for dealing with the need for change and action. Problem solving is used to promote client understanding of action plans for resolving problems.

Steps or stages of problem identification and exploration are as follows:

1) Defining the problem as to what is the issue clearly.

2) Exploring the problem by gathering necessary information and then exploring various alternatives in finding solution to the problem.

3) Integrating the information that has been gathered from the client and then summarising it and putting it down clearly for the possible course of action to be taken in resolving the problem.

3.6.3 Plan for Problem Solving

Once the counselor has determined that all relevant information regarding the client's concern is available and understood, and once the client has accepted the need for doing something about a specific problem, the time is ripe for developing a plan to solve or remediate the concern of the client. Here, effective goal setting becomes the vital part of the counseling activity. Mistakes in goal setting can lead to nonproductive counseling procedures and clients loss of confidence in the counseling process. In this stage there are some sequential steps in viewing the processes involved.

1) Define the problem

2) Identify and list all possible solutions

3) Explore the consequences of the suggested solutions.

4) Prioritize the solutions on the basis of priority needs.

In the further development of this plan, the counselor recognises that the client will frequently not arrive at basic insights, implications, or probabilities as fast as the counselor will. However, most counselors will agree that it is better to guide the client toward realising these understandings by himself or herself, rather than just telling the client outright. To facilitate the clients understanding, the counselor may use techniques of repetition, mild confrontation, interpretation, information and obviously encouragement.

3.6.4 Solution Application and Termination

In this final stage, the responsibilities are clear cut. The client has the responsibility for applying the determined solution, and the counselor has a responsibility to encourage the client's acting on his or her determined problem solution. During the time that the client is actively encouraged in applying the problem solution, the counselor will often maintain contact as a source of follow up, support and encouragement. The client may also need the counselor's assistance in the event things do not go according to plan. Once it has been determined that the counselor and client have dealt with the client's issue to the extent possible and practical, the process should be terminated.

The termination is primarily the counselor's responsibility, although the client can terminate the sessions any time they like. The counselor usually gives some sort of an indication that the next interview should just about wrap it up and may conclude by summarising the main points of the counseling process. Usually, the counselor leaves the door open for the client's possible return in the event additional assistance is needed. Since counseling is a learning process, the counselor hopes that the client has not only learned to deal with this particular problem, but has also learned problem solving skills that will decrease the probability of the clients need for further counseling in the future.

3.7 COUNSELING SKILLS

The skills required in counseling are very important for a good counseling process to happen and these have to be reinforced both by practice and research. The counselor acquires these through learning and practice.

3.7.1 Communication Skills

Verbal communication skills: Effective Speaking as a mean of communication, effective speaking plays a vital role in people's lives. Though everybody speaks everyday and is able to express ideas, thoughts, or requests, not everybody can do it well. Some people are difficult to follow, some explain their thoughts in a complicated manner, and some are simply boring to listen to. Avoid these mistakes.

- Use plain and simple words unless the audience is specialised in the subject area.
- Use complete simple sentences for the message to be easier to comprehend.
- Do not speak too fast. It is difficult to comprehend information if much of it is presented in a short period of time.
- Make pauses. Pauses between sentences and ideas will give a listener some space to think the words over, to understand the message.
- Structure and connect ideas. Major points should be presented in a logical manner. Otherwise it is difficult to follow the speaker. So, make sure that each next thought expressed expands on the subject and on the previous point.
- Support ideas not only with words, but with intonation and nonverbal means of communication as well. Proper intonation can stress certain ideas you want to draw attention to. Nonverbal means of communication, such as gestures and facial expression, establish a closer connection with the audience, and enhance the message being communicated.

3.7.2 Communication for Effective Counselling

Effective communication is also facilitated by knowing what not to do. George and Chritiani (1995) list these barriers to communication:

1) Giving advice
2) Offering solutions

3) Moralising and preaching
4) Analysing and diagnosing
5) Judging or criticising
6) Praising and agreeing: giving positive evaluations
7) Reassuring

The effectiveness of counseling is determined by the effectiveness of counselor client communication. From the counselor's standpoint, communication is primarily designed to influence and motivate the client.

3.7.3 Non Verbal Communication Skills

We all are judged by our first impressions. People react to us just on how we look physically. This is a type of non-verbal communication. We receive information non verbally first and foremost. This means one does not have to use language to communicate. Non verbal communication skills are just as important as verbal communication. When we transmit information to a person, the important things is to note how we say something is also transmitted in addition to what was said to them. In fact a lot of times the receiver interprets what we have said to them by how we have said it and not the words themselves. If our non verbal communication skills are less than adequate, then there is more of a chance that the person who receives the information will misinterpret what was said.

Non verbal communication skills include a common system of symbols, signs and gestures. Even the way we dress conveys non verbal communication. People make conclusions and assumptions by the way they perceive our clothing. That is where the term dress for success has come into being. People think if you wear suits, you look the part of the business world. This is true but not necessarily correct.

Non verbal communication skills give expression to our messages that we are transmitting to be received as a communication. Virtually anything that we can communicate and receive with the senses is a form of non verbal communication. Non verbal communication involves what we call body language, which includes things like facial expressions, hand gestures, tone and pitch of voice, smell, essentially anything non verbal.

Scientific studies have shown that verbal communication is 7% of a verbal communicative transmission. The other 93% is attributed to non verbal and symbolic communication also called listening skills. Listening is the most complicated and hard part of the communication process. Many people are not good listeners. Just because one does not have a hearing problem does not mean he is listening. Listening is a skill that is also acquired. When one listens they have to hear the emotion in the words and read between the lines of the words to get the full meaning of a transmission that is received.

Listening consists of 5 key elements. Hearing, attending, understanding, responding and remembering are all components of effective listening. The actual process of hearing is a physiological process when sound waves hit the eardrum at a certain frequency. Attending is a filtering process. It includes filtering in and filtering out certain messages. Understanding happens when we interpret the

message with our capabilities. Responding is acknowledging the message with the appropriate response such as eye contact or gesture. Remembering means we can recall the message given to us. All these are factors in non verbal communication skills as well.

In order to be proficient with our nonverbal communication skills we must remember we are what we look like and what we do as well as what we say. Our body language must match our words so the listener can receive our message correctly. If we do not match in our non verbal communication with our verbal communication that there is sure to be misunderstanding between ourselves and the one we are communicating to. In fact this is the reason most people do not understand one another because the words do not match the body.

3.8 LET US SUM UP

In conclusion this section on the counseling process, we are aware of our frequent reference to the client's problem and we remind our readers that problems are not always based on perceived inadequacies or failures requiring remediation and restorative therapy. Clients can have equally pressing needs resulting from concerns for developing their human potential-for working and strengthening on their strengths and in the counseling process the emphasis is on development, growth, or enhancement rather than remediation.

3.9 UNIT END QUESTIONS

1) What are some examples of formal and informal counseling interview situations?

2) What should you consider when conducting a thorough self analysis?

3) What should you consider when analysing the interviewee in a counseling interview?

4) Why is it important to perform analyses of yourself and the interviewee prior to conducting the interview?

5) What are the directive and nondirective approaches to interviewing?

6) What are the affective and cognitive phases and what happens during each?

7) What type of setting should you select to create an appropriate climate and tone?

8) What are some strategies for the opening of the counseling interview?

9) Discuss the importance of listening, observing, and questioning in the counseling interview.

10) What does it mean to say that one should use a client-centered approach in the counseling interview?

11) What are the differences between highly directive, directive, nondirective, and highly nondirective approaches to responding?

12) What are some issues you should consider when evaluating the interview?

3.10 SUGGESTED READINGS

Benjamin A. (1974). *The Helping Interview* (2nd ed.) Boston: Houghton Mifflin

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UNIT 4 COUNSELLING IN THE INDIAN CONTEXT

Structure

4.0 INTRODUCTION

This unit deals with counseling in the Indian context. We start with counseling definition and differentiate it from guidance. We then present the characteristics of counseling and put forward the perspectives of counseling. Then we deal with origin of counseling movement in India in which we present the orgin of counseling from 1938 onwards. Then we move on to discuss changing India and how the role of the counsellor also has changed. The various counseling approaches are discussed . Then we discuss the Primal psychotherapy under which Adlerian therapy, person centered therapy and gestalt therapyare presented. This is followed by brief therapies with a focus on solution focused therapy. Then we discuss the eclectic therapies in which many therapeutic approaches are combined as per the needs of the client concerned. Then we discuss counseling

in India, its relevance and suitability. Then we present the characteristics of contemporary India and discuss the implications of counseling in that context. We also present changing trends in counseling in India.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe counseling;
- Differentiate counseling from guidance;
- Elucidate the origins of counseling in India;
- Describe the various approaches to counseling;
- Elucidate brief therapies and eclectic approach in counseling; and
- Explain the counseling and its relevance in the modern India.

4.2 COUNSELING IN THE INDIAN CONTEXT

Counseling in its widest connotation existed in one form or the other from time immemorial. In all cultures the elders not only set the norms of behaviour within that culture but also counselled the youngsters to follow the norms. In India, elders especially parents and teachers thought that imparting counseling in the form of advice and guidance was one of their fundamental, and sacred duty. The often repeated adage, *"Mata, Pita, Guru, Deivam"* (Mother, Father, Teacher, God) reminded the youngsters not only of the agents of counseling but also of the priority as to who should impart counseling at various stages of life.

Ancient epics of India are replete with depictions of counseling. Elders were only too ready to take up the role of counselors and youngsters sought counseling with prompt compliance. Many such incidents could be explained away as mere acts of 'giving advice'. But in most of those ancient transactions it is not difficult to see the scientific practice and ethics of modern counseling techniques. The most widely acknowledged counseling situation in the epics is that of the dialogue between Krishna and Arjuna in the battlefield of Kurukshetra. Whether this dialogue had all the characteristics of modern counseling may have to be answered by committed researchers in this area. Many, often ask questions regarding the relevance and suitability of modern counselling techniques in all cultures. Experts in this field are of the opinion that the culture of India with the above heritage is potentially oriented to the modern techniques of counseling.

4.2.1 Guidance and Counseling

The term guidance denotes explicit directions given by an informed person regarding any subject. An expert in career guidance can impart information regarding different career possibilities. He may also be able to tell us where the careers are open and even the possible openings at the time of consultation. In imparting such information the guidance expert can give considerable information about the career or the job, irrespective of the suitability of the client for the job. However, he has also the option to test the suitability of the client using suitable psychological test.

Counselling, on the other hand is more dynamic. It aims at the solution of clients' problems. Counselling is a much-misunderstood concept. To the laymen it is an occasion where an expert solves the problems of others. Laymen believe that the expert has ready made solutions for all the problems of human beings. On the contrary counselors do not give solution to any problem, they only facilitate the client to such an exdent that they are able to find solution to their own problems. Thus Counselling is a process between the counsellor and the client in which solutions emerge as a joint venture of the two.

4.2.2 Characteristics of Counseling

1) It is a process.
2) Counselling is usually for normal people with problems.
3) It is essentially a dynamic interaction between the client and the counsellor.
4) Client is expected to be frank and forthright in his approach.
5) It is the duty of the counsellor to keep confidentiality regarding the client.
6) Counsellor is to show warmth and sympathy while listening to the client's problems.
7) Counsellor is expected to be non judgmental and non critical.
8) The relationship between the client and the counsellor is expected to be genuine.
9) Counselling usually works at the level of rapport and not at the level of transference.
10) Client's conscious motives are explored rather than the unconscious motives.

4.2.3 Perspectives of Counseling

The perspective of Counseling may change from counselor to counselor. There are differences in training, clients and settings, and even goals. But the basic perspective of counseling remains the same, through with different emphasis. The best examples are the three different definitions of counseling given by Good (1945), Pepinsky and Pepinsky (1954) and Wrenn (1951). Good defined counseling as the "...individualised and personalised assistance with personal, educational, vocational problems, in which all pertinent facts are studied and analysed, and a solution is sought, often with the assistance of Specialists, school and community resources, and personal interviews in which the counselee is taught to make his own decisions".

According to Pepinsky and Pepinsky, "Counseling is a process involving an interaction between a counselor and a client in a private setting, worth the purpose of helping the client change his/her behaviour so that a satisfactory resolution of needs may be obtained". To Wrenn, "Counseling is a dynamic and purposeful relationship between two people in which procedures vary with the nature of students' needs, but in which there is always mutual participation by the counselor and the student with the focus upon self-clarification and self-determination by the student". All these definitions have common base but are different in their emphasis. The difference among the three definitions stems from the fact that they have three different orientations.

Hann (1953) identifies one group as the social welfare advocates with ideographic interest. The second group is more medically oriented and the thirds group consists of people with student personnel administration and has great interest in measurement. Along with the differences it is worth noting the commonalties. Common to all these perspectives are the notions that,

a) counseling is aimed at helping people make choices and act on them,

b) counseling is a learning process, and

c) counseling enables personality development

A recent and much accepted definition is:

"Counseling denotes a professional relationship between a trained counselor and client. This relationship is usually person-to-person, although it may sometimes involve more than two people. It is designed to help clients to understand and their self determined goals through meaningful resolution of problems of an emotional or interpersonal nature" (Burks and Stefflre, 1979).

The merit of the definition by Burks and Steffler is that it is sufficiently theoretical and at the same time reasonably operational.

Counseling is not a novel institution in India. The first counselor was Lord Krishna himself and the Bhagawad Gita embodies the finest principles of counseling for all lands, all ages and all times. The Gita or the song celestial explains how Arjuna, whose mind was in great conflict, was helped to overcome this conflict through an insight into him. Arjuna's conflict was one of "mine and thine", that is between Sva and Para. The conflict was solved through self-understanding or through self realisation. One has to act in accordance with his Swadharma. Man should act in accordance with the demands of his situation and his duties in life. Self realisation understood in the context of Gita is not the same as what we understand by Rogerian or Existential sense. Man has to realise his inner nature, that is, his spirituality which reveals oneness with the ultimate. This helps to overcome the illusory difference between the Atma and the Parmatma. In the pursuit of the higher spirit, man is concerned with freedom, freedom to obtain self realisation. In modern times the word freedom is used in a different sense. Its connotation is limited to action, speech, religious faith as well as freedom to find its fullest expression of one's potential. In this sense of the term, we are immediately concerned with material existence and the physical world.

Indian society came to be much maligned by Varnashram dharma. The society century after century, become more rigid in its dogmatic adherence to it. There was no opportunity for social mobility. The Indian society became highly traditionalistic and conventional. The Vedic prayer lost its significance in the degeneration of the during the the colonial period in India. Freedom and independence have been substituted with dependence.

The youth in India even today is dependent on adult members for such important decisions as the choice of residence, choice of a job and choice of a marital partner to mention a few. The important sources of behaviour change namely industrialisation, urbanisation; mass media communication and the like have battered the traditional social conventions and institutions and have made several dents on them.

Compared to 19th century Western society, contemporary Indian society is more radical and provides enormous choice of opportunities for individual choice of action. The kind of counseling assistance sought for and provided in the western world is not necessarily applicable to the Indian society. However, counseling is as much needed in India as it is elsewhere in the world.

4.2.4 Origin of Counselling Movement in India

The origin of the counseling movement in India should be naturally traced to the beginnings of psychology in India. It was at the Mysore University in south India that the first Chair in psychology was endowed. Perhaps less than a year or so before this, the Calcutta University started a department of psychology with a lecturer as the in charge Head of the Department.

For more than two decades since then psychology did not make much of headway at the other universities in India. During the mid 1940's Patna University, started a department of psychology, closely followed by one started at the Banaras Hindu University, the Lucknow University and the others. However, much of the progress manifested in the opening of new departments came about during the 1960's. The various departments have since been preparing students for post graduate degrees in psychology with its emphasis on experimental approach.

Alongside this movement applied psychology came to be established as an independent department or section of the existing departments of psychology. The applied psychology section of the Calcutta University was established in 1938 and the department of psychological services at Patna University in 1945. However, counseling psychology or its forerunner, vocational guidance did not figure as an important service at universities where psychology was offered. First in Calcutta and later in Bombay, voluntary private agencies came to be established to provide guidance on a modest scale. In Calcutta the guidance movement became associated with David Hare training college. In Bombay, Batliboy and Mukherjee started, in 1941, a private agency known as Batliboy Vocational Guidance Bureau. The founders of this bureau who came from Calcutta had some years of experience since they worked at the Calcutta Bureau. The Batliboy bureau ran for 6 years, after which it stopped functioning. However during this period it rendered valuable service to the community. It successfully conducted for the first time, a short term orientation course in guidance for teachers. This was the forerunner of all the later training courses conducted for career masters at several places in India (Khorshed, 1963).

Counseling was recognised as an important service in India as early as 1938 when Acharya Narendra Dev committee underlined the importance of counseling and guidance in education. The guidance and counseling were considered to be new and emerging forces that were vitally important to the education system. The same vigor was not seen in the 1980'sand 1990's and interest in guidance and counseling diminished. Evidence of this decline of interest was seen in the number of research literature available for review. Despite all this, the recent past has seen a significant increase in the demand for counseling services at the national level. Counseling was also identified an essential service by the national framework curriculum in 2005 by the NCERT ((National Council for Educational Research and Training). The strongest attention for counseling has arisen from the school sector. During its 2001 National conference, the CBSE resolved that it would be mandatory for all its schools to have trained school counselors.

Training opportunities have become available over the past few years and range from full time post graduate degree programs to certificates and diplomas. Post graduate degrees are offered by a small number of university departments of psychology, education and social work. NCERT, Government of India offers a post graduate diploma in guidance and counseling. Private organisations offer post graduate diplomas and certificates in specific branches of counseling. Certificate courses are available through distance education mode. In length these courses range from short 12 day certificate and diploma courses to full time 2 year post graduate courses. Students have the option of specialising in a specific client group. Some common specialisations are marital therapy, counseling adolescents, career counseling, and educational counseling. The better courses require students to obtain internship experiences in organisations that deliver counseling services. In addition to facing a written examination, a common requirement is for students to submit detailed case reports of a prescribed number of clients they have seen.

The nature and scope of counseling itself remains poorly articulated. At present there is no licensing system for counselors as anyone can become a counselor and there is no system to monitor the skills in a systematic manner.

A recent evaluation of the cultural sensitivity of existing curricula revealed that very little has emerged in terms of Indian models of counseling (Arulmani, 2007). The attempt seems to have been to adopt western concepts with little or no consideration for "discovering" new approaches and validating them for the Indian situation. On a more positive note, an emerging trend is a gradual move towards more varied approaches to counseling. Although these courses are few and far between, they have suitable valuable training objectives to sensitize learners to the possibilities and availability of alternate methods of healing with focus on indigenous and culturally accepted and practiced therapeutic methods.

Access to counseling service is a matter of great concern. A survey by Arulmani & Nag, 2006, conducted in 12 different Indian regions revealed that less than 10% of this sample has access to any form of counseling. There is also a lack of clarity regarding the role of a counselor. Referrals to counselors cover the entire gamut of mental needs, ranging from severe psychotic problems to issues such as parenting concerns, childhood disorders, adolescent difficulties and reproductive health (including HIV/AIDS issues). Marital discord, interpersonal problems, scholastic and educational difficulties, stress mediated disorders, substance abuse, counseling for career development, and questions about sexual orientation are other kinds of referrals a counselor might receive.

Self Assessment Questions

1) Differentiate between counseling and guidance.

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2) What are the characteristics of counseling?

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3) Delineate the perspective of counseling.

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4) Trace the origin of counseling movement in India.

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4.3 CHANGING INDIA AND ROLE OF THE COUNSELOR

Finally, the need for counseling in modern India manifests itself against the background of social change, the nature and pace of which are indeed unprecedented. A decade of economic reforms has pushed India towards becoming one of world's fastest growing economies. This in turn has given counseling a new look. The effect of rapid globalising of the world, is increasingly coming under the control of free market economy, has also arrived at the doorsteps of Indian counselor. Economically empowered women for instance, no longer need to silently accept abuse and disregard. Age old values are being questioned. The belief that marriage is a lifetime commitment, for better or for worse is no longer unshakable as it was before. The marital discord is on the increase, as are divorce rates. The Indian middle class student is typically required to put in almost 16 hours of study a day to bear the competition and win a seat in the course leading to a degree in engineering or medicine. Counselors are repeatedly presented with young people who are forced to choose careers that are popular and "in demand" but who soon discovered that their real interests and talents lay elsewhere. Increasing number of young workers show wavering motivation and want a career shift within the first year of working. Aggression and violence being fed by resentment are increasingly obtained in the Indian society. These are all complexities a counselor practicing in India is seeing and facing these days.

4.4 COUNSELING APPROACHES

The approaches of counseling are:

1) **Cognitive Approach**: We define this as any therapy that is based on the belief that our thoughts are directly connected to how we feel. The cognitive therapies include Rational-Emotive, Cognitive-Behavioural, Reality, and Transactional Analysis.

   Therapists in the cognitive field work with clients to solve present day problems by helping them to identify distorted thinking that causes emotional discomfort. There's little emphasis on the historical root of a problem. Rather, what's wrong with my present thinking that it is causing distress.

   Common traits among the cognitive approaches include a collaborative relationship between client and therapist, homework between sessions, and the tendency to be of short duration. These therapies are best known for treating mild depression, anxiety, and anger problems.

2) **Behavioural Approach**: This is based on the premise that primary learning comes from experience. The initial concern in therapy is to help the client analyse behaviour, define problems, and select goals.

   Therapy often includes homework, behavioural experiments, role playing, assertiveness training, and self management training. Like its cognitive therapy cousins it utilises collaboration between client and therapist, and is usually of short duration.

3) **Psychoanalytic Approach**: The original so called "talking therapy" involves analysing the root causes of behaviour and feelings by exploring the unconscious mind and the conscious mind's relation to it. Many theories and therapies have evolved from the original Freudian psychoanalysis which utilises free association, dreams, and transference, as well as other strategies to help the client know the function of their own minds. Traditional analysts have their clients lie on a couch as the therapist takes notes and interprets the client's thoughts, etc.

   Many theories and therapies have evolved from the original psychoanalysis, including Hypnotherapy, object relations, Progoff's Intensive Journal Therapy, Jungian psychoanalytic therapy and many others.

   One thing they all have in common is that they deal with unconscious motivation.

Usually the duration of therapy is long though many modern therapists use psychoanalytic techniques for short term therapies.

4.5 PRIMAL PSYCHOTHERAPY

4.5.1 Adlerian Therapy

Named after its founder, Alfred Adler, it is also called individual psychology. Considered the first "common sense" therapy, the basic premise is that human beings are always "becoming," that we're always moving toward the future, and our concerns are geared toward our subjective goals rather than an objective

past. We are constantly aiming towards what Adler calls superiority. When we have unrealistic or unattainable goals, this can lead to self-defeating behaviours and discouragement which may foster neurosis, psychosis, substance abuse, criminal behaviour, or suicide.

The role of the therapist is to help the client identify mistaken goals, and to help the client do away with self-centeredness, egotism, and isolation, and to develop positive, meaningful interpersonal relationships.

Generally in a long term therapy, the sessions involve the therapist listening and questioning towards the goal of knowing the client as fully as possible, so that the therapist can provide to the client feedback regarding the faulty objectives and behaviours of the client.

4.5.2 Person Centered (Rogerian) Therapy

Founded by Carl Rogers in the 1940's, like Adlerian therapy, a basic premise is that we are all "becoming;" we are all moving towards self actualisation. Rogers believed that each of us has the innate ability to reach our full potential. As infants we are born with it, but because of early experiences, we may lose our connection to it. The self concept we develop in response to our early experiences may tend to alienate us from our true self. In this theory there is no such thing as mental illness. It is just a matter of being disconnected from our self potential. This therapy is often considered the most optimistic approach to human potential.

This often lengthy therapy is based on developing the client therapist relationship. The therapist is to provide the conditions necessary for the client's growth, that is genuineness, unconditional positive regard, and empathic understanding. To be genuine the therapist must strive to be transparent, open, willing to express at opportune times their own identity in the relationship. There is no hiding behind expertise or degrees. Therapists must be constantly doing their own inventory.

Unconditional positive regard is synonymous with acceptance and appreciation of the client who has approached the counsellor for help. Empathic understanding is based on the therapist's ability to see the world through the client's eyes, to move into the client's world at the deepest levels and experience what the client feels. If the process works, the client moves back toward self actualisation.

4.5.3 Gestalt Therapy

This term was first used as the title of a book in 1951, written by Fritz Perls,et.al. The therapy did not become well known until the late 1960's. "Gestalt," a German word meaning "whole," operates as a therapy by keeping the person in what is known as the here and now. Therapists help clients to be attentive to all parts of themselves, that is posture, breathing, methods of movement, etc. Unresolved conflicts are worked out in the therapy session as if they are happening in that moment. An emphasis is placed on personal responsibility for one's own well being through being as aware as possible at all times of one's interactions with the environment.

This is usually a lengthy therapy which is accomplished by the therapist asking questions and suggesting experiments which will increase the awareness and sensitivity of the client to the many parts of the client's total self.

Self Assessment Questions

1) Explain the role of counsellor in changing India.

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2) What are the important counseling approaches? Explain in detail.

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3) Under primal psychotherapy discuss Adlerian therapy.

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4) Discuss Gestalt therapy and compare it with person centered therapy.

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4.6 BRIEF THERAPIES

While most therapy approaches have developed short term versions (often in response to the demands of managed care), one specific model is called Solution focused brief therapy. This short term work is based on

1) Focusing on solutions instead of problems
2) Exceptions suggest solutions, i.e. "We fight all the time." "Think of a time recently when you weren't fighting".
3) Change is occurring all the time.
4) Small changing leads to large changing.

5) Cooperation is inevitable between therapist and client.

6) People have all they need to solve their problems.

The premise is that if one does a step by step process, following these and six other assumptions, the client can find quick solutions to whatever may be facing them. Like the cognitive behavioural therapies, this is short term therapy and usually involves homework and clearly defined goals.

While Solution focused therapy is aimed at short term interventions, it can be successfully used over a longer period.

Not every counseling client is ready to move on in 3 - 8 sessions, it is perfectly feasible to follow the aims of solution focused therapy, on a multitude of issues over many sessions.

For instance, working with a client around their substance misuse issues, the client may well attain their goal of reduction or abstinence, but may need longer term work around regaining self esteem, getting a job/education, re-establishing family links etc.

As the counselor/client relationship develops (leaning toward the person centered), the client may become more and more accustomed to the counselors use of solution focused techniques; the client may adapt techniques for him/herself, i.e.: “Give a hungry man a fish and he eats today, but teach him to fish, and he eats for a lifetime”.

4.7 ECLECTIC APPROACH

When therapists are asked their theoretical orientation, this is the answer most often given. This is essentially a common sense approach to helping people by tailoring the therapy to the needs of the individual client.

While this seems like a good idea, there is so much to know to become an adequate therapist in any one of the schools, that it is unlikely that any practitioner knows enough to utilise and integrate the vast complexities of the many theories of therapy.

Instead, if one looks just below the surface, there is probably a primary therapeutic orientation that is simply not strictly adhered to by the therapist. For instance, the therapist may start out as a person centered therapist, but may have found a way to add cognitive or reality therapy techniques to their personal approach. It’s probably a good idea to check this out with the therapist.

4.8 COUNSELING THERAPIES

When deciding on an appropriate counselor or psychotherapist, it can be useful to understand the different therapies they may use. Although all can be effective, you may find one approach more appealing than another, or find that some approaches are better for a certain area of counseling or psychotherapy than others.

Psychological therapies generally fall into three categories. These are behavioural therapies, which focus on cognitions and behaviours, psychoanalytical and

psychodynamic therapies, which focus on the unconscious relationship patterns that evolved from childhood, and humanistic therapies, which focus on self development in the 'here and now' situation.

This is a generalisation though and counseling or psychotherapy usually overlaps some of these techniques. Some counselors or psychotherapists practice a form of '*integrative*' therapy, which means they draw on and blend specific types of techniques. Other practitioners work in an '*eclectic*' way, which means they take elements of several different models and combine them when working with clients.

4.8.1 Cognitive and Behavioural Therapies

Behavioural Therapies are based on the way you think (cognitive) and/or the way you behave. These therapies recognise that it is possible to change, or recondition, our thoughts or behaviour to overcome specific problems.

a) **Behavioural Therapy:** Behavioural Therapy focuses on an individual's learnt, or conditioned, behaviour and how this can be changed. The approach assumes that if a behaviour can be learnt, then it can be unlearnt (or reconditioned) so is useful for dealing with issues such as phobias or addictions.

b) **Cognitive Therapy:** Cognitive Therapy deals with thoughts and perceptions, and how these can affect feelings and behaviour. By reassessing negative thoughts an individual can learn more flexible, positive ways of thinking, which can ultimately affect their feelings and behaviour towards those thoughts.

c) **Cognitive Behavioural Therapy (CBT):** Cognitive Behavioural Therapy (CBT) combines cognitive and behavioural therapies. The approach focuses on thoughts, emotions, physical feelings and actions, and teaches clients how each one can have an affect on the other. CBT is useful for dealing with a number of issues, including depression, anxiety and phobias.

4.8.2 Psychoanalytical and Psychodynamic Therapies

Psychoanalytical and psychodynamic therapies are based on an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts.

a) **Psychoanalysis:** Psychoanalysis was developed by Sigmund Freud and focuses on an individual's unconscious, deep-rooted thoughts that often stem from childhood. Through free associations, dreams or fantasies, clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

b) **Psychoanalytic Therapy:** Based on Psychoanalysis, Psychoanalytic Therapy also focuses on how an individual's unconscious thoughts are influencing them. However, Psychoanalytic Therapy is usually less intensive than Psychoanalysis.

c) **Psychodynamic Therapy**: Psychodynamic Therapy evolved from Psychoanalytic Therapy and seeks to discover how unconscious thoughts affect current behaviour. Psychodynamic Therapy usually focuses on more immediate problems and attempts to provide a quicker solution.

4.8.3 Humanistic Therapies

Humanistic Therapies focus on self development, growth and responsibilities. They seek to help individuals recognise their strengths, creativity and choice in the 'here and now'.

a) **Person-Centered Counseling (*also known as "Client-Centered" or Rogerian" counseling*):** Person-Centered Counseling focuses on an individual's self worth and values. Being valued as a person, without being judged, can help an individual to accept who they are, and reconnect with themselves.

b) **Gestalt Therapy:** Gestalt Therapy can be roughly translated to 'whole' and focuses on the whole of an individual's experience, including their thoughts, feelings and actions. Gaining self-awareness in the 'here and now' is a key aspect of Gestalt Therapy.

c) **Transactional Analysis:** Transactional Analysis is based on the theory that we each have three ego states: Parent, Adult and Child. By recognising ego-states, Transactional Analysis attempts to identify how individuals communicate, and how this can be changed.

d) **Transpersonal Psychology and Psycho-synthesis:** Transpersonal Psychology means "beyond the personal" and seeks to discover the person who transcends an individual's body, age, appearance, culture etc. Psycho synthesis aims to discover a higher, spiritual level of consciousness.

4.8.4 Existential Therapy

Existential Therapy focuses on exploring the meaning of certain issues through a philosophical perspective, instead of a technique-based approach.

Self Assessment Questions

1) Discuss and put forward the brief therapies in counseling.

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2) Explain critically what is eclectic approach to therapies?

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3) What are the techniques involved in cognitive and behavioural therapies?

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4) What are the important features of psychoanalytic and psychodynamic therapies?

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5) Differentiate between humanistic and existential therapies.

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4.9 COUNSELING IN INDIA: ITS RELEVANCE AND SUITABILITY

Indian scholars have consistently pointed out that modern western psychotherapy and counseling have had a failure on Indian soil as the development of India has been a largely Euro-American enterprise. Historically, psychology in the west actively distinguishes itself from theology and metaphysics, separated itself from its earlier preoccupation with the soul, and oriented itself instead to the study of human behaviour. It committed itself to logical positivism and chose as its tool the inductive process of logical scientific reasoning.

The discipline of psychology emerged from this framework in direct response to psychological needs that had their roots in western socio cultural milieu. This continues to be the ethos that is founded on materialist individualism: a culture that celebrates the individual's freedom for self determinism.

The notion of cultural preparedness is critical here. The methods of counseling that emerged in the west were created by members of a particular culture in response to needs expressed from within this culture. The approaches in effect were developed by a people and for a people with certain cultural orientations.

One of the reasons for the success of these approaches could be that both the creators of the service and the consumers of the service had been culturally prepared in a very similar manner to offer and partake of the service. They share a similar vocabulary of values and cherish a particular approach to life. A counseling approach that is empirical and individualistic in its orientation, for example, may not find resonance amongst Indians, whose culture has prepared them from over the ages to approach their existence in an intuitive, experimental and community oriented manner. To flourish in the contemporary globalised context, counseling cannot be viewed only solely or even primarily as a western specialty (Savikas, 2007).

4.9.1 Contemporary India

Contemporary India evokes images of a booming technology industry and an economy that is growing at an unprecedented rate. Economic development has triggered tremendous social change. The need for counseling in contemporary India manifests within a social, cultural and economic ethos that this country has not faced before.

4.9.2 Implications for Counselling

Cultural preparedness

Religion and spirituality: Religion and spirituality is the foremost representation of cultural preparedness in the Indian context. The first step for which the Indian culturally is to seek, in times of distress, the emotional ties offered through religion and representatives of religion. The implications of this aspect of cultural preparedness are profound for the development of a relevant counseling strategy. The common western understanding that these traditional approaches are primitive and unscientific reflects a suspicion of methods that are culturally alien. The loyalty of the masses to these methods has been routinely attributed to ignorance and lack of knowledge.

Some scholars, have however, attempted to draw a balance and argue that it is the scientists who are not able to transcend boundaries of their education to examine these alternate methods with equanimity. Others have pointed that these are ancient practices filtered over hundreds of years from the collective experience of the community, that in fact have a high degree of efficacy at the practical and everyday level (Kakar, 2003).

Holistic conception of life: Traditional Indian approaches of healing focus on the person as a whole. This would include the physical being as well as the individual's mind, emotions, beliefs, spiritual inclinations, occupational status and all other aspects of his or her existence. It would also include the nature of the individual's linkages with society and the relationship to which he or she is bound.

Ayurveda, the ancient traditional Indian medicine provides detailed descriptions of how emotions are linked to physical illnesses and how health is the function of maintaining the correct balance between the individuals self and the aspects of his or her social interactions (Das, 1974). In the Indian context, an approach to counseling that separates mind from body and individual from family would most likely fail to address the felt need.

Determinism: The philosophic constructs of Karma and Samsara are often described as fatalistic approach to life. The proposition is that the present is determined by past actions could evoke a sense of inevitability. The concept of Karma and Samsara do not negate the concept of free will. The exercise of effort in the present is linked to the future gain and development. Accordingly, the quality of future life could be influenced and shaped by the manner in which one lives one's present life.

This emphasis on personal responsibility offers a valuable pointer to counseling techniques that draw on the client's cultural preparedness.

4.9.3 Changing Trends in Counselling

Duncan, Hubble and Miller (The Heart and Soul of Change) show that the single most important factor of change in counseling is the strength of the therapeutic alliance (30 percent). Other key issues are extra therapeutic factors (40 percent), which are the stage of readiness of change of the client and the setting to which the client returns. Hope and expectancy accounts for 15 percent of change and only 15 percent of change can be attributed to technique.

Thus counsellors who have been practicing cognitive behavioural approaches, DBT, EMDR, etc., have to understand that if they want to be more effective counsellors, they have to focus on their rapport with the client and what the client wants and needs. The single most important question a counselor can ask a client is, "What do you want, and how can I help you get there?"

The counsellor must learn the stages of change. They do not look for motivated clients. The reality is that all clients are motivated, by something. Your task is to find out what motivates them. They have to learn to treat the whole person rather than any specific problem or issue.

Self Assessment Questions

1) What is the relevance and suitability of western therapies in the Indian context?

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2) How is counseling important in contemporary India?

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3) What are the changing trends in counseling in India?

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4.10 LET US SUM UP

Counseling needs in the Indian context emerge against the background of tremendous social change. In addition, the last ten years of economic reform have enhanced the pace of these changes and further transformed life styles. Counseling services are poorly defined and presently anyone at all with little or no training can offer these services. Available counseling services are largely based on Western approaches to psychology. These approaches have been widely criticised as not being relevant to the Indian cultural context. A relevant and culturally valid counseling psychology therefore has remained a fledgling discipline. Psychological thought is not new to India, and ancient traditions present ideas and constructs that are rich in possibilities for application. This paper examines the Western and the traditional Indian approaches and proposes that these approaches could together inform the development of a psychology of counseling that is empirically sound and culturally relevant to the Indian context.

4.11 UNIT END QUESTIONS

1) Describe the changing role of the counselor in the Indian context.
2) Explain the counseling approaches in the Indian Context.
3) What are the various kinds of counseling therapies used in India?
4) What is the relevance and suitability of counseling in the Indian context?
5) What is cultural preparedness? What are the implications of counseling in India?

4.12 SUGGESTED READINGS

Lawrence H. Gerstein, P. Paul Hepner, Stephania Egisdottir, Seung-Ming Alven leung & Kathryn L. Norsworthy (2009). *International Handbook of Cross-cultural Counseling: Cultural Assumptions and Practices Worldwide*. Sage Publications Inc. NY.

Sharma, Ramnath and Sharma, Rachna (2010). *Guidance and Counselling in India*. Atlantic publishers, New Delhi.

UNIT 1 COUNSELLING THEORIES AND PRACTICE

Structure

1.0 INTRODUCTION

We start with the nature and definition of counselling followed by listing out the goals of counselling. A discussion ensues regarding the reasons for clients seeking counselling and how various professionals use counselling as part of their skills. This is followed by a discussion on the qualities required of an effective counsellor. Three theories of counselling are presented which includes the psychodynamic theory, behaviour theory and humanistic theories of counselling. These theories are discussed in terms of their contribution to counselling practice. Then we discuss the various types of counselling available and in this we include also the HIV/AIDS counselling, grief counselling etc. This is followed by a discussion on counselling skills which includes establishing rapport, and the basic skills that are needed in three different stages and at the termination of counselling. Application of counselling skills to different set ups are taken up and presented.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define counselling;
- Explain the nature of counselling;
- Elucidate the goals of counselling;
- Delineate the Characteristics of an effective counsellor;
- Describe the Counselling structure; and
- Analyse the various Counselling skills needed for applying in different settings.

1.2 NATURE AND DEFINITION OF COUNSELLING

The terms 'helping' and 'counselling' are interchangeably used in the present society to denote any kind of assistance offered to other people in enabling them manage their adverse situations. These situations could be financial crisis, ill – health, lack of social support, disturbed relationships to name a few. But, there is a wide difference between helping and professional counselling. Let us understand these differences.

- Helping relationships involve giving advice while counselling does not.
- There may be a conflict of interests in some helping relationships.
- Helper might be judgemental but counsellor cannot be.
- Helpers may offer sympathy rather than empathy.
- Counsellors do not impose conditions or expectations upon clients while other helpers may expect their clients to behave in certain ways.
- Counselling is a relationship and it is a special form of communication.
- It involves listening
- One person helps another person or a group.
- It is based on the principle of empowerment.
- It is an activity carried out by trained people.
- It is guided by theories about the causes of problems and the methods needed to help.
- It recognises that each person is unique with unique experiences.

Counselling is an interactive process characterised by a unique relationship between counsellor and client that leads to change in the client in one or more of the following areas.

***Behaviour* :** Overt changes in the ways clients act, their coping skills, decision-making skills and relationship skills.

***Beliefs* :** Ways of thinking about one'self, others and the world.

***Emotions* :** Uncomfortable feelings and over and under reactivity to stimuli.

Counselling is defined as a process which takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or their dissatisfaction with life or loss of a sense of direction or purpose. This can be seen in the figure given below which provides the key aspects of counselling.

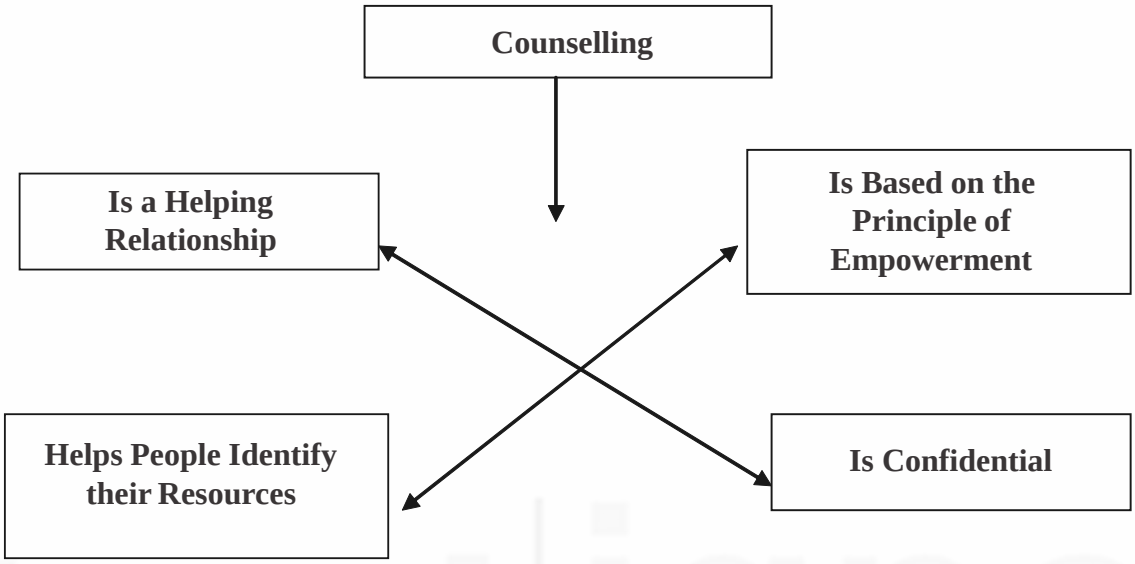

Fig. 1.1: Key Aspects of Counselling

Counselling is also defined as a process which takes place in a one to one relationship between an individual troubled by problems with which he cannot cope alone and a professional worker whose training and experience have qualified him to help others reach solutions to various types of personal difficulties.

These definitions indicate that counselling is not an advice giving activity but its primary aim is to help each individual who asks for help to resolve or reorganise his difficulties with a maximal degree of self sufficiency and self control.

The counsellor is not directly concerned with making plans and decisions for his clients.

His major mission is to organise learning situations in such a manner that the client will change his behaviour from what it was to something more personally satisfying and socially acceptable after gaining new perception and insight into his problem.

1.3 GOALS OF COUNSELLING

Counsellors may have different goals with different clients. Some of them are:

- Assisting them to heal past emotional deprivations;
- Manage current problems;
- Handle transitions;
- Help to make decisions;
- Manage crises;
- Develop specific life skills.

Counselling goals emphasise increasing client's personal responsibility for creating and making their lives better. The goal of counselling is to help the clients to make choices that enable them to feel, think and act effectively.

Counselling process helps the clients to acquire the capacity to experience and express feelings, think rationally and take effective actions to achieve their goals.

Self Assessment Questions

1) Define counselling.

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2) Describe the nature of counselling.

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3) Explain the goals of counselling.

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1.4 REASONS FOR SEEKING COUNSELLING

People seek counselling for a variety of problems:

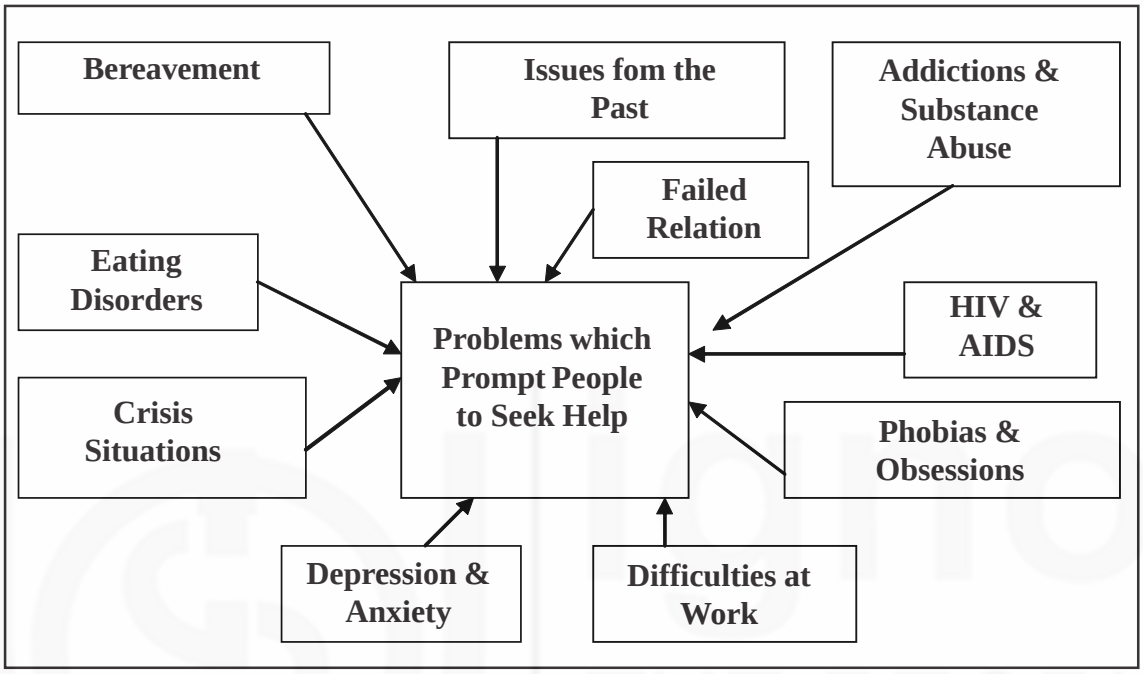
Sometimes problems may have become unmanageable or enhance the feelings of dissatisfaction or unhappiness with life. People may find themselves in self destructive relationships or fail to anticipate the consequences of their action. Though they express a desire to change, they feel it difficult. This could be because of lack of self awareness and insight into their problems. Sometimes, when physical symptoms fail to respond to medical investigation, people seek counselling. For example, this can be seen in the case of psychosomatic symptoms like skin problems, tension headaches, sleep disorders, tiredness, stomach problems and other symptoms.

Sometimes, when people lack motivation or direction they are propelled towards counselling. Academic under achievement, difficulties at work, lack of

assertiveness and low self-esteem are also reasons why people seek help through counselling.

Addictions and phobias are problematic for many people while others are troubled with anxiety, feelings of worthlessness and the belief that they would break down if help is not obtained.

Figure below outlines some of the reasons which may prompt people to seek counselling.



Apart from these, other reasons for seeking counselling include:

- Social problems
- Chronic illness
- Gambling
- Job loss and problems related to retirement
- Developmental crises
- Problems associated with sexual orientation or sexual identity
- Violence, rape and assault
- Bullying at school or at work.

1.5 USE OF COUNSELLING SKILLS AS PART OF MANY PROFESSIONS

Many people, including doctors, nurses and teachers require some counselling skills as part of their work. For example, doctors listen to their patients and they try to understand the complex messages which people in distress wish to convey. But doctors and others cannot devote necessary time to individual patients. Moreover, doctors tell their patients what to do, but their focus is more towards factual aspects than on the emotional aspects of the problems presented. So, the need is felt to impart counselling skills training to many professionals to enable them to discharge their duties more effectively.

Despite the limitations, many professionals use counselling skills as part of their work.

Some of these professionals are:

- Psychologists
- Welfare workers
- Career Counsellors
- Teachers
- Nurses
- Occupational therapists and Speech therapists
- Social workers
- Physiotherapists
- Voluntary and youth workers.

1.6 CHARACTERISTICS OF AN EFFECTIVE COUNSELLOR

It is necessary to possess some traits to become an effective counsellor. They are:

- A counsellor should be first committed to his own growth that is, physical, intellectual, social, emotional, in order to help others achieve.
- He should have adequate basic intelligence.
- He should be good at social and emotional intelligence.
- He should possess empathetic skills to understand the clients problem.
- He should respect the client and express his respect by being available to him, working with him and not judging him.
- He should genuinely care for the person who has come for help. It means he should be non-defensive, spontaneous and willing to say what he thinks and feels in the best interests of his client.
- A good counsellor is at home with people. He can handle crises, mobilise his own energies and those of others in order to act forcefully and decisively.
- An effective counsellor focuses on action to enable the client bring a constructive behaviour change.
- He should be able to use humour to ease the clients from distressing feelings.

Self Assessment Questions

1) What are the reasons for people to seek counselling?

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2) Which are the various professions that use counselling skills and why?

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3) What are the characteristics required of an effective counsellor?

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1.7 COUNSELLING THEORY (APPROACH)

Counselling theory deals with assumptions and hypotheses about the process of human development. The problems and difficulties which arise at various stages through out our life span as a result of environmental or other influences are considered under counselling theory.

The ways in which different forms of therapy and counselling approach these problems, and their individual methods of helping clients have evolved theories about human development and the acquisition of helpful and unhelpful behaviours.

1.7.1 Three Approaches to Counselling

Psychoanalytical and psychodynamic therapies

These are based on an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts. Psychoanalytic and psychodynamic are examples of this approach.

Due to the complexity of counselling there are many different approaches to supporting a client through the counselling process. This can depend on the style of additional support used or the individual exercises and teachings a counsellor demonstrates during the one to one counselling sessions. A psychodynamic approach provides a broad range of therapeutic approaches.

Psychodynamic therapy helps in counselling clients understand the root cause of their problems and issues. It also helps equip them with knowledge and suggestions to enable them to cope with further difficulties. With a strong emphasis on the trust between a client and counsellor or psychotherapist, psychodynamic therapy provides the tools required to make progress.

This form of counselling has roots in the theories of Sigmund Freud, and was initially developed in the 1940s. His studies focused on the belief that our emotions, thoughts and behaviour stem from the unacceptable thoughts from one's childhood that are allowed to influence the current thinking. These repressed thoughts and feelings eventually manifest as depression, fears and conflicts. The therapy is relationship centered and is powered by one's interactions with close friends and family.

Psychodynamic therapy helps by understanding and acknowledging that most emotional problems originate in a client's childhood, and that all experiences will have some kind of subsequent subconscious effect on the individual. Identification of subconscious thoughts and understanding how these thoughts affect behaviour are accomplished by reflecting and looking inward at the feelings, thoughts and reactions a client expresses.

Problems like depression etc. can be successfully treated and improved using some form of psychodynamic approach. This form of counseling relies on the interpersonal exchange between a counselor and client in order to establish and develop positive strategies that a client can use to create changes. Counsellors use non directive counseling in which they encourage the client to express feelings and emotions while they listen and watch out for clues to the root cause of a problem or issue.

Psychodynamic approaches take many forms and the key principles include:

i) Early experiences of a client in childhood is important

ii) All internal experiences relate to relationships with other people

iii) Free association and other techniques provide more information in exploring the problem

iv) Insight is essential in order to achieve positive progress and success in counseling.

Behavioural Therapy

This therapy focuses on an individual's learnt, or conditioned, behaviour and how this can be changed. The approach assumes that if behaviour can be learnt, then it can be unlearnt (or reconditioned). So it is useful for dealing with issues such as phobias or addictions. Examples of this therapy are behaviour therapy and cognitive behaviour therapy.

The behavioural approach to counselling makes the basic assumption that most problems are problems in learning and as such the behavioural counsellor tries to help the individual to learn new and more adaptable behaviours and to unlearn the old non adaptable behaviours. The behavioural counsellor focuses attention on the individual's ongoing behaviours and their consequences in his own environment of school and home. He tries to restructure the environment so that more adaptable patterns of behaviour can be learned and nonadaptable patterns of behaviour can be unlearned.

Humanistic Therapies

These focus on self-development, growth and responsibilities. They seek to help individuals recognise their strengths, creativity and choice in the 'here and now'. Person-centered, Gestalt and existential therapies come under this category. For

over fifty years a humanistic approach has been used in the field of therapeutic counselling. Although behavioural and psychoanalytic forms of counselling are also available, the humanistic approach is an extremely successful option.

Counselling clients with a humanistic approach provides them with an opportunity to explore creativity, personal growth and self-development, as well as acknowledging a variety of choices. The foundations of the humanistic approach provide the client with a deeper understanding of who they are, what they feel and the opportunity to explore the possibility of creating personal choices. It encourages self-awareness and self-realisation.

A humanistic approach provides a distinct method of counselling and focuses predominately on an individual's unique, personal potential to explore creativity, growth, love and psychological understanding.

Counsellor's specialising in providing clients with humanistic counselling are skilled in offering a non-judgmental, supportive and understanding service, in a safe and confidential environment.

There are many different types of humanistic counselling, all of which involve a close counselling relationship between the counsellor/therapist and the client. These include Gestalt Counselling, Transactional Analysis, Transpersonal Psychology, Depth Therapy and Humanistic Psychotherapy, to name but a few.

Self Assessment Questions

1) Discuss the psychodynamic theory of counselling.

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2) Describe how behaviour theory contribiutes to counselling.

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3) What are humanistic theories? How are they influential in cousnelling skills? Discuss

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1.8 TYPES OF COUNSELLING

The method a counselor chooses may be either direct approach (counselor-centered) or indirect approach (counselee-centered)—although a combination of both is often appropriate.

i) **Direct Approach:** When the counselor assumes the initiative and carries a major part of the responsibility for problem identification and resolution he or she is using the direct approach. This approach is called as "I talk, you listen". This direct approach to counseling might also be called the problem solving approach. It has both advantages and disadvantages that are given below.

Advantages of Direct Approach:

- Quickest method.
- Good for people who need clear, concise direction.
- Allows counselors to actively use their experience.

Disadvantages of Direct Approach:

- Doesn't encourage clients to be part of the solution.
- Tends to treat symptoms, not problems.
- Tends to discourage clients from talking freely.
- Solution is the counsellor's, not the client's.

ii) **Indirect Approach:** The indirect approach was developed primarily by the renowned psychologist Dr. Carl B. Rogers. In this method, the counsellor's participation is minimal, and the techniques of reflection and acceptance are used to encourage the counselee to freely express himself. The counsellor pays particular attention to the emotion and attitudes associated with the problem. The counselee is encouraged to choose the goals, make the decisions, and take responsibility for those decisions.

- Encourages maturity.
- Encourages open communication.
- Develops personal responsibility.
- Disadvantages:
- More time-consuming
- Requires greatest counsellor skill.
- Combined counselling
- Depending on the nature of the client, intensity of the problem and the available resources, combination of directive and nondirective approaches are used.

Advantages of Indirect approach:

- Moderately quick.
- Encourages maturity.
- Encourages open communication.

- Allows counsellors to actively use their experience.

Disadvantages of Indirect approach:

- May take too much time for some situations.

Counseling" is a very broad category that encompasses many opportunities in any number of types of counseling subfields.

Counselors do work in schools, hospitals, rehabilitation facilities, among other locations, or they can maintain a private practice, and there are many ways in which to specialise during their counseling career.

Here are some of the most common types of counselling:

- Marriage and family counselling
- Guidance and career counselling
- Rehabilitation counselling
- Mental health counselling
- Substance abuse counselling
- Educational Counselling

Other types of counselling used in other settings such as army etc., include the following:

- event-oriented counselling
- counselling for specific instances
- reception and integration counselling
- crisis counselling
- referral counselling
- promotion counselling
- adverse separation counselling
- performance counselling
- rofessional growth counselling

Guidance and career counseling are more geared toward those who are looking for career opportunities. Many have a difficult time deciding what career choice would be best for them. When it comes to considering talents, abilities, likes and opportunities, a career counselor is one that would most likely be best to help with these issues.

Rehabilitation counseling is relatively straightforward. It basically helps anyone who needs rehabilitation for any issue they have dealt with. This is somewhat similar to mental health counseling. Those who have suffered with mental issues of all kinds are those who should look into mental health counseling.

Substance abuse counseling is a therapy more in demand as there is a growing need for substance abuse victims in recent years. Substance abuse could include drugs, alcohol or anything else one becomes dependent upon. Indeed, there are several different types of specialised counseling available to fit the needs of any individual who would like to seek therapy for his or her problems.

In addition to the main specialties listed above, counselors can also assist their clients using techniques in areas such as these:

- Debt counseling
- Child development counseling
- Eating disorder therapy
- Grief counseling
- Art therapy
- Musical therapy

There is a huge body of empirical evidence supporting the effectiveness of counselling and psychotherapy for addressing many different kinds of psychological distress.

Self Assessment Questions

1) What are the various types of counselling?

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2) Discuss guidance and counselling and bring out the differences.

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3) Delineate the characterisitic features of rehabilitation counselling and HIV AIDS counselling.

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1.9 COUNSELLING PRACTISE (SKILLS)

Counseling involves a process, the aim of which is to help others to help themselves by making better choices and becoming better choosers of options. The counselor's repertoire of skills includes those of forming an understanding

relationship, as well as interventions, focused on helping clients change specific aspects of their feeling, thinking and acting.

In a counseling relationship, the counselor and client work together to explore every aspect of the client's circumstances, enabling the individual to re evaluate his or her experiences, capabilities and potential.

Counselors facilitate full and confidential expression of the client's feelings, without diverting any attention to their own feelings.

The responsibility for change is placed with the client. This means that when changes are made, they are self motivated, and therefore more likely to last and to be effective. Self reliance is a central tenet of counselling.

The counselor is perhaps the first person that the individual has met for a long time who truly listens without prejudice and whom he or she can trust utterly.

1) **Judgement:** A good counselor is someone who can learn not to make judgments on behalf of the person being helped. Although counsellors have their own values, these should not be imposed on the client and the counsellor must retain the ability to listen to and accept the views of clients with other standards.
2) **Experience Patience and Acceptance:** A counselor rarely needs to use his or her self control in dealing with people, even those people who are not likeable.
3) **Experience:** Learning to grow into a more complete person from the experience of life's hard knocks can be a valuable quality in a counselor.
4) **Education:** Formal degrees in psychology do not necessarily make good counsellors, but a common sense approach is not sufficient. Good counsellors are willing and able to learn about themselves and other people too.
5) **Social Skills:** It is not enough to be considered a good listener. Counselors learn through training how to perceive all aspects of verbal and non verbal communication, and deliberately improve their listening skills by using appropriate techniques during counselling.
6) **Genuineness and Warmth:** Effective counsellors have a genuine interest in other people. This is often referred to as respect or unconditional positive regard for the person being helped. People who do not need others in their lives may find this sort of warmth to unknown people as being problematic.
7) **Discretion:** Counselors must show complete discretion, never revealing what others say or do within the counselling context. Confidentiality is paramount in counseling relationships.
8) **Practice:** Counseling requires a lot of training, followed by much practice. A current job that will allow the possibility of a helping role could be very useful.

Learning to grow into a more complete person from the experience of life's hard knocks can be a valuable quality in a counselor.

The word 'skills' thus refer to the interpersonal tools which counsellors need to possess or acquire in order to communicate effectively with clients. These essential skills include those of:

- Listening and attending
- Paraphrasing
- Summarising
- Asking questions
- Encouraging clients to be specific
- Reflecting their feelings
- Helping them to clarify their thoughts
- Encouraging them to focus on key issues
- Offering forms of challenge and confrontation when needed.

1.9.1 Structure of Counselling

Counselling is a process which requires a coherent framework or structure. This structure acts as a guide for both counsellor and client. Egan devised a structural model of counselling which divides the process into three main components. They are:

Stage One: Review of the present situation

Stage Two: Development of a new or preferred scenario

Stage Three: Moving into action

i) *Stage One* of the models refers to the initial phase of counselling, where clients are encouraged to explore their problems so that they may develop a deeper understanding of them.

ii) *Stage Two* refers to the process of helping clients identify what they want and need in order to deal more effectively with problems.

iii) *Stage Three* is the phase of action, during which clients devise ways of actually dealing with problems.

Most clients experience a beginning phase where they seek to make a sense of their problems, a middle phase during which they consider what to do, and a later stage where they start to act.

All clients experiences are not identical in counselling. Most clients experience a beginning phase where they seek to make sense of their problems, a middle phase during which they consider what to do and a later stage where they start to act.

On the other hand, some clients come to counselling for a brief period and leave once they have been given the opportunity to explore their problems in the presence of someone who really listens. Such clients identify ways of coping with problems very early and feel able to formulate and implement courses of action quickly.

1.9.2 Establishing Rapport

Many clients find it difficult to get started unless they are asked one opening question. Some examples are:

Please sit down. How would you like to start?

Is there anything in particular that you would like to begin with?

Can you tell me about the issues which concern you at the moment?

How do you see your situation at present?

Once contact has been established and the client starts to talk, the counsellor can use a range of continuation skills to encourage further exploration. For example:

Yes, I see……

After that……

Please go on…..

Tell me more about……

So you feel…….

1.9.3 Basic Skills- Stage I

There are certain basic skills which are to be executed by all counsellors irrespective of the approach or theory they adopt in the counselling process. These skills are essentially used in the first stage and also through out the counselling process. Some of these skills are:

Attending and Listening: Active listening is an important skill in counselling. It refers to observation of client's non-verbal behaviour and as well as understanding of verbal content and meaning. The way something is said is as important as the actual words spoken. Since many clients have difficulty in using the words that express their feelings, observing non –verbal cues is important.

Attending and listening skills always go together in counselling. This is because it is not always possible to give full attention to the clients without actively listening to them. The counsellor also communicates to the client verbally and non-verbally.

Non-Verbal communication: Egan emphasised on the acronym SOLER to understand the aspects of non-verbal behaviour which encourage active listening.

S	Sit facing the client squarely as it assures the client that he has your attention.
O	Be Open in your posture.
L	Lean slightly towards the client as it shows attitude of interest.
E	Establish Eye contact with the client.
R	Relax

Gestures and Touch: Excessive use of gestures creates uneasiness between client and counsellor. So counsellors need to minimise these. Sometimes clients themselves may be anxious and restless initially, but when counsellors model attitudes of calm and stillness, clients become relaxed.

The issue of touch is problematic in relation to therapeutic counselling and in most instances touch is considered inappropriate for a variety of reasons. For example, clients who have experienced physical or sexual abuse in the past are fearful of this contact. Nurses may use touch in their interaction with patients but this may be impersonal. However, counsellors may use tactile expressions but considering cultural differences with regard to touch.

Silence: To listen effectively to the client, it is necessary to be silent. Counsellor need to show through his demeanour that he is 'with' the client in everything he says. Sometimes, clients require periods of silence in order to collect their thoughts or as a way of experiencing a strong feeling or emotion. If counsellors are tempted to fill in the spaces either through asking questions or finishing the client's sentences, clients regard this as intrusive and insensitive.

Verbal Communication

Reflection : It refers to the skill of communicating back to the client that her words and feelings have been heard. It indicates that the counsellor is listening carefully to her and especially on the emotional content of what the client has expressed.

Paraphrasing: It refers to the rewording of the content of what clients say. But it should not be the verbatim of client's narration. This skill can be developed by concentrating first on content and then focusing on emotional content.

Summarising : This skill is used when a helper wishes to respond to a series of statements or to a whole session. This skill requires active listening, empathy, the ability to stay with client's frame of reference and the ability to connect all random threads into a coherent framework.

Asking Questions : Sometimes counsellors ask variety of questions depending on the nature of problems inorder to get the facts from the clients. Some of them are —

Open questions : These are used to encourage clients to explore their problems in greater depth.

Multiple questions: Several questions are asked at once and the client doesn't know which to reply.

Leading questions: These questions lead the client in a certain direction, usually in the counsellor's viewpoint.

Probing skills: These are meant to encourage clients to expand on their initial response.

Focusing questions: These questions encourage clients to look more closely at specific aspects of a problem and to define issues more clearly.

Self Assessment Questions

1) Explain the acronym SOLER.

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2) Discuss the significance of verbal communication.

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3) Delineate the various skills in counselling.

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1.9.4 Challenging Skills - Stage II

Along with basic skills, stage –II of counselling requires the use of challenging skills which will help clients to develop new perspectives about themselves and the problems they experience. The word challenge refers to the skill of encouraging clients to confront their own behaviour, attitudes or beliefs. The skills used in this phase are –

Immediacy: This skill is used to describe the process of discussing what is actually taking place right now in the counselling situation.

Self-disclosure: Counsellor discloses his experience or information related to him to the client when he feels the need of it. But this disclosure has to be appropriate and properly timed. This is especially used in contexts like counselling for substance abuse or addiction.

Giving information to clients: Information giving can also prove challenging for clients, especially when their expectations are unrealistic in some way.

Identifying patterns and themes: Sometimes there are recurrent themes which are discernible in the problems which clients recount. Once a relationship of trust has been established between counsellor and client, it is possible to identify these patterns so that clients are challenged to consider them seriously.

1.9.5 The Action Phase - Stage III

In the third stage of the counselling process, clients are encouraged to act, helped by the new understanding and knowledge which they have acquired in the previous two stages. Along with the counsellor, the client explores a variety of ways and means to achieve goals. A plan of action is discussed and formulated, and through out this process the counsellor supports the client and helps him monitor and evaluate any changes proposed.

All the skills of stage I & II are used here along with new set of skills which include the following —

Goal setting and Choosing Programmes

Many clients may have unsatisfactory work, relationship or other problem situations over long periods of time. So setting realistic goals is one way of helping clients to plan the changes they need to make by providing them the needed support and encouragement. Realistic goals are dependent on the internal and external resources and when there is a discrepancy between goals and resources, adjustments need to be made. The following questions can be asked in relation to any goals which are formulated:

Are they clear?

Are they specific?

How realistic are they?

Are they measurable?

Clients can be encouraged to write down their goals in clear and specific terms. For instance, the client can be asked to explore –

What is it I want?

How can I achieve this?

Why should I do this?

Creative thinking

When clients are emotionally upset or under great stress, creative thinking may be difficult for clients. However, when clients are ready to act, there are certain strategies for encouraging creative thinking which help them to look at new ways of tackling their problems. These are *idea storming, visualisation and imagery.*

Giving encouragement

It is important to encourage clients through out the counselling process. It expresses trust and confidence in the client's ability, judgement and capacity for self-development. When clients are confronted with barriers, they easily give up at which time, the counsellors need to direct the attention of the clients to their personal resources and achievements.

Evaluation

It is necessary if clients have to achieve their goals. The appropriateness of any goal or action should be monitored and reviewed and when this is done clients tend to feel more confident about their progress.

1.9.6 Ending Sessions

The counsellors need to develop the skill of ending individual sessions especially when clients talk at great length. One way of dealing this is to mention the time boundaries at the begin of counselling. Another idea is to state the time ten minutes before the session is due to end.

1.10 APPLICATION OF COUNSELLING THEORY AND PRACTICE (SKILLS)

There is a wide range of specific contexts in which counselling and therapy are used. Counselling practitioners can work alone, work together within an agency or organisation or as specialists work in multidisciplinary teams. The diverse modes and settings in which counselling is provided are –

- Couples counselling
- Family therapy
- Group counselling
- Telephone counselling
- Schools, colleges and university
- Voluntary work
- Health centre
- Hospitals and
- Work place

1.11 LET US SUM UP

The terms 'helping' and 'counselling' are interchangeably used in the present society to denote any kind of assistance offered to other people in enabling them manage their adverse situations. These situations could be financial crisis, ill – health, lack of social support, disturbed relationships to name a few. But, there is a wide difference between helping and professional counselling.

Counselling is defined as a process which takes place in a one to one relationship between an individual troubled by problems with which he cannot cope alone and a professional worker whose training and experience have qualified him to help others reach solutions to various types of personal difficulties.

Counselling goals emphasise increasing client's personal responsibility for creating and making their lives better. The goal of counselling is to help the clients to make choices that enable them to feel, think and act effectively.

The word 'skills' refer to the interpersonal tools which counsellors need to possess or acquire in order to communicate effectively with clients. The basic skills include– listening and attending, paraphrasing, summarising, asking questions and encouraging clients to be specific and reflecting their feelings. Stage-II skills include – self-disclosure, immediacy and identifying patterns and themes. Stage –III skills include – goal setting, creative thinking and encouragement.

Counselling theory and skills can be used in couples counselling, family therapy, group counselling, telephone counselling, schools, colleges and university, voluntary work, hospitals and work place.

1.12 UNIT END QUESTIONS

1) Discuss the difference between helping and counselling process.

2) Explain the goals of counselling.

3) How would you develop a rapport with the client?

4) Explain the importance of verbal and non-verbal communication in counselling.

5) Discuss the challenging skills that are required at stage-II.

6) Explain the skills required in action phase.

7) How is a counselling session terminated?

1.13 GLOSSARY

Paraphrasing : It refers to the rewording of the content of what clients say. But it should not be the verbatim of client's narration.

Summarising : This skill is used when a helper wishes to respond to a series of statements or to a whole session.

Immediacy : This skill is used to describe the process of discussing what is actually taking place right now in the counselling situation.

Self- disclosure : Counsellor discloses his experience or information related to him to the client when he feels the need of it.

1.14 SUGGESTED READINGS

Gibson, R. L. & Mitchell, M. H. (2005). *Introduction to Counseling and Guidance.* Sixth edition. Prentice Hall of India, New Delhi.

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UNIT 2 PERSON CENTRED THEORY OF COUNSELLING

Structure

2.0 INTRODUCTION

This unit deals with person centered theory of counselling and also presents the person centered counselling. It starts with the basic concepts of Rogers' person centered approach. Within this we discuss the concepts of self, the self actualising tendency, the self concept, the frame of reference, the dignity and worth of the individual and the experiential field. This is followed by the development of self concept and how it happens and how it is influenced by the positive self regard and conditions of worth. Then we discuss the role of self concept in sustaining maladjustment and explain how such maladjustments come about as a result of incongruence between self concept and experience of a person. Then we delineate the self concept and its importance and bring out the difference between the real and the dieal self. Then we take up the various conditions required to facilitate development of positive self concept. This is followed by person centered counselling and its goals. We discuss the counselling relationship and the qualities of a mature person and a person of the future and who benefit from person centered counselling.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define basic concepts of person centerd theory;
- Describe development and maintenance of self- concept;
- Explain role of self concept in sustaining maladjustment;
- Delineate the importance of self concept;
- Explain the core conditions for developing positive self concept;
- Analyse the conditions for effective counselling;
- Describe Counselling relationship; and
- Elucidate the qualities of mature person and a person of the future.

2.2 PERSON CENTRED APPROACH TO COUNSELLING

According to Sigmund Freud's psychoanalytical theory, people are governed by powerful forces originating in the unconscious, and it is these forces which compel them to act in certain ways. Freud stressed on the concepts of drives, instincts, impulses and urges as motivating factors in human behaviour. Freud's theory focused on sexual and aggressive tendencies as the primary forces driving human behaviour..

In sharp contrast to this, the human potential movement, by contrast, defined human nature as inherently good. From its perspective, human behaviour is motivated by a drive to achieve one's fullest potential. Carl Rogers developed person centered approach to counselling based on the premise of humanistic theory. Humanistic approach believes in the uniqueness and goodness of each individual. Humanists believe that human beings are capable of thinking rationally, can make their choices wisely and are also aware of the consequences of their actions.

In all of Rogers's writings, the emphasis has been on the importance of each person being an architect of his or her own destiny.

Carl Rogers firmly believed that every individual has sufficient innate resources to deal effectively with the problems in life. Even though sometimes these innate resources are obscured, forgotten or even denied, they are nevertheless, always present with the potential for development and growth. Rogers' insistence on the uniqueness of the individual, and individual's innate tendency towards growth and wholeness, seemed to represent a more optimistic and positive view point of humans in contrast to the totally deterministic view of Psychoanalytic theory of Freud.

Rogers emphasised that just as the plants need the right conditions to grow, so do the human beings require the right conditions to grow and develop. The following saying (refer to the box below) sums up many of his deeper beliefs about human growth:

> If I keep from meddling with people, they take care of themselves,
>
> If I keep from commanding people, they behave themselves,
>
> If I keep from preaching at people, they improve themselves,
>
> If I keep from imposing on people, they become themselves.

2.3 BASIC CONCEPTS OF ROGERS PERSON CENTERED APPROACH

Person centered therapy, which is also known as client centered, non directive, or Rogerian therapy, is an approach to counseling and psychotherapy, that places much of the responsibility for treatment process on the client, with the therapist taking a nondirective role.

Person centered therapy has two primary goals , viz., (i) increased self-esteem and (ii) greater openness to experience. Some of the related changes that this form of therapy seeks to foster in clients include the following:

- closer agreement between the client's idealised and actual selves
- better self-understanding
- lower levels of defensiveness, guilt, and insecurity
- more positive and comfortable relationships with others
- increased capacity to experience and express feelings at the moment they occur.

2.3.1 Self

The human organism's "phenomenal field" includes all experiences available at a given moment, both conscious and unconscious (Rogers, 1959). As development occurs, a portion of this field becomes differentiated and this becomes the person's "self". The "self" is a central construct in this theory. It develops through interactions with others and involves awareness of being and functioning. The self concept is "the organised set of characteristics that the individual perceives as peculiar to himself/herself". It is based largely on the social evaluations that the individual has experienced.

2.3.2 Self-Actualising Tendency

A distinctly psychological form of the actualising tendency related to this "self" is the "self-actualising tendency". Self-actualisation, a term derived from the human potential movement, is an important concept underlying person centred therapy. It refers to the tendency of all human beings to move forward, grow, and reach their fullest potential.. The person centred approach states that all psychological difficulties are caused by blockages to this actualising tendency and consequently the task of counselling is to release this motivating drive.

Individuals appear to have two motivational systems, their organismic actualising tendency and their conscious self. The actualising tendency is responsible for every aspect of human endeavour and achievement. The actualising tendency is present from birth onwards. It describes the holistic development of all aspects of the person, including the spiritual, emotional, physical and creative dimensions. When humans move toward self actualisation, they are also pro social. That is, they tend to be concerned for others and behave in honest, dependable, and constructive ways. The concept of self actualisation focuses on human strengths rather than human deficiencies. According to Rogers, self actualisation can be blocked by an unhealthy self concept (negative or unrealistic attitudes about oneself).

It involves the actualisation of that portion of experience symbolised in the self (Rogers, 1959). It can be seen as a push to experience oneself in a way that is consistent with one's conscious view of what one is. Connected to the development of the self concept and self actualisation are secondary needs which all have been learned in childhood as one grows up interacting with caregivers and parents. That is, for healthy growth and development of the person, the individual needs positive regard from others and this need for positive self regard, if is present in the child's life as he grows up, he develops a healthy personality a positive outlook and a positive self regard. These in turn make the person behave in a way that is in congruence with his self regard and positive self concept.

2.3.3 Self-Concept

In the person centred therapy, it is essential to comprehend some basic concepts of self in understanding the client's personality. Self concept has at least three major qualities of interest to counsellors which are given below.

1) it is learned,
2) it is organised, and
3) it is dynamic.

Self concept is learned.

It is of course well known that, no one is born with a self concept. It gradually emerges in the early months of life and is shaped and reshaped through repeated perceived experiences, particularly with significant others. The fact that self concept is learned has some important implications. These are enumerated below.

- Because self concept does not appear to be instinctive, but is a social product developed through experience, it possesses relatively boundless potential for development and actualisation.

- Individuals perceive different aspects of themselves at different times with varying degrees of clarity. Therefore, inner focusing is a valuable tool for counseling.

- Any experience which is inconsistent with one's self concept may be perceived as a threat, and the more of these experiences there are, the more rigidly self concept is organised to maintain and protect itself. When a person is unable to get rid of perceived inconsistencies, emotional problems arise.

Self Concept is organised.

Most researchers agree that self concept has a generally stable quality that is characterised by orderliness and harmony. Each person maintains countless perceptions regarding one's personal existence, and each perception is orchestrated with all the others. It is this generally stable and organised quality of self concept that gives consistency to the personality. This organised quality of self concept has corollaries as given below.

- Self concept requires consistency, stability, and tends to resist change. If self concept changed readily, the individual would lack a consistent and dependable personality.

- At the heart of self concept is the self as doer, the "I," which is distinct from the self as object, the various "me's." This allows the person to reflect on past events, analyze present perceptions, and shape future experiences.

- Perceived success and failure impact on the self concept. Failure in a highly regarded area lowers evaluations in all other areas as well. Success in a prised area raises evaluations in other seemingly unrelated areas.

Self Concept is dynamic.

To understand the active nature of self concept, it helps to imagine it as a compass , the pointer of which shows consistently the North direction. Similarly self concept is a continuously active system that dependably points to the person's true perceived existence. This guidance system

a) shapes the ways a person views oneself, others, and the world,

b) it also serves to direct action and enables each person to take a consistent "stance" in life.

Rather than viewing self concept as the cause of behaviour, it is better to consider it as providing consistency in personality and direction for behaviour. The continuity of self concept can be seen as given below.

- Self concept development is a continuous process. In the healthy personality there is constant assimilation of new ideas and expulsion of old ideas throughout life.

- Self concept continuously guards itself against loss of self esteem, for it is this loss that produces feelings of anxiety.

- Self concept is perceptual or subjective frame of reference, the actualising tendency and experiences of the client.

2.3.4 Perceptual or Subjective Frame of Reference

Behaviour is generally viewed from either external or internal frame of reference. External frame of reference means that an individual's behaviour is seen in terms of the point of view of an outsider. On the other hand, the internal frame of reference means that the behaviour of the individual is seen in terms of one's own subjective perceptual frame of reference. This emphasis on the subjective, perceptual view of clients has led to the term 'client centred.'

According to Carl Rogers an individual has an innate tendency toward actualisation, which means that the individual has an inherent tendency to move in directions that can be roughly described as growth, health, adjustment, socialisation, self-realisation, independence, and autonomy so as to maintain or enhance the organism. The person expresses himself (herself) in varied ways in his or her interactions with the self and the environment and others. Rogers thinks that the person's life is an active and not a passive process, one of growth and development.

2.3.5 Recognising the Dignity and Worth of Individual

According to Rogers' theory, one must believe in the dignity and worth of individuals as both independent and self directing. Every individual has an internal frame of reference, that is a subjective reality that attempts at emphasising objective reality too.

Genuineness, respect, warm acceptance, and accurate empathy if shown by the counselor to the client and registered fairly early, there is a far better chance that the personality changes will not only occur, but will be steadied and maintained.

2.3.6 The Experiential Field

The individual may not be aware of much of his experience, until his attention is drawn to that experience. However, this experience is available to conscious awareness. The total range of experience at any given moment may be called the 'experiential', 'perceptual' or 'phenomenal field'.

Self Assessment Questions

1) Delineate the basic concepts of person centered approach / theory of Carl Rogers.

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2) Describe self actualising tendency.

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3) What do you understand by the term recognising the dignity and worth of the individual ?

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2.4 DEVELOPMENT OF SELF CONCEPT

Rogers believed that people will move towards autonomy and self-direction if given the right conditions and opportunities. The concept of 'Self' is important and refers to the 'I' or the 'me' part of each person. According to Rogers, personality development can be viewed in terms of self concept development, which in turn depends on the individual's interaction with other people and the environment.

From a very early age children seek to please their parents or care takers who are, after all, the most important people in the world to them. Each person's self concept is acquired in this way, and is continually reinforced throughout life as a result of ongoing interaction with others. The small child sees herself reflected in the attitudes expressed by parents and other important people. And when very little love and a great deal of criticism are received, a negative self concept is bound to follow.

Clients in counselling often refer to their 'real' selves. They often do so with regret and sadness, especially when they have never before been given the opportunity to identify and express their authentic needs and feelings.

2.4.1 Need for Positive Regard

A need for positive regard from others is a learned need development in early infancy. On many occasions the young person's behaviour and experiencing of his behaviour will coincide with positive regard from others and hence meet his need for positive regard. For instance, smiling at parents may reflect a pleasurable experiencing as well as generating positive regard.

However, on other occasions, the young person may feel that he is experiencing conflicts with his need for positive regard from significant others. Rogers gives the example of the child who experiences satisfaction at hitting his baby brother, but who experiences the words and actions of his parents saying 'You are bad, the behaviour is bad, and you are not loved or lovable when you behave this way'.

As a consequence the child does not acknowledge the pleasurable values of hitting his baby brother and place a negative value on the experience because of the attitudes held by his parents and his need for positive regard.

2.4.2 Conditions of Worth

This refers to when a person alters the true self in order to receive positive regard from others. These people are incongruent with their true selves. E.g. a person becoming a doctor to please parents not because he want to be one. People learn to alter the self's values at a young age if unconditional positive regard is not received. Individuals differ in the degree to which they internalise conditions of worth depending on the emotional quality of their environment and the extent of their need for positive regard.

For some, their positive self concepts will allow them to perceive their experiences accurately while those who had negative self concept develop negative notions.

Some common examples of conditions of worth are:

'Achievement is very important and I am less of a person if I do not achieve'.

'Making money is very important and, if I do not make much money, then I am a failure'.

'Sexual fantasies and behaviours are mostly bad and I should not like myself for having them'.

Thus, conditions of worth entail not only internalised evaluations of how individuals should be, but also internalised evaluations about how they should feel about themselves if they perceive that they are not the way they should be.

2.5 ROLE OF SELF CONCEPT IN SUSTAINING MALADJUSTMENT

For the counsellor, the emphasis is not on how clients become the way they are, but what is causing them currently to perpetuate behaviour which does not meet their real needs.

Rogers observed that when experiences occur in the life of an individual there are four possible outcomes as given below.

i) First, the experiences may be ignored.

ii) Second, they may be accurately perceived, and because they are consistent with the self concept, they may be reinforced.

iii) Third, their perception may be distorted in such a way as to resolve the conflict between self concept and experiencing. For instance, a student with a low academic self concept may receive some positive feedback about an essay and perceive 'The teacher did not read it properly,' or 'The teacher must have low standards'.

iv) Fourth, they may be denied or not perceived at all. For example, a woman may have had her self concept deeply influenced by a strict moral upbringing and thus be unable to perceive her cravings for sexual satisfaction.

Individuals have two valuing processes, viz., (i) their own organismic valuing process and (ii) an internalised process based on conditions of worth.

The low functioning person is out of touch with his own valuing process for large areas of his experiencing. In these areas his self concept is based on conditions of worth which cause him to distort and deny much of his experiencing. On the other hand, the high functioning person has fewer conditions of worth and thus is able to perceive most of his experiences accurately. Figure below represents the processing of experience by low and high functioning persons.

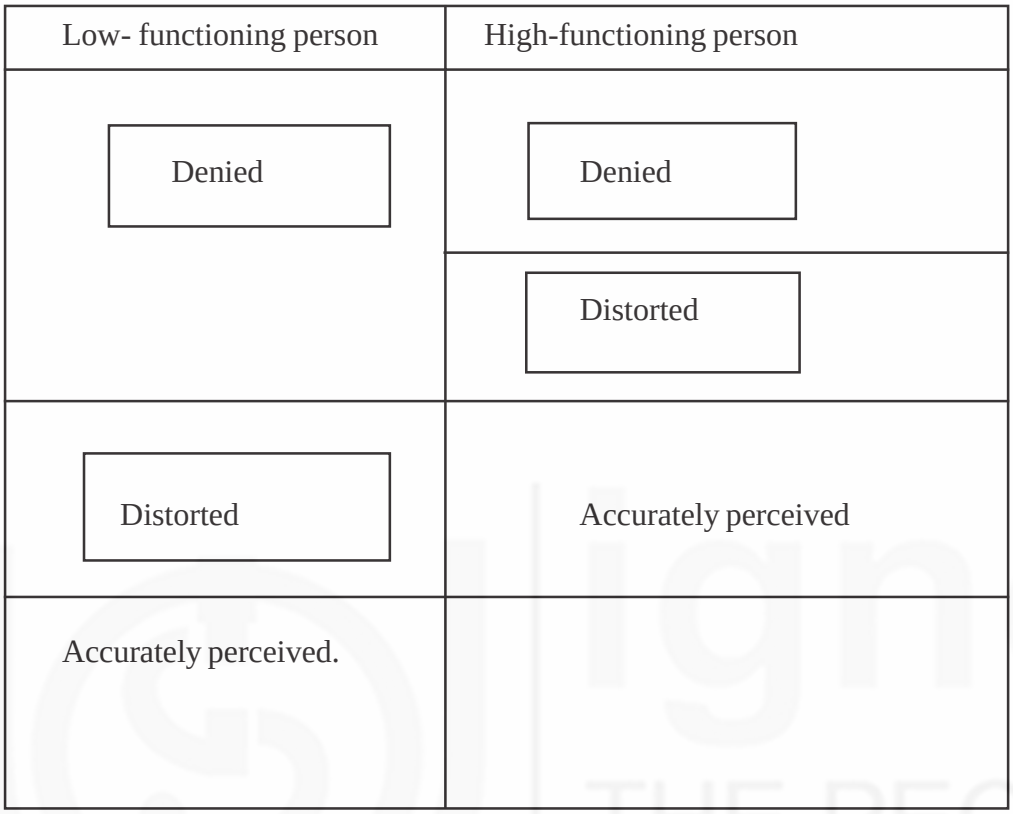

Fig.2.1: Diagrammatic representation of processing of experience by low functioning and high functioning people

2.5.1 Incongruence between Self Concept and Experience

When experiences are accurately symbolised and included in the self concept, there is a state of congruence between self concept and experience.

But, when experience is denied and distorted, there exists a state of incongruence between self concept and experience. This state of incongruence may exist where experiences are positive as well as where they are negative.

Clients tend to have low self concepts and frequently deny and distort positive feedback from outside as well as inhibit positive feelings from within.

2.5.2 Breakdown and Disorganisation

The self concept of a very low functioning person blocks his accurate perception of experiences. If, however, a situation develops, in which a significant experience occurs suddenly, the process of defence may be unable to operate successfully.

Thus, anxiety may be experienced to the extent to which the self concept is threatened.

Also as the process of defence was unsuccessful, the experience is symbolised in awareness. That is, the individual is brought face to face with more of his denied experiences than he can handle. This in turn leads to an ensuring state of disorganisation and the possibility of a psychotic breakdown.

Self Assessment Questions

1) Define self concept.

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2) What are the factors that contribute to the development of self concept?

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3) How does self concept sustain maladjustment?

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4) Describe breakdown and disorganisation of self.

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2.6 IMPORTANCE OF SELF CONCEPT

The self concept is a unique complex of many different self conceptions which constitute an individual's way of describing and distinguishing himself. For instance, the shape of one's nose may be felt as important by one person while another may not be aware of it. The self concept may be described in statements such as 'I am a good carpenter,' 'I like Ice-cream' and 'Meeting new people makes me nervous'.

2.6.1 Congruence-Incongruence

When self conceptions match the person's experiences in reality, there is congruence between self conception and experience.

When self conceptions are different in varying degrees from the reality of a person's experiences there is a state of incongruence.

2.6.2 Conditions of Work

Incongruence implies that a self conception is based on a condition of worth rather than on the organism's own valuing process. For example, an incongruent self conception for a particular individual may be 'I want to be a doctor', whereas a congruent self conception for that individual may be 'I want to be an artist'. Being a doctor may be based on values internalised from parents, whereas being an artist represents the organism's own valuing process.

2.6.3 Subception and Defence

Experiences may be denied or distorted by the process of subception. Subception means a perceptual defence that involves unconsciously applying strategies to prevent a troubling stimulus from entering consciousness. This defends existing self conceptions by preventing the person from perceiving incongruence and hence possibly changing both self conceptions and behaviour.

2.6.4 Level of Self-Regard

Another way of expressing 'level of self-regard' is the degree to which the individuals prise themselves'. Rogers state that when individual's self concept is such that no self experience can be discriminated as more or less worthy of positive regard than any other, then he is experiencing unconditional positive self regard. 'Level of self-acceptance' is a further way of stating level of self regard.

2.6.5 Real and Ideal Self

Real self conceptions represent perceptions of how I am, ideal self conceptions represent conceptions of how I would most like to be. Both real and ideal self conceptions forms parts of an individual's self concept complex.

2.7 CONDITIONS FACILITATING AND DEVELOPING POSITIVE SELF CONCEPT

The adequacy of the self concepts of parents affects the way in which they relate to their children. The level of self acceptance or self regard of parents may be related to their degree of acceptance of the behaviour of their children.

Rogers observes that parents are able to feel unconditional positive regard for a child only to the extent that they experience unconditional self regard. Further more, the greater the degree of unconditional positive regard that parents show toward the child, the fewer the conditions of worth in the child and the higher the level of its psychological adjustment.

High functioning parents create the conditions for the development of high functioning children. By 'unconditional positive regard', Rogers means prising a child even though the parent may not value equally all of his behaviour.

Self Assessment Questions

1) Discuss the importance of self concept.

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2) Define subception and defence . How do they contribute to self concept?

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3) Differentiate between the real and ideal self.

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4) What are the conditions required to facilitate developing positive self concept?

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2.8 GOALS OF COUNSELLING

Person centred goals are the same for clients, for counsellors and for every one. Rogers also made a later statement on the qualities of the 'person of tomorrow' who can live in a vastly changed world. He considers that a 'paradigm shift' is taking place from old to new ways of conceptualising the person.

2.8.1 The Fully Functioning (Mature) Person

Through person centered counselling the therapist aims to make a person fully functioning person or a mature person. Such a person will have the following qualities.

- Open to experience and able to perceive realistically
- Rational and not defensive
- Engaged in existential process of living
- Trusts in organismic valuing process
- Construes experience in extensional manner
- Accepts responsibility for being different from others
- Accepts responsibility for own behaviour
- Relates creatively to the environment
- Accepts other as unique individuals
- Prises himself
- Prises others
- Relates openly and freely on the basis of immediate experiencing
- Communicates rich self-awareness when desired.

2.8.2 The Person of Tomorrow

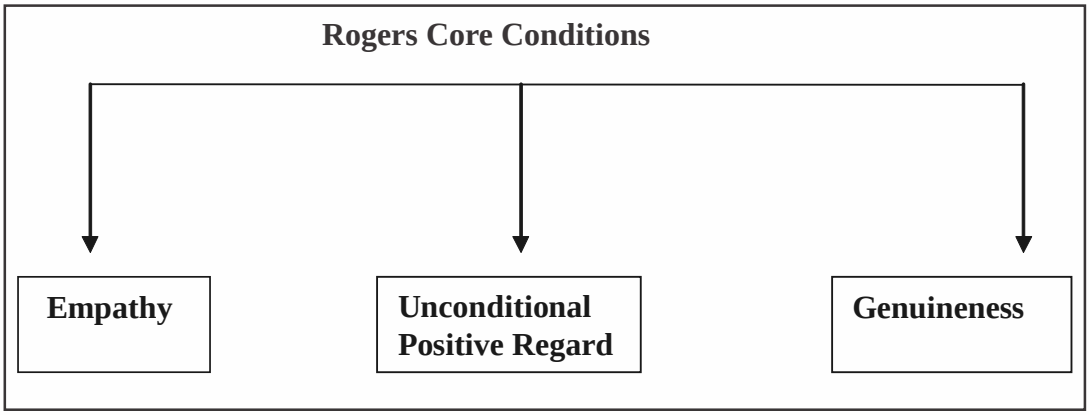
The person of tomorrow will develop the qualities given below as a result of person centered counselling.

Qualities

- Openness to the world, both inner and outer
- Desire for authenticity
- Scepticism regarding science and technology
- Desire for wholeness as a human being
- The wish for intimacy
- Process persons
- Caring for others
- Attitude of closeness towards nature
- Anti-institutional
- Trust of the authority within
- Material things unimportant
- A yearning for the spiritual.

2.9 THE CORE CONDITIONS FOR EFFECTIVE COUNSELLING

Rogers identified certain core conditions which he believed to be necessary if clients are to make progress in counselling. These conditions describe counsellor qualities and attitudes which will facilitate change and growth within the client. Among the most important of these attitudes is the counsellor's ability to understand the client's feelings. Another is respect for the client, while a third is described as counsellor congruence or genuineness. Figure below shows the core conditions for effective counselling.



2.9.1 Empathy

The word empathy describes the counsellor's ability to understand the client at a deep level. It involves an awareness of what it that the client is actually experiencing. Rogers refers to the internal frame of reference to denote the client's unique experience of personal problems.

The task for the counsellor is to get inside the client's frame of reference. If this is not achieved, then no real point of contact is made between counsellor and client. Rogers uses the term external frame of reference to describe this lack of understanding and contact.

When a counsellor perceives the client from an external frame of reference, there is a little chance that the client's view be clearly heard. In order to stay within the client's internal frame of reference, it is necessary for the counsellor to listen carefully to what is being conveyed (both verbally and non-verbally) at every stage of counselling.

The counsellor needs to imagine and appreciate what it is like to actually be the client, and this appreciation of the client's experience then needs to be conveyed to him.

2.9.2 Unconditional Positive Regard

The need for positive regard is to present in all human beings from infancy onwards. This need is so imperative that small children will do almost anything in order to achieve it. People need love, acceptance, respect and warmth from others. But on fortunately these attitudes and feelings are often only given conditionally.

Parents may say, or imply, that their love is given on condition that certain criteria are met, and when this happens it is impossible for children to feel valued for themselves alone. Rogers believed that counsellors should convey unconditional positive regard or warmth towards clients if they are to feel understood and accepted. This means that clients are valued without any conditions attached, even when they experience themselves as negative, bad, frightened or abnormal.

Acceptance implies a non-judgmental approach by counsellors, and it also caring in a non-possessive way. When attitudes of warmth and acceptance are present in counselling, clients are likely to accept themselves, and become more confident in their own abilities to cope. However, acceptance of clients does not mean that

counsellors must like to approve of everything they do. The values and views held by clients may differ quite dramatically from those held by individual counsellors, but even in these circumstances clients deserve (and should receive) respect and positive regard from the people in whom they confide.

2.9.3 Congruence or Genuineness

The words genuineness and congruence describe another quality which Rogers believed counsellors should possess. This quality is one of sincerity, authenticity and honesty within the counselling relationship. In order to be congruent with clients, counsellors need to be themselves, without any pretence or façade. This means, of course, that counsellors need to know themselves first. In the absence of self-knowledge, it would be totally impossible to develop attitudes of openness and honesty in relation to clients.

A very important aspect of counsellor genuineness is that it acts as a model for clients who may find difficult to be open and genuine themselves.

Self Assessment Questions

1) What are the qualities required for a fully functioning or a mature person?

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2) What qualities are important for the person of tomorrow?

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3) What are the core conditions for effective counselling?

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2.10 THE COUNSELLING RELATIONSHIP

The person centred counselling relationship is based on respect for the client, on the establishment of an empathic bond, and on willingness on the counsellor's part to be open and genuine with the client. In addition to these qualities, however, there is also an emphasis on facilitating each client's growth or self-actualisation. Self-actualisation can only be achieved when the core conditions described above are present in the relationship. The counselling skills are necessary for the development of a therapeutic relationship between counsellor and client.

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

2.11 CLIENTS WHO BENEFIT FROM PERSON CENTERED COUNSELLING

The person centred approach has wide application within the helping professions, the voluntary sector, human relations training.

Group work, education and institutional settings where the goals are to foster good inter personal skills and respect for others.

In the context of therapy and counselling, the person centred approached is suitable for use with clients in the first stages of crisis. Later on, however, clients to crisis may need a more directive approach to help them cope with the practical and long-term aspects of their problems.

Person-centred counselling has significant advantages over some of the other models. This is because it encourages clients to consider and identify their own feelings and needs, something which many women (especially those who have spent a lifetime earning for others) may never have been able to do before.

Clients who have been bereaved should also benefit from the person-centred approach, since one of the things which bereaved people appear to need most of all is validation of their individual responses to loss.

People with relationship difficulties should derive some advantage from working with a counsellor who gives them respect, understanding and openness which they may not have experienced in everyday life.

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

Many support groups work by extending the core conditions to its members. Alcoholics Anonymous is a case in point, and is a good example of the therapeutic effects of respect, understanding and openness for people who want to change.

Telephone counselling is another therapeutic medium through which Rogerian attitudes can be extended to clients, especially those clients who are in deep crisis.

2.12 LIMITATIONS OF PERSON CENTERED COUNSELLING

Person-centred counselling is an approach which is suitable for most clients, though some with deeply repressed traumas and conflicts may benefit from a more psychodynamic perspective. However, the core conditions which Rogers described would certainly work effectively if combined with appropriate skills from the psychodynamic model.

People with depression, addiction, phobias or eating disorders are also likely to derive more help from other models.

Clients with alcohol problems may need more support than the kind which can be offered through individual counselling. Even when the core conditions are present in a one-to-one therapeutic situation, they may not be enough to sustain change for clients with some addictive problems.

Another important factor to remember here is that deeply distressed and addicted clients (providing they are committed to change) may respond more positively in the presence of others with similar problems. Clients with respective thoughts and obsessions will probably gain more from cognitive behavioural approach to counselling, and there is no doubt that certain clients benefit from a more directive and structured approach generally.

Cultural difference can also influence they way clients perceive those who help them, and person-centred counsellors may sometimes be seen as passive or lacking in initiative by people who value advice or other more directive forms of intervention.

Self Assessment Questions

1) Describe the counselling relationship.

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2) Who are the persons who would benefit from person centered counselling?

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3) What are the limitations of person centered counselling?

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2.13 LET US SUM UP

Carl Rogers developed person – centered theory of counselling based on the premise of humanistic approach. Humanistic approach believes in the uniqueness and goodness of each individual. Humanists believe that every human – being is capable of thinking rationally, can make his choices wisely and is also aware of the consequences of his actions. It is essential to comprehend some basic concepts of self in understanding the client's personality. These are perceptual or subjective frame of reference, the actualising tendency and experiences of the client.

The concept of 'Self' is important and refers to the 'I' or the 'me' part of each person. According to Rogers, personality development can be viewed in terms of self concept development, which in turn depends on the individual's interaction with other people and the environment.

Rogers identified certain core conditions which he believed to be necessary if clients are to make progress in counselling. These conditions describe counsellor qualities and attitudes which will facilitate change and growth within the client. Among the most important of these attitudes is the counsellor's ability to understand the client's feelings. Another is respect for the client, while a third is described as counsellor congruence or genuineness.

The counselling skills are necessary for the development of a therapeutic relationship between counsellor and client. They are active listening, responding to clients through reflection of feeling and content, paraphrasing and summarising, asking open questions and responding appropriately to silence and client non-verbal communication.

2.14 UNIT END QUESTIONS

1) Delineate the basic concepts of Rogers Person centered counselling theory
2) Define self concept. What are the factors that contribute to the development of self concept?
3) What are the ways in which maladjustment develops in an individual?
4) Discuss the importance of self concept highlighting the factors that would affect the self concept.
5) Discuss the conditions required for facilitating and developing positive self concept.
6) Discuss the goals of counselling and point out the qualities of a mature person.

7) What are the core conditions for effective counselling?

8) Discuss critically the counselling relationship.

9) Which type of clients will benefit from Person centred counselling?

10) What are the limitations of this type of counselling theory and approach?

2.15 GLOSSARY

Self : It refers to the 'I' or the 'me' part of each person.

External frame of reference : When behaviour is observed from the point of view of an outsider, it is called external frame of reference.

Internal frame of reference : When behaviour is observed from the point of view of the client, it is called internal, subjective or perceptual frame of reference.

Actualising tendency : It refers to the urge of the humans to grow, to develop and to reach maximum potential.

Self concept : It is a unique complex of many different self-conceptions which constitute an individual's way of describing and distinguishing himself.

Empathy : It refers to the counsellor's ability to understand the client at a deep level. It involves an awareness of what it that the client is actually experiencing.

Unconditional positive regard: Valuing human-beings for what they are without imposing any conditions.

Genuineness : This refers to the qualities of a counsellor as sincerity, authenticity and honesty within the counselling relationship.

2.16 SUGGESTED READINGS

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UNIT 3 PSYCHODYNAMIC THEORY OF COUNSELING

Structure

3.0 INTRODUCTION

This unit presents the psychodynamic theory of counselling. It starts with psychoanalytical theory and its implications. A discussion on the basic concepts and dynamics of psychoanalytical theory is presented such as the role of the unconscious etc., the id, ego and the superego and their interactional functions in the development of the personality etc. This is followed by the psychosexual stages of development and the use of defense mechanisms. Then the next section deals with the concept of anxiety and the important features of psychodynamic therapy and the constituent parts.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the Structure of the Mind as oput forward by Freud;
- Describe the role of the unconscious, Id Ego and the Superego;
- Delineate the psychosexual stages of development and their importance in therapy;
- Define defense mechanisms and indicate their importance in maladjustment;
- Elucidate the concept of anxiety;
- Explain the psychodynamic therapy in reducing anxiety; and
- Analyse the skills used in psychodynamic counseling.

3.2 STRUCTURE OF THE MIND

The word *psychodynamic* is sometimes used to refer to psychoanalysis as this theory focuses on dynamics of unconscious processes. However, it is now commonly used to describe those models of therapy which have evolved from classical psychoanalysis. These models have retained many of the skills and techniques which Freud pioneered as well as most of the concepts which derive from his original work. The term *'psychoanalysis'* refers to the form of treatment invented by Freud. It is also used to describe his theory of human psychological development, and his hypothesis about the structure of the human mind. There are several other important ideas like the role of the unconscious, the structure of personality, the psychosexual stages of development, the importance of the past and childhood experience, the use of ego defense mechanisms, transference and the nature of the therapeutic relationship, the significance of dreams, free association or the 'talking cure' and interpretation.

According to Freud, the human mind contains three layers – *conscious, preconscious and unconscious.* Conscious mind contains the information that is easily available to us at the time of retrieval. For instance, when some one asks you 'which class are you studying?' you are able to give information immediately. Preconscious mind contains the information which is not easily accessible to us but with little effort at the time of retrieval. For example, 'What did you do on this same day, last week?' you are not able to give the information immediately, but after thinking for a while and scanning your memory, you are able to come out with answer. Unconscious mind is filled with those thoughts, feelings and

ideas which are repressed and therefore unavailable to recall. Very few people can remember their first day in the school as a child or the name of their class teacher in the nursery class. Freud compared the structure of the mind to an iceberg. The tip of the iceberg that is visible is compared to the conscious level, beneath the tip to preconscious and the rest of the iceberg merged in the water to the unconscious mind.

3.3 THE ROLE OF THE UNCONSCIOUS

The role of the unconscious is a fundamental concept of psychodynamic theory. As a result of his clinical experience with patients in hypnosis, Freud came to see that many of their problems were the result of mental processes which were hidden to them. The idea that problems could be located in an unknown region of the human mind was a novel and challenging one. Long before Freud expressed these views, it was generally accepted that conscious experience was the motivating factor in all human endeavor. Freud was concerned to show that the mind is not always clear to itself, and that there are many inaccessible memories, wishes and impulses which are often unacceptable to a person's consciousness.

Case Study: Unconscious Meaning

A fifty-five-year-old man was very upset by what he described as 'sloppiness in dress or appearance'. He became especially irritated when he saw someone wearing a jacket or coat casually over the shoulders. In his view, coats should be worn properly with the arms inserted in the sleeves like many personal eccentric views. His opinion did not constitute a major problem for him or his relatives. On one occasion, however, he upbraided his wife for wearing her coat in this fashion. In response to this, she suggested that he should try to remember when he first started to think in this way since, after all, the problem was clearly his and not hers.

Several days later he mentioned to her in surprise that he remembered an old man who lived in the neighbourhood where he grew up. This man was a frightening local character who had lost an arm in the war, and frequently shouted at children in the street. Because of his injury, he always wore his coat draped over his shoulders. Once this association had been made by the client, his preoccupation with appearance diminished.

This case study indicates that the client, Mr. Vasu, was unaware at first of the origin of his strong feelings about dress and appearance. His response to his wife's style of dress was irrational. Many phobias are similar to this, and clients are seldom able to identify the factors which triggered them. With help and encouragement, however, it is possible for clients to locate the original (usually traumatic) event which prompted the fearful response. Mr. Vasu's wife was interested enough to encourage him to look for the cause of his irritation.

The cause was repressed and buried in his unconscious mind. Through effort, he was successful in recalling this childhood event of the old man in the street who frightened him. Material which is repressed in this way is often of a frightening and disturbing nature, and so it is repressed.

3.4 THE STRUCTURE OF PERSONALITY

Freud described the personality in terms of three components – *ID*, which operates at the unconscious level, EGO, which operates at the conscious level and SUPEREGO which operates mostly at the unconscious level but sometimes also at the conscious level . These three areas of personality constantly interact with one another as a means of regulating an individual's behaviour.

3.4.1 The Id

It is the most primitive part of the system, is present from birth, and is derived from Freud's concept of the unconscious. The Id can therefore be seen as the repository for everything which is fixed, instinctual and inherited in a person's make up. The Id is also, according to Freud, the repository of all our impulses, especially those relating to sex and aggression. These impulses are constantly demanding attention and expression, but because of the constraints placed on us by society and the need for civilised behaviour, immediate gratification of instinctual urges is not always possible or desirable. The Id, which is governed by the *Pleasure Principle*, therefore needs to be modified or regulated, and this function is fulfilled by the Ego, the second part of Freud's system.

3.4.2 The Ego

The Ego is sometimes described as the arbiter, the manger or the executive of the total personality system, since its function is to deal with the demands of the Id in a realistic way. The Ego is governed by the *Reality Principle* – which means that it must devise ways of satisfying the demands of the Id, while simultaneously deciding what behaviour and actions are appropriate at any given rime. At about the age of one to two, children begin to learn that they must wait for certain things, and that very often it is a good idea to ask. This second part of personality is rational, logical and also incorporates problem solving abilities, memory and perception. Skills like talking, planning, negotiating and explaining are important dimensions of the conscious Ego. While the Id is concerned with subjective needs and internal reality, the Ego is concerned with things as they exist in the real world.

3.4.3 The Superego

The Superego, or *Morality Principle*, is the third psychological process in Freud's model of human personality. This develops at around the age of three and is composed of internalised values, ideals and moral precepts, all of which derive from parental and other authority figures.

The Superego is that part of personality which is concerned with right and, wrong, and is capable of generating guilt when people transgress their own or society's moral code. When children develop this aspect of personality they become effective, over a period of time, in regulating their own behaviour. Before this mature stage is reached, however, parents and teachers socialise the child through a system of rewards and punishments. Once society's standards have been incorporated, any infringement of them is likely to produce anxiety or guilt. For some people, the Superego can develop as excessively punishing so that attitudes of perfectionism are fostered which can, in turn, lead to depression and other psychological problems. The task for the Ego is to maintain a balance or

equilibrium between the demands of the Id on the one hand, and the strictures of the Superego on the other.

3.5 THE PSYCHOSEXUAL STAGES OF DEVELOPMENT

One of the most important contributions to the psychodynamic approach is its focus on childhood experience, and the way this experience can influence adult life. In the latter part of the nineteenth century, Freud decided that many adult problems originated from early childhood abuse. It is clear that many children do indeed suffer sexual and other forms of abuse in childhood. It would be a mistake, however, to assume that it is only sexual trauma, or other child abuse, which is significant in psychodynamic theory. Children encounter - numerous problems while growing up and many of these can also cause difficulties in adult life.

Freud believed in the quote, 'The child is the Father of man' and so focused on childhood experiences, considered the ways in which children develop to sexual maturity and the stages through which they pass in order to achieve this.

Prior to Freud, the popular notion is that sexual instinct only awakens at puberty. But, he was concerned to show that events take place much earlier than this, and that sexuality evolves through a series of stages which are commonly referred to as *the 'psychosexual stages of development'*.

3.5.1 The Oral Stage: Birth - 1 Year Approximately

This is the first phase of a child's life - from birth until about eighteen months - when pleasure is concentrated on the mouth with the experiences of feeding and sucking. The mouth is the centre of existence at this stage, since survival is dependent on taking in nourishment. The word Libido, which Freud uses to describe this energy, is a broad term. It does not refer to sexual feelings in a narrow sense; instead, it denotes a comprehensive force or vitality which is found up with feelings of pleasure, comfort and the need to survive.

There are two phases during this stage of development: the first is the *sucking phase* when only fluids are taken, and the second is the *biting phase* which is linked to weaning and eating. Weaning can be traumatic for babies, especially if it is introduced abruptly or without sensitivity to emotional needs, and problems associated with either the earlier or later oral stages can be carried over into later life.

Food and love are closely linked in infancy, and when early feeding experiences are negative, this link between food, love and security may persist into adult life and become manifest through eating disorders, alcohol or drug addition, and smoking. Sarcasm and gossip, which stem from aggressive impulses, are also sometimes associated with problems arising at the weaning oral stage. If weaning is delayed, difficult or emotionally traumatic for example, the natural activities of chewing and biting may not be given adequate expression, and may then seek expression in destructive ways later on. Adult problem behaviours, linked to either of the stages of weaning, tend to become more pronounced at times of stress or unhappiness.

3.5.2 The Anal Stage: Age 1-3 Approximately

This is the second important stage of a child's development, and during this time the young child is beginning to understand what is expected by parents and society in general. The Ego is beginning to emerge, and the Reality Principle is replacing the Id or Pleasure Principle. At this time, a toddler is also subjected to a major socialising process in the form of toilet training.

Conflict can and does arise between the wishes of parents and the impulses of the child. These areas of conflict concern issues of power, and control. On the one hand, the child derives pleasure from both withholding and expelling faces, while on the other hand there is the desire to please parents and to establish the kind of routine they demand. The issue of hygiene is an important one too, so several major learning experiences are undertaken in a short space of time. Parents often reward small children for using the toilet at specific times. This teaches children about the need to defer gratification.

Parents may also seem disapproving when mistakes are made, and these parental attitudes are linked to the emergence of the Superego in the child.

Attitudes to cleanliness and order are fostered at this stage, and if these are punishing, problems can develop in adult life leading to habits of compulsive cleanliness and order. On the other hand, there are those people who tend to spread disorder and mess wherever they go, habits which may have begun at, the anal stage when toilet training was not rigorous enough.

3.5.3 The Phallic Stage: Age 3-5 Years Approximately

During the Phallic stage, a child's interest becomes focused on the genital area. According to classical Freudian theory, boys at this stage experience Oedipus *complex* which means boys become very interested in their mothers and envious of their fathers. Father is, after all, the person who is closest to mother, and to a small boy this represents an impediment to his own - often explicitly stated - ambition to own or 'marry' mother. Since these aspirations cause anxiety to the child - Father might become angry and punish him - the situation is resolved through a process of identification. The identification occurs when the child begins to emulate and adopt his father's mannerisms, style, goals, interests and ambitions. Such a response solves the Oedipal problem and serves a dual purpose: on the one hand the child has established a male role model for himself, while on the other hand he is beginning to learn about the structure of society in general, and his own place within it.

Girls are considered to experience a similar constellation of impulses, known as *Electra complex*. In their case, the mother is seen as the rival and the father as the object of desire. The concept of *'penis envy'* is linked to this stage of development in girls, for according to Freudian theory small girls blame their mothers for the fact that they are anatomically different from boys. The punishment which a boy fears from his father *(castration)* cannot happen to a girl. What she fears therefore, is that it has already taken place. The situation is resolved for her through eventual identification with her mother.

3.5.4 The Latency Stage: Age 5-10 Years Approximately

During latency all available energy is directed towards the development of social and intellectual skills. Friendships, especially those with members of the same sex, become very important, and recreational activities including hobbies and sport, are a central focus of this stage. The sexual feelings which are repressed during latency will, however, return at the next (genital) stage of development.

The hormonal changes which take place at the adolescent stage that is after 10 years, bring forth a resumption of sexual interest generally. This interest is, however, much less auto-erotic than it was in the Oedipal stage. The main focus of concern, according to Freud, is with forming heterosexual relationships with a view to lasting commitment and marriage. Mature adult sexuality with a member of the opposite sex is the outcome of successful progression through all the earlier stages.

3.5.5 The Genital Stage: Age 7-12 Years Approximately

The hormonal changes which take place at this stage encourage a resumption of sexual interest generally. This interest is, however, much less auto-erotic than it was in the Oedipal stage. The main focus of concern, according to Freud, is with forming heterosexual relationships with a view to lasting commitment and marriage. Mature adult sexuality with a member of the opposite sex is the outcome of successful progression through all the earlier stages.

Self Assessment Questions

1) Explain the concepts of id, ego and super ego.

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2) Explain different stages of development according to Freud.

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3.6 THE USE OF EGO DEFENSE MECHANISMS

The Ego, which is -governed by the Reality Principle, has the task of coping with the demands of the Id, while constantly appraising external reality and making decisions about the kind of behaviour which is appropriate at any given time, The threat of punishment from the Superego is another factor to be considered, and the combined pressure from these forces (Id and Superego) has the effect of generating anxiety for the individual. The conflict which occurs between a person's wishes and external reality is dealt with by the use of defense mechanisms.

Defense mechanisms are psychological processes which people use in order to protect themselves against extreme discomfort and tension. They are also effective in maintaining mental composure and self-esteem in a variety of what might otherwise be very painful situations. Defense mechanisms operate at an unconscious level, and all of us use them occasionally. However, prolonged and

persistent use of them is counter-productive, because such defenses serve to distort reality and falsify experience. Some of the main defense mechanisms are–

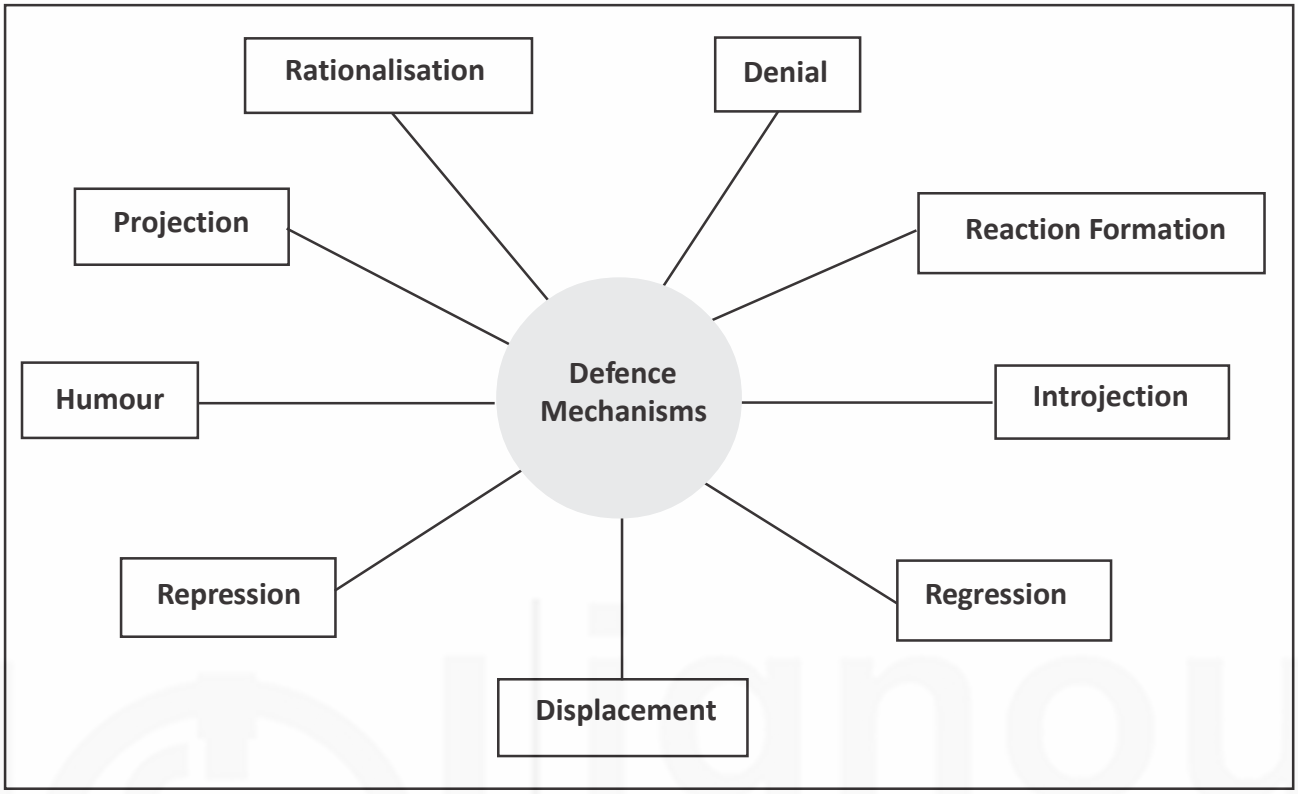

Fig. 3.1: Defense Mechanisms

3.6.1 Repression

Repression is a process whereby traumatic or painful experiences are forgotten or pushed out of consciousness. This is the most fundamental of all the defense mechanisms and, like the others, is operated unconsciously. A child might, for example, repress a truly threatening experience like abandonment or loss, since this may be the child's only method of coping at the time. Repressed material does not go away, however, but continues to exist in the unconscious.

Occasionally disguised signals break through into consciousness, and these may take the form of physical symptoms. Repressed material may also surface in dreams or at times of stress or illness. Certain major life events may prompt the re-emergence of repressed material. The following short case study illustrates this last point.

A great deal of mental energy is needed in order to ensure that repressed material does not surface into consciousness. However, the force which prevents unconscious material from becoming conscious is particularly strong, and is known as resistance. Resistance, like repression, is unconsciously motivated and is used as a means of avoiding the anxiety which awareness of repressed material would entail.

3.6.2 Denial

Denial is used as a defense mechanism when reality is unpleasant or disturbing in some way. A person with a serious illness might, for example, deny the condition. This denial may serve a useful purpose initially, since it helps to protect

the person against anxiety and high levels of stress. In the long term, though, its use will distort reality and prevent the adjustment and acceptance which are important at such a time.

Denial is also used frequently by people who have been bereaved. In this context, it also works effectively in the short term but can lead to complicated grief reactions in the long term.

3.6.3 Rationalisation

Rationalisation is a face-saving defense which people often use to explain away personal failures, vices or inadequacies. Instead of accepting that failure has taken place, 'rational' explanations are given, and these explanations are sometimes partly true. A parent might, for example, say that a particular child is 'difficult' and this label may then be used to excuse parental aggression towards that child.

3.6.4 Projection

The defense mechanism of projection ensures that internal anxiety or discomfort is directed outwards towards other people. It is a way of attributing our own faults to others. A person with a tendency to be hypocritical might, for example, suspect or even accuse other people of hypocrisy. In a similar way, someone who is aggressive or domineering may see these characteristics in others, but fail to recognise and own them personally.

3.6.5 Displacement

Unacceptable impulses and desires are often aimed at the wrong person. This is most likely to happen when the real target is seen as too threatening to confront. Thus, a man who has had problems with his boss at work might be tempted to take it out on someone else - his wife or children for example.

Strong feelings are also sometimes displaced towards authority figures in public life. A person who has had a difficult relationship with a parent may develop hostile attitudes towards the police or judges.

3.6.6 Reaction Formation

Reaction formation is a defense in which the conscious feeling or thought is exactly opposite to the unconscious one. An example of this is the person who expresses strong views against liberal sex attitudes, while at the same time fighting to control personal sexual impulses. Reaction formation is evident in many areas, and may be implicit in a variety of attitudes.

People who claim to dislike lateness may have a tendency in that direction, while those who deplore bad manners may well lack social confidence themselves.

3.6.7 Introjection

This describes the process of taking in the views and attitudes expressed by other people. This can work in either a positive or a negative way. One example of positive use is the process whereby children incorporate the values and standards of parents and teachers.

Introjection is problematic when less healthy experiences are taken in and held as part of the self. An extreme example of this is the person who has been kidnapped and who, in order to survive mentally, identifies with the captors and their cause.

A less dramatic, though equally problematic, use of the defense is evident when abused children absorb their experiences and then pass them on to the next generation.

3.6.8 Regression

People often retreat to an earlier stage of development in the face of threat or failure. Regression is a defense mechanism with which hospital nurses are familiar with. Patients often revert to less adult forms of behaviour once they find themselves in hospital.

This defense works well for people in many situations, since it ensures that care and attention are elicited from others. It works well for victims of trauma who certainly need the added care and attention. Regression is a problem when it is used habitually as a way of being noticed.

3.6.9 Humour

Some people use humour as a shield or barrier against painful experience and trauma. It is interesting that many comedians have suffered from depression, which would seem to indicate a close link between humour and sadness.

Humour is, of course, not always used as a defense mechanism, it is quite possible to be funny without any underlying agenda. Freud refers to the 'high yield of pleasure' which people derive from humour.

However, clients sometimes use humour as a way of avoiding serious and reflective consideration of their problems. Humour may have become an habitual defense with them, and one which is difficult to relinquish.

3.7 THE CONCEPT OF ANXIETY

Anxiety is an important concept in psychodynamic theory and in Freudian terms is seen as the catalyst which signals impending danger to the Ego. Defense mechanisms are used in order to reduce anxiety. Danger situations include fear of losing another person's love, the fear of punishment (by others or by the Superego) and the fear of abandonment. There are three types of anxiety- neurotic anxiety, realistic anxiety and moralistic anxiety.

3.8 TRANSFERENCE AND THE NATURE OF THE THERAPEUTIC RELATIONSHIP

Transference refers to the client's emotional response to the counsellor.The concept of transference is significant in the psychodynamic model as it focuses on clients' emotional responses.

Clients may 'transfer' to counsellors, their feelings which are either positive or negative. These feelings stem from childhood emotional responses to parents,

and are therefore not based on any real relation between counsellor and client. Transference feelings operate at an unconscious level, so the client is unaware that responses to the counsellor may be inappropriate or out of date. Evidence of the client's early emotional life is, therefore, often clearly seen in the counseling relationship. This has advantages for the client, since he will be able to identify the cause of some of his current difficulties with the help of a counsellor.

Case Study: Transference

A twenty-six-year-old client became angry because his counsellor had gone into hospital for a minor operation. The client (Harsha) had been told in advance that the counsellor would be away for a week, but this notice did little to reassure him. During a subsequent counseling session he discussed his reaction with the counsellor. At first he was puzzled by the strength of his own reaction, but he later identified some earlier experiences which had some bearing on his heightened emotional response to the counsellor's absence.

Harsha's parents had divorced when he was five years old and shortly afterwards his father had been ill with allergy problems. No one had taken time to talk to the small child, nor had he been taken to visit his father in hospital. One consequence of this was that, for many years, Harsha blamed himself for his father's illness and departure.

Once he was able to explore all these issues, Harsha understood why he became angry and frustrated when the counsellor left to go into hospital. The feelings which he had transferred to the counsellor were really feelings stemming from the past and his relationship with his parents. In exploring them, however he was able to look more realistically at his childhood experience of loss and at the burden of blame he had carried for so many years.

Transference is not a mysterious occurrence only seen in counseling and therapy. People may experience strong emotional responses in a variety of 'helping' situations. These situations include patient/doctor and- nurse/patient relationships and indeed any other context where one person is depending on another for assistance or support. Nurses, doctors and social workers are aware that the people they help respond in inappropriate emotional ways. Problems often arise because helpers do not understand the reasons for such feelings, and may indeed be flattered to receive them. This is especially true when the feelings transferred are love, idealising, admiring or erotic. Abuse of clients can arise in these circumstances, so the underlying dynamic of transference needs to be understood and the central role of supervision for counsellors recognised.

3.9 COUNTER TRANSFERENCE

The word counter transference refers to the counselor's emotional response to the client. Counsellors are also capable of displacing feelings from the past into the present situation with the client. From the above case study, we can understand that if Harsha's counselor had taken his attitude personally such a response would have been inappropriate in the therapeutic context and would not have helped the client in any way. The counsellor needed to understand that the client was

not angry with her personally. His reactions, which were unrealistic in the present context, were used by the counsellor in order to help him achieve deeper understanding of his problems.

However, counsellors, since they are also human, may not be always objective in their response to clients. Counsellors have life histories which can colour or affect their reactions, and it is these areas of personal bias which are defined as counter transference. Once again, this highlights the importance of supervision for counsellors, since it is only through supervision that they can identify and deal with their counter transference reactions.

There are some forms of counter transference which are more common than others. Seeing clients as helpless, or as victims, is one form. When this attitude is pronounced, over-protection or even advice may be offered by the counsellor. This kind of over-protectiveness says a great deal about the counsellor's need to be in control, and it will certainly inhibit the client's self-development and autonomy. Counter transference responses may also appear in the counsellor's inability to confront or disagree with a client. This may stem from a fear of being disliked, or of being seen as incompetent.

Counsellors may also feel themselves to be in competition with particular clients, or to feel envious of them. These responses may be related to childhood problems with siblings and parents. Whatever the reason, it is essential that counsellors monitor their counter transference feelings and discuss them in supervision.

However, it is important to remember that every imaginable human prejudice or bias may present itself in the form of counter transference and when such bias is left unexamined it will ultimately distort the therapeutic relationship and work against clients.

It is also possible for counsellors to have biased feelings towards certain people or groups of people. One example of this is the kind of partiality which may be extended to specific groups such as women, minority groups or people seen as disadvantaged in some way. The crucial point to make here is that individual clients are entitled to be treated as individuals, and not as stereotypes.

Case Study: Counter Transference

Arun, who was a qualified psychiatric nurse, completed counsellor training to diploma level. Afterwards he worked for an agency which specialised in addiction counseling. Although he received regular supervision, Arun was surprised by the strength of his responses to one of his clients.

When he was a child, Arun's parents were neglectful and dependent on alcohol, and as a teenager he experimented with drugs and alcohol too. From an early age he had learned to fend for himself; he often took care of his parents too, cooking for them, and shopping when there was some money to do so. After his turbulent teenage addictive phase, he decided to make something of himself, studied at night class and then went into nurse training.

One of Arun's clients was a middle-aged man who had been addicted to alcohol for many years. As soon as he met him, Arun sensed some

characteristics in the man which reminded him of his own father. Supervision provided an opportunity for him to discuss his feelings about his client. On several occasions, Arun found himself 'taking care of' his client in ways which were inappropriate. He had, for example, worried about his client, and had more than once given him direct advice. In addition, Arun wanted his client to like and approve of him. At other times he felt strong negative feelings towards the man, and although he was careful to conceal these, they were sufficiently disturbing to prompt Arun to seek extra supervision.

This case study indicates the importance of past experience in determining the way counsellors may respond to certain clients. Arun did not react like this to every client he had, but this particular client resembled his father in certain ways. These similarities were not directly obvious, but they triggered something in the relationship between counsellor and client which was reminiscent of Arun's early relationship with his father. This meant that Arun was relating to the client as he would have to his own father. It is not difficult to see how unhelpful this would be for the client who was not seen as a separate individual in his own right.

The case study also highlights the importance of regular supervision for counsellors. It is only through supervision that these often complicated counter transference feelings can be identified and seen for what they are.

Self Assessment Questions

1) What are the various defense mechanisms? Give suitable examples

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2) What are the techniques of psychodynamic therapy?

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3) Discuss the concepts of transference and counter transference.

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3.10 THE SIGNIFICANCE OF DREAMS

Freud regarded dreams as *'the royal road to knowledge of the unconscious activities of the mind'*. In classical psychoanalysis, dream interpretation is a central component of therapy. Dream interpretation is important in all other psychodynamic models of therapy and counseling also.

The difference here is that whereas in the past psychoanalysts might devote long periods of time in the analysis of just one dream, psychodynamic counsellors and therapist focus on them only when clients request or understand such a focus.

It is important to note that all clients are not regularly in touch with their unconscious and dream life. However, dream interpretation is entirely subjective. Only the client can say what the dream means for her personally, though counsellors who work from a psychodynamic perspective can help clients to examine the symbolism contained in dreams and to discuss what they mean.

It is important to remember that dream interpretation through the use of standardised symbols found in popular self-help texts is not useful for clients. This is because dreams are unique to the individual dreamer.

3.11 FREE ASSOCIATION OR THE 'TALKING CURE'

All theoretical models of counseling are based on the premise that clients need to talk through their problems in order to make sense of them. The term 'free association' was first used by Freud to describe the process of encouraging his patients to say whatever they liked on the grounds that whatever occurred to them would be relevant and revealing.

In psychodynamic counseling clients are encouraged to talk at their own pace and express their feelings and thoughts, no matter how insignificant these may appear to be. What clients wish to say is obviously important to them in any case, and it is never the counsellor's task to decide what should be voiced by clients during sessions. What is important is that counsellors listen carefully to clients, and respond appropriately and at the right time.

Free association also forms the basis of dream interpretation. When clients use this technique in relation to their own dreams, significant links are often made so that apparently disconnected symbols come together and form a more coherent picture.

3.12 SKILLS USED IN PSYCHODYNAMIC COUNSELING

The following is a list of skills which are central to the psychodynamic approach:

- Establishing a contract
- Listening
- Observing

- Clarifying
- Giving reflective responses
- Linking
- Interpreting
- Attending to transference
- Looking at defenses and resistance
- Drawing parallels between past and present
- Interpreting dreams.

3.13 THE IMPORTANCE OF STRUCTURE: CONTRACTS

Counseling takes place in sessions which last for fifty minutes. Clients need to know the basic details of counsellor/client contracts well in advance of sessions if possible, so that structure and stability are an integral part of the relationship. It is essential to establish clear boundaries with clients, a practice which is not, of course, exclusive to the-psychodynamic approach. However, the difference is that in psychodynamic counseling the client's response to such a contract has special significance. A client who misses sessions, for example, or who arrives late, is clearly expressing something which is not being said in words. Clients can, of course, arrive later for sessions or miss them occasionally because of transport or other problems. But when poor time keeping is habitual, there is always the possibility that some form of resistance is operating within the client. Such resistance is usually unconscious or outside the client's awareness.

In a situation like this, the counsellor's task is to encourage the client to look closely at the underlying meaning of the behaviour, and to place it in the context of any other problems or difficulties which the client is experiencing. It may be that the client is avoiding some painful subject, or it may be that she feels unable to disagree with the counsellor or to express negative or angry feelings. Even though clients come into counseling with the intention of sorting out and understanding their problems, the exploration this involves is often so difficult for them that the temptation to resist further self scrutiny is often hard to overcome. The following Case study is an example of this last point.

3.14 LIMITATIONS OF PSYCHODYNAMIC COUNSELING

This approach is criticised as being very abstract with little empirical evidence.

The critics felt there is overemphasis on childhood experiences and on child's preoccupation with his body parts.

Undue emphasis on the role of unconscious processes has also been pointed out.

This approach is uneconomical and duration is too long to sustain the motivation of the client.

3.15 LET US SUM UP

The term *'psychoanalysis'* refers to the form of treatment invented by Freud. It is also used to describe his theory of human psychological development, and his hypothesis about the structure of the human mind.

According to Freud, the human mind contains three layers- *conscious, preconscious and unconscious.* Conscious mind contains the information that is easily available to us at the time of retrieval. Preconscious mind contains the information which is not easily accessible to us but with little effort at the time of retrieval. Unconscious mind is filled with those thoughts, feelings and ideas which are repressed and therefore unavailable to recall.

Freud described the personality in terms of three components – *ID*, which operates at the unconscious level, EGO, which operates at the conscious level and SUPEREGO which operates mostly at the unconscious level but sometimes also at the conscious level .

Freud focused on the 'psychosexual stages of development'– oral, anal, phallic, latency and genital stages to understand the current problems of the client.

There are several other important ideas like: the use of ego defense mechanisms, transference and the nature of the therapeutic relationship, the significance of dreams, free association or the 'talking cure' and interpretation.

3.16 UNIT END QUESTIONS

1) Explain Freud's Structure of Personality.
2) Bring out the analogy between the layers of the mind and iceberg.
3) Discuss the psychosexual stages of development.
4) Explain any five defense mechanisms with examples.
5) Explain the concept of transference and counter transference.
6) What is the process of sychodynamic counseling?
7) What is the importance of dreams in psychodynmamic counseling?

3.17 GLOSSARY

Id : It is the most primitive part of the system, is present from birth, and is derived from Freud's concept of the unconscious.

The Ego : It is described as the arbiter, the manger or the executive of the total personality system, since its function is to deal with the demands of the Id in a realistic way.

The Superego : It is that part of personality which is concerned with right and, wrong, and is capable of generating guilt when people transgress their own or society's moral code.

Defense mechanisms : These are psychological processes which people use in order to protect themselves against extreme discomfort and tension.

Transference : It refers to the client's emotional response to the counsellor. The concept of transference is significant in the psychodynamic model as it focuses on clients' emotional responses.

Counter transference : It refers to the counselor's emotional response to the client. Counselors are also capable of displacing feelings from the past into the present situation with the client.

3.18 SUGGESTED READINGS

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UNIT 4 BEHAVIOUR AND COGNITIVE THEORY OF COUNSELING

Structure

4.0 INTRODUCTION

The previous units (2 & 3) focused on person-centred approach and psychodynamic approaches and person-centred approach to counseling .person-centred approach focused on the role of choice, freedom and will-power of the client in understanding his life situations. This approach strongly emphasises on the innate potential of the client, his awareness towards the problem and also his ability in dealing the problems. The psychodynamic approach assumes that the behaviour of an individual is predetermined. It is influenced by the instincts, impulses, and unconscious motives. By unveiling the content of the unconscious mind, it is possible to understand, the root cause of the client's problem.

The present unit provides a comprehensive overview of the behavioural and cognitive approach to counselling. The behavioural approach believes that any behaviour good or bad is learned. So, it can also be unlearned if the client is taught some of the behavioural techniques. Moreover, the role of environment cannot be ignored in understanding the behaviour of an individual.

But in recent decades, there is a slight change from the stimulus response chain to the cognitive elements in comprehending the causes of a client's problem and also in enabling him to assess his situation and cope with the life 's situations.

4.1 OBJECTIVES

After reading this unit, you will be able to understand:

- Process of behaviour theory of counseling;
- Developing therapeutic relationship and assessment of the client;
- Techniques of behaviour theory of counseling;
- Process of cognitive theory of counseling;
- Identifying irrational thoughts; and
- Process of cognitive restructuring.

4.2 BEHAVIOUR THEORY OF COUNSELLING

Behaviour therapy, evolved from the theories of learning formulated by Pavlov, Watson, Thorndike, Skinner, Wolpe and Eysenck, and later from the experiments of Bandura and other psychologists who were interested in the effects of observation on the individual's learning experience. The behavioural approach, widely used in the 1950s, emphasised the importance of overt behaviour and its environmental context.

Behaviour therapy has been effective in shifting attention away from the intensely introspective approach to clients. The Freudian approach, emphasised on the role of unconscious forces and unseen impulses which were the root cause of most human problems. In order to deal with these problems it was necessary to engage in a series of verbal transactions between client and therapist, as they would throw light on the hidden areas of personality.

Contrast to this, the behavioural approach focuses directly on the client's undesirable behaviour. This approach facilitates relearning and healthy behavioural change through various methods.

The rationale of behaviour therapy is that maladaptive and neurotic problems which have been learned can, according to the same principles of acquisition, be unlearned.

The counselor or therapist is concerned with a person's observable behaviour, and also with the environmental context in which behaviour takes place. Details of the past are important only to relate to present behaviour and to understand the client's emotional life. The term *'counter-conditioning'* is sometimes used to describe the processes and techniques which are central to behaviour therapy.

4.2.1 The Therapeutic Relationship

The behavioural approach places some emphasis on the quality of the client - counselor relationship. The importance of rapport and partnership within the therapeutic relationship is recognised. Richards and McDonald (1990) refer to this *'joint approach'* which they see as necessary, especially in the early stages of counseling. In relation to handling strong emotions expressed by clients, they also stress the value of using *'empathic statements'* which will convey the counselor's attitudes of *acceptance* and *understanding*. Empathy, therefore, has

some place in behavioural counseling, but is not especially highlighted or deliberately fostered.

Clients are encouraged to become active participants in their own therapy. A fundamental goal of the behavioural approach is to encourage a sense of personal control in clients. Clear communication between counselor and client is valued, and this is especially relevant in relation to specific problem behaviour which needs to be changed, and the goals which the client wishes to achieve. They are also directive in formulating and maintaining individual programmes of therapy for clients.

Focus of Therapy – In behavioural counseling there is strict adherence to principles and procedures, which have been scientifically tested for their effectiveness in relation to specific problems. Techniques and methods used are adapted to meet the individual needs of clients.

A basic aim of counseling is to enable clients to exercise more control over their own behaviour and the environment.

Another aim is, to help clients reduce the distress, anxiety and inconvenience central to most behavioural problems.

Behavioural counseling can also be conducted in groups, and this is highly successful for therapy since many clients experience problems in their social and family relationships. The group becomes a source of support and feedback for clients, provides valuable training, opportunities for overcoming limited skills and changing problem behaviour in a safe environment.

4.2.2 The Initial Assessment

The initial assessment of the client's problems should be accurate and comprehensive so that an individual action plan can be devised. The client's problems should be identified early, and these should also be set in the context in which they occur. In addition, the client's physical and emotional responses in these situations need to be identified. The following considerations are also important:

- The nature of the problem
- The client's first experience of the problem and where it occurred
- The sequence of events following the experience
- Factors which may have prompted the problem
- The client's actions and thoughts in the problem situation described How frequently the problem behaviour occurs
- The duration and intensity of the problem behaviour
- Any factors which worsen or relive the problem
- Effects of the problem on aspects of everyday life, including work, social life and family
- Identification of other people associated with the problem.

4.2.3 Observation of Clients

Apart from the information clients convey verbally at the initial assessment, they also provide non-verbal clues about the nature and severity of their problems. Changes in voice, tone and general demeanor will, for example, say much about the level of distress a specific problem causes to a client.

Interview assessment affords an opportunity to identify the factors which individual clients find personally reinforcing. These factors include praise, attention and encouragement, and they can prove useful in helping clients to change problem behaviour.

4.2.4 Setting and Implementing Goals

The setting of specific goals follows the initial assessment or behavioural analysis. These goals need to be considered jointly by both client and counselor, and the client should be fully aware of the purpose of these, goals.

Commitment to objectives is important too, and one way of achieving this is to establish a contract between counselor and client in which desired changes are clearly stated. It is essential that clients experience some measure of control in the setting and implementation of goals and to this end ongoing communication and negotiation between client and counselor is the norm.

When goals have been discussed and correctly defined, an action plan is set up and a definite decision is made by both client and counselor to work together.

There are some clients who do not respond well to a behavioural approach. In behavioural therapy, assessment continues throughout all the sessions. This is important in order to ensure that goals are either being met or altered in the light of changing situations.

4.2.5 Behavioural Methods and Procedures

The methods and procedures used in behavioural therapy are all designed to meet the needs of individual clients. However, behaviourism does have within its repertoire a wide range of methods which can be used with clients and counselors creativity and innovations are valued as well.

Some of the behavioural techniques, which are frequently used successfully in Therapy:

- Relaxation training
- Systematic desensitisation
- Client self-monitoring
- Practicing and planning behaviour
- Assertiveness training
- Social skills training
- Reinforcement methods
- Modeling
- Focus on physical exercise and nutrition
- Imagery and visualisation

1) **Relaxation Training:** Anxiety and stress are common problems for many clients who seek behavioural counseling. In view of this, relaxation training is a central focus of the approach and is used extensively for a variety of problems. Anxiety affects people at three levels – *psychological, physiological and behavioural.* When clients talk about anxiety they sometimes describe it as a vague feeling of losing control or as a sense that something awful will happen.

Anxiety tends to increase the heart and breathing rates and may cause a variety of other symptoms including muscle tension, irritability, sleep problems and difficulty in concentrating. Counselors can show clients how to reduce these effects by teaching concentration on the following key areas:

Many anxious people tend to breathe in a shallow fashion from the chest, and clients can be taught to change this pattern so that deeper abdominal breathing is learned. This has the effect of increasing oxygen supply to the brain and muscles which, in turn helps to improve concentration, promote a state of calmness along with deeper feelings of connectedness between mind and body. When deep breathing is accompanied by progressive relaxation of body muscles, and visualisation of a peaceful scene, reduction of general anxiety is bound to follow. Figure below explains the same diagrammatically.

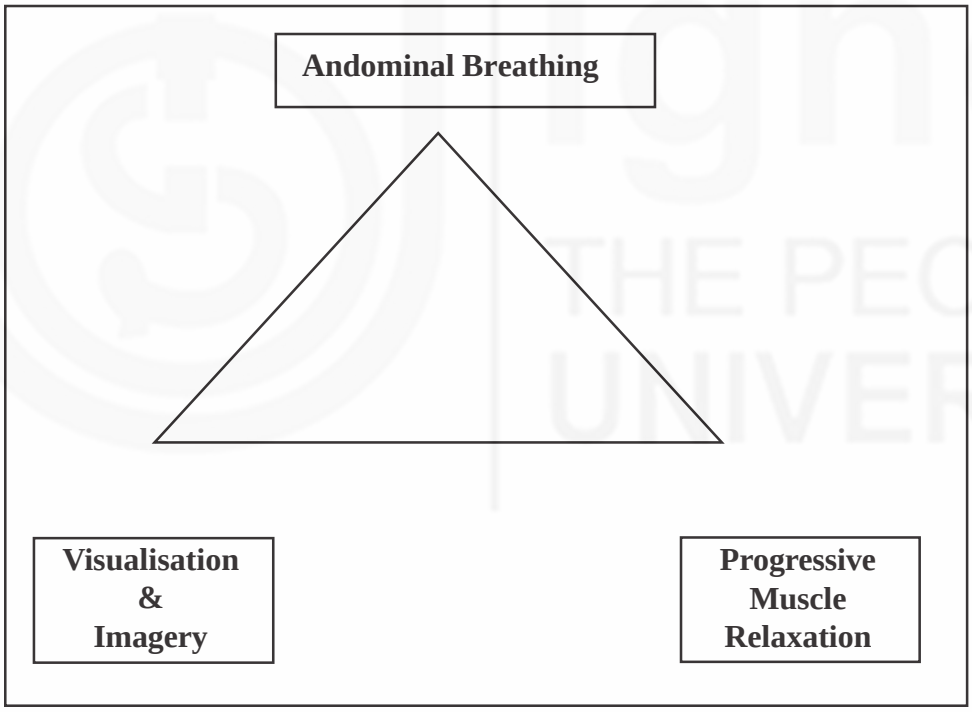

Fig.: Aids to Relaxation

Clients can be taught to set aside time each day for relaxation, and this is especially beneficial for those people who suffer from stress-related conditions such as tension headaches, poor sleep patterns and high blood pressure.

Activity

1) **Relaxation**

The technique to make a person relaxed is given in the box below.

Sit quietly in a chair until you feel still and comfortable. Beginning with your feet, allow all the muscles of your body to relax. Place your hand on

your abdomen and breathe in slowly and deeply through your nose. You should feel your abdomen extend as you do this. Now breathe out slowly through your mouth, noting how your abdomen returns to its usual shape. Repeat the breathing exercise for about five minutes, then sit still again and experience your relaxed state.

A slight variation of the exercise is to repeat a chosen word or phrase each time you breathe out.

2) **Systematic Desensitisation**

Systematic desensitisation is a technique devised by Joseph Wolpe. It is used in behavioural counseling as a means of helping clients deal with irrational fears and phobias.

Wolpe believed that anxiety responses are learned or conditioned, and that it is possible to eliminate these responses if the anxious individual is helped to relax in the face of the anxiety-producing stimulus. The person is, therefore, *'systematically desensitized'* to the fearful object or situation through a process of exposure to it, while in a relaxed state. Progressive muscle relaxation methods and deep breathing are integral to this technique, and clients are taught how to reduce anxiety in this way before they confront their fear.

Constructing an appropriate *'hierarchy'* is another important feature of systematic desensitisation, and involves outlining a series of situations or scenes relating to the phobia. Each scene in the hierarchy is ranked from mildly anxiety-provoking to extremely anxiety-provoking.

Case Study 1: Constructing Hierarchy

The following is an example of a hierarchy which was used to help a client called Vanitha, aged twenty, who had a phobia about eating in front of strangers. Vanitha's phobia was embarrassing and inconvenient because it meant that she refused to socialise on many occasions. She also found herself increasingly isolated at work, and decided to seek help when she no longer felt able to accompany her friends to the lunch canteen. The counselor taught Vanitha the relaxation procedure and breathing methods and then helped her to design and work though the following hierarchy, which she was encouraged to practice on regular basis.

Visualise:

Asking a close friend to accompany you on a visit to a restaurant.

Phoning a restaurant to make a reservation.

Getting dressed for your evening out.

Doing your hair and putting on make up.

Opening the door to greet your friend.

Walking to the restaurant a short distance away.

Meeting people along the way.

Passing other cafes and restaurants as you walk along.

Arriving at the door of the restaurant.

Speaking to the waiter about your reservation.
Walking to the table with your friend and the waiter.
Looking at the menu and discussing it with your friend.
Placing an order with the waiter.
Looking at your food when it arrives.
Picking up the knife and fork and starting to eat.
Tasting the food and enjoying it.
Looking around at the other diners.
Noting that other people are enjoying themselves, becoming aware that other people occasionally glance at your table.
Continuing your meal and the conversation with your friend.

Designing the Hierarchy

Clients need to give a detailed history of the phobia, with special emphasis on those aspects of it which cause the most anxiety. What made this client most anxious was the thought of being observed while eating. For this reason, observation was presented towards the end of the hierarchy which meant that Vanitha could work gradually towards it.

3) **Real-life Desensitisation**

This exercise was based on imagery, and that later on the client and counselor constructed a hierarchy for *'real-life'* exposure. Real-life desensitisation is perhaps the most effective method of dealing with phobias, and is quite often used following a period of visual or imagery desensitisation.

'Exposure therapy' is another term used to describe this form of treatment, and it is especially effective for phobias which include a 'social' element. However, real-life exposure does take time, because the introduction of anxiety-provoking stimuli needs to be very gradual. Not all clients with phobias are willing to undertake real-life exposure, since the process causes some degree of initial discomfort at least. It also needs to be practiced over a period of time, on a regular basis and inspite of probable setbacks.

4) **Client Self-Monitoring**

In behaviour therapy, clients are sometimes asked to maintain records of their behaviour, which are problematic along with any attendant conditions. A self-record may take the form of a daily diary, and one of the benefits of this kind of self-monitoring is that clients often react to their own observations by reducing the frequency of their own problem behaviour. People, who smoke, for example, may not realise how many cigarettes they get through in a day, until they see the evidence on record. Client self - monitoring does have great therapeutic potential, though clients need to be well motivated to pursue it.

5) **Assertiveness Training**

Assertiveness training is widely used in behaviour therapy and counseling. Clients often experience difficulties in several key areas which include:

- Expressing their feelings
- Asking for what they need or want
- Saying no to requests from others

The most important aspect of assertiveness training is in helping clients differentiate between *'submissive', 'aggressive' and 'assertive'* styles of communication. When people are submissive they tend to ignore their own rights and needs, and this can result in feelings of depression and anger which are never really expressed. Aggressive people may be bullying and demanding, characteristics which inevitably alienate others. On the other hand, assertive behaviour involves direct person-to-person communication, without manipulation, hostility or self-abnegation.

Assertiveness training is often conducted in a group setting, and non-assertive clients who express an interest are sometimes referred to them so that they can increase their self awareness and confidence generally.

Case Study – 2: Assertiveness

Suma who was twenty-seven and unemployed attended an assertive training programme. During the first session, the group facilitator asked each person to identify their usual style of relating to others. Suma said straight away that she usually found herself helping other people. She found it difficult to refuse once someone asked her for help. When she did help, she often felt resentful afterwards. In spite of her resentment, however, she lacked the courage to refuse friends or family when they made their requests. During the training sessions, the group facilitator helped Suma to see that it wasn't courage but skill which she lacked in dealing effectively with repeated requests.

The course provided Suma and the other group participants with a set of skills which would help them develop assertiveness. They were taught to differentiate between assertive, aggressive, passive and manipulative behaviour. They were also given practice in dealing with conflict, expressing feelings appropriately, dealing with awkward situations, and saying 'no' confidently.

The skills which Suma learned on the course helped her in her next job interview. She did not allow herself to become overawed by the interviewers. She expressed herself confidently and clearly, and was offered the job. In addition, Suma stopped giving in automatically to family and friends when they asked for favors.

6) **Social skills Training**

Clients also frequently experience difficulties in social situations, and this is another area in which behavioural counseling offers some support to clients.

Practicing and planning behaviour is one aspect of social skills training, and this may take the form of role play of a specific situation seen as problematic or daunting by the client. The practice of interview techniques is one example of this kind of approach, and in behavioural counseling such methods and techniques are commonly used. In social skills training there is an emphasis on setting achievable goals so that maximum positive reinforcement is obtained for new behaviours early on.

7) **Modeling**

Observational learning or modeling is sometimes used to help client's acquire new forms of behaviour. The emphasis in this technique is on showing clients that certain behaviours can be undertaken (in this case by the counsellor) in a calm and non-threatening way. This is especially effective when used in conjunction with systematic desensitisation, especially when the counselor 'models' the behaviour which the client associates with anxiety and stress. Videotapes are sometimes used as part of a modeling programme, and 'participation modeling' is another variant.

This technique refers to a process in which both client and counselor participate. A counselor might, for example, model attitudes of composure and calm while walking into a restaurant. Later on, the client can practice this behaviour in the company of the counselor.

8) **Reinforcement**

Understanding of reinforcement principles is essential in behavioural counseling. Certain problems, such as persistent cleansing rituals or hypochondria, require environmental reinforcement to make them continue.

As Avery (1996) points out, people who look for dirt will always find it, and those who seek reassurances about their health are likely to get it from friends and family. In these two problem situations the environmental reinforcement can be broken, in the next instance, by helping the client to interrupt the cleansing ritual and substituting something else. In the second instance, they can enlist the help of the client's friends and persuade them to 'withhold reassurance'.

Positive Reinforcement

Positive reinforcement is based on the work of Skinner and his theory of operant conditioning. The behavioural approach to counseling places considerable emphasis on the practice of systematically reinforcing a client's desired behaviour, while at the same time ignoring any problematic behaviour. If positive reinforcement is continued over a period of time, then maladaptive behaviour should become extinct.

Clients can also be encouraged to identify and use their own reinforcers. This kind of self-reinforcement will vary for different-clients, but activities which are calming or relaxing are effective in most cases. One client, a woman in her mid-forties, suffered from Obsessive Compulsive Disorder (OCD), which in her case took the form of persistent tidying and checking. In conversation with her counselor she mentioned that she used to love playing the piano, and later on she returned to this interest and used it as a calming self-reinforcer which helped her to break the tidying and checking compulsion.

9) **Physical Exercise and Nutrition**

In recent years a great deal of attention has been given to the importance of exercise and diet in the maintenance of individual fitness. Although the link between physical health and these two factors has always been accepted, the significance of diet and exercise in relation to psychological health was traditionally less emphasised. Clients often eat less or more while under stress and it is a good idea to address this aspect of their behaviour with them.

Case Study - 3: Diet and exercise

One client, called Jaya, described the depression and feelings of tiredness that she experienced at work. During counseling, she revealed that she regularly skipped breakfast, and then snacked on convenience food for the rest of the day. She also worried about her weight, and took no exercise because she felt she was too busy to do so. Through a process of self-monitoring, Jaya was able to chart her mood swings in diary form, and afterwards to see that her depression was certainly exacerbated by dietary neglect and inertia.

It is possible to 'unlearn' patterns of behaviour which contribute to feelings of depression, stress and tiredness, and it is also possible for clients to're-learn' healthier habits though they do need encouragement, feedback and support in order to do this.

Self Assessment Questions

1) Explain the difference between systematic desensitisation and real - life desensitisation.

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4.3 CLIENTS WHO BENEFIT FROM THIS APPROACH

Clients with a wide range of problems – phobias, certain aspects of depression and lack of assertiveness respond well to behavioural counseling. However, any psychological difficulty manifest through observable behaviour is likely to respond well to this approach.

Clients who suffer from obsessions and compulsions often find that behavioural counseling enables them to deal more effectively with their problems.

People with sexual difficulties often seek help through behavioural therapy and counseling, and clients with speech problems such as stammering or an inability to speak publicly-can also be helped.

Behavioural therapy is widely used in stress management and assertiveness training and its principles arc applicable in the management of childhood behaviour problems, and very often care of the elderly

4.4 LIMITATIONS OF BEHAVIOUR THEORY OF COUNSELLING

The behavioural approach is especially helpful in dealing with problems manifest through overt behaviour. This strength is, in fact, also its weakness, since the problems often stem from deeper and hidden origins which need to be addressed

in the long-term. A client who has a phobia about the dark, for example, may well respond to a behavioural approach in counseling, but unless the hidden insecurity which prompted the phobia in the first place is identified, lasting cure of the problem is unlikely. On the other hand, even temporary alleviation of the phobia might give the client sufficient inclination to look at less obvious issues, so that overall real progress is made and insight gained. Clients need to be fully committed, especially at the beginning of counseling when stress levels are high and the gratification gained obtained through problem behaviour is still very attractive.

Counselors who work from a strictly behavioural perspective are at risk of adopting a mechanistic or over-simplified view of clients. This is because a basic principle of this approach is that people react in an automatic way to stimuli – a view which leaves little room for the influence of thinking, or cognition in determining behaviour. However, now, there is an increasing emphasis on the role of thinking in determining behaviour, which means that clients seeking help are now more likely to be offered Cognitive-Behaviour Therapy than the older form of behaviour therapy.

4.5 COGNITIVE THEORY OF COUNSELING

Cognitive counseling provides a model for understanding and intervening in human behaviour in which the point of entry is through the thinking process. The fundamental assumption is that more effective thinking will result in more satisfactory (to the client) behaviour and feelings. For certain clients, identifying faulty thinking and learning more effective ways of viewing life experiences can result in rapid improvement.

Cognitive counselors regard erroneous thinking as the source of emotional upset and ineffective behaviour. Events occur in each person's life that involve loss, disappointment, and failure to accomplish valued goals. Cognitive therapists believe that people who are able to think effectively about their experiences are able to put negative events in perspective and get on with life, and those who do not think effectively tend to perseverate on negative happenings and allow them to disrupt their happiness and effectiveness.

Albert Ellis (1997), founder of *rational-emotive behaviour therapy*, is probably the best known cognitive therapists. Like Rogers and Perls, he was trained as a psychoanalytic therapist, but he came to believe that the traditional approach was inefficient and that the process sidetracked clients from learning how to live more effectively. Influenced by learning theory, Ellis began to develop a new approach to counseling in which clients are taught to think rationally about blocks to accomplishing love and work goals. Psychiatrist Aaron Beck and psychologist Donald Meichenbaum have both gained recognition for their development of related theories of cognitive counseling and psychotherapy.

4.5.1 The Nature of People

For cognitive theorists, humans are thinking beings with the capacity to be rational or irrational, erroneous or realistic, in their thinking. According to Patterson and Watkins (1997), "*Cognitive therapy is based on the commonsense idea that what people think and say about themselves-their attitudes, ideas, and ideals-are relevant and important*". Cognitive therapists subscribe to the view that what people think about their experiences determines how they feel about those experiences and what they will do.

Ellis, Beck, and Meichenbaum all posit internal dialogue that mediates a person's reactions to stressful events. Ellis explains that negative emotion and ineffective behaviour are the results of irrational thinking. It is not the events in people's lives that create bad feelings, but how they think about these events. For example, suppose a person is snubbed at a party by someone he or she thinks is attractive. Such an event might be unpleasant for almost anyone, but it becomes a problem, according to *rational-emotive behaviour therapy* (REBT), when the snubbed individual "catastrophizes" about the event. The individual may have such "irrational" thoughts as "I can't stand being snubbed" or "If this person can't like me, no one else ever will."

If the person simply thinks, "It's too bad that person snubbed me; I'd like to spend time with, him or her," then negative emotion will not get out of hand and the person can plan to work toward another opportunity for contact. However, if the person catastrophizes about the incident, negative emotion and ineffective behaviour result. Energy is wasted in self-pity and in either avoiding contact with or planning retaliation against the other person. Such behaviour does not achieve the desired result of having further opportunity to spend time with the person.

The REBT view of personality is often referred to as an ABC theory, in which A is an *activating event*, B is the *person's thought about the event*, and C is the *emotional and behavioural reaction.* If the thinking at B is irrational, the emotional reaction will be negative and the behaviour is likely to be inappropriate and ineffective for accomplishing the desired outcome.

This is a highly active and directive approach which incorporates elements of teaching, persuasion, debate and even humor within its repertoire. Figure below depicts the ABC model for a comprehensive understanding of the theory.

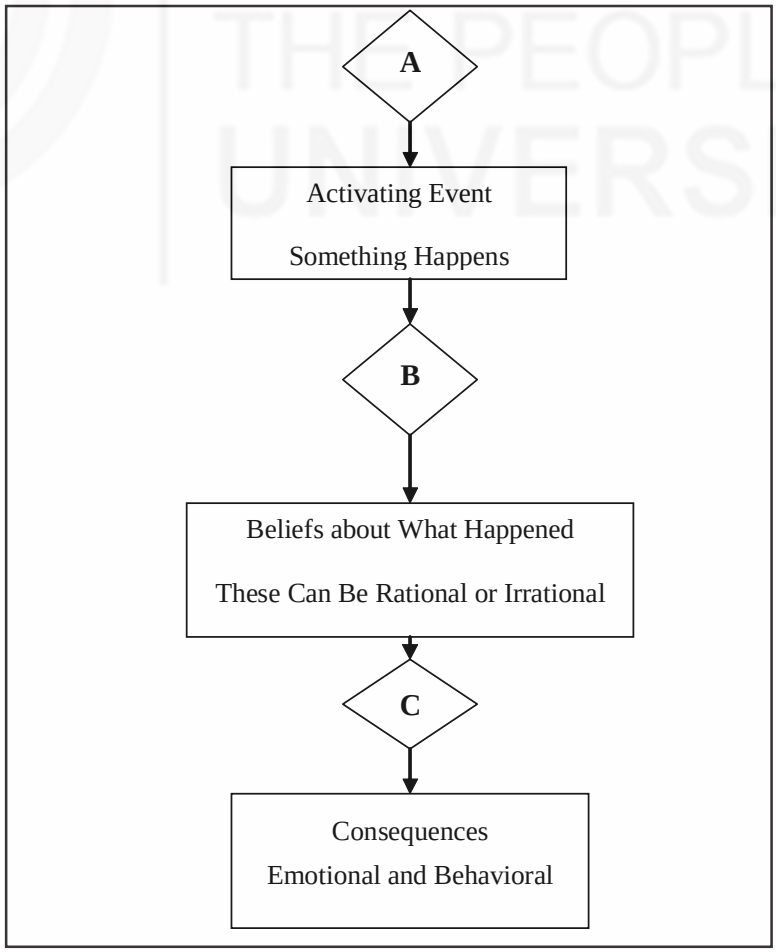

Fig. : The ABC Model

There are many similarities between Beck's and Ellis's views of how humans come to behave ineffectively. Ellis has listed eleven specific irrational thoughts. Anyone or more of which may lie at the source of an individual's difficulties. Examples include the following:

- "I must be unfailingly competent and perfect in all I undertake."
- "It is horrible, terrible, or catastrophic when things do not go the way I want them to go".
- I should always be loved and approved of by everyone.
- I cannot change my behaviour because of my awful past.
- I have no real control over my problems, which are caused by external factors.

Ellis has identified all the statements as applying to love and/or work motives. It is easy to see how extreme ideas like those just quoted would result in feelings that one could not be successful and behaviours that are not well designed to bring about success.

Beck (1972) has focused more on the nature of erroneous thought processes than on specific life events. He identified several patterns of erroneous thinking including the following:

Selective abstraction: Focusing only on certain details while ignoring others.

Dichotomous thinking: Believing that everything is good or bad, black or white, with, nothing in between.

Overgeneralisation: Arriving at far-reaching conclusions on the basis of little data.

Magnification: Overestimating the importance of an event (the same as the REBT concept of catastrophizing).

Arbitrary inference: Drawing conclusions that things are bad with no evidence.

Personalisation: viewing events as related to oneself when they are not.

Ellis speaks of *'irrational and rational thoughts,'* Beck of *"automatic thoughts,"* and Meichenbaum of *"self-instructions"* all of which are spontaneous thought processes that occur when an individual is confronted with experience. These thought processes derive from adults instructions that children internalise while growing up and later apply to new situations.

Thus, from this perspective, parenting practices influence one's subsequent ability to think effectively, to feel confident and competent, and to behave using the maximum amount of one's resources. For clients to change their behaviour, they must learn new ways of thinking, which is the means by which cognitive counseling achieves its purpose.

Self Assessment Questions

1) What are the main features of cognitive theory of counseling?

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2) Discuss the ABC model of the theory.

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3) Explain different patterns of erroneous thinking. According to Albert Ellis.

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4) Explain the erroneous thought processes according to Aaron Beck.

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4.5.2 The Counseling Process

The counseling process has similar elements in each of the cognitive systems and *cognitive restructuring* is the principal mechanism of change.

The first step is to have the client describe the stressful situations in his or her life and to identify the faulty thinking that underlies the feelings. The counselor identifies the irrational thoughts, automatic negative thoughts, and silent assumptions that the client uses to interpret (erroneously) his or her experience. The cognitive errors and distortions may be explained to the client, (as occurs in REBT), or discussion is structured so that the client comes to see his or her errors of reasoning (as in Beck and Meichenbaum's approach). Then more adaptive alternative patterns of thinking can be developed.

In REBT, the alternatives are relatively easy to construct once the irrational thinking is identified because they are direct modifications of Ellis's list of irrational thoughts.

For example, the thought "I must be loved and accepted 'by almost everyone" might be modified to "It would be nice to be widely cared for, but there are some significant people who like me and I can get along okay even if I don't get the attention I want from everyone else.'

The counseling process adds *D & E* components to ABC theory of personality where D is the *disputing intervention (D)*. The scientific method is used to identify Where E is *new rational thoughts* (E) about the client's situation.

When this occurs, the client will change in cognition, affect, and behaviour.

Ellis has referred to this process as *"de propagandizing"* because it results in the client's giving up irrational beliefs that he or she was taught (as propaganda) during the formative years. Techniques such as persuasion, suggestion, instruction, and discovery of new ways of thinking through the 'Socratic' method are common in the cognitive therapies. Planning of specific actions to take place outside of counseling, rehearsing the client's role in these new actions, and reviewing success are also parts of the cognitive counseling process. Thus, clients are given homework assignments in order to experiment with their environment between sessions and acquire new learning.

Beck's cognitive approach leads to examination of the client's story for examples of selective abstraction, dichotomous thinking, overgeneralisation, magnification, arbitrary inference, and personalisation in the client's response to troublesome circumstances. Seeing that a client looks at behaviour in an all-or-nothing manner, makes mountains of molehills or jumps to conclusions, the counselor helps the client understand the erroneous nature of his or her thinking.

Meichenbaum also suggests that it is important to look for *self-talk* that, if present, would lead to better conclusions. Thus, it is important to consider what the client has overlooked as well as the cognitive errors that he or she has made.

The cognitive approach to counseling is placed near the rational and counselor-controlled end of the continuum of counseling theories. The counselor enters the client's world of experience through his or her thinking (cognitive) processes, and the counselor takes charge of the counseling. Nevertheless, it is the client's goal of coping more effectively with troublesome experience that shapes the content for counseling.

4.5.3 Stages of Counseling

Although Ellis places little importance on first-stage counseling skills, the other cognitive therapists see the conditions of the first stage as important to establishing a therapeutic alliance with the client, creating a climate of trust so that the client will respond to the interventions the counselor suggests. None of the cognitive therapists would see the first-stage conditions alone as sufficient for effective and efficient treatment.

In cognitive counseling, the in-depth exploration process of the second stage allows the client to identify issues with which he or she is experiencing difficulty and to explore the thought patterns that underlie the unpleasant feelings and ineffective behaviours.

The counselor helps the client identify fallacies in perceptions, inaccuracies in information, and self-defeating behaviours. Although the affect attached to certain circumstances signals where the client is experiencing difficulty and the severity of that difficulty, discussion focuses more on thoughts and actions than on feelings.

The client's goal of becoming more effective in managing troublesome aspects of his or her life becomes clearer. Some cognitive counselors (e.g., Ellis) tend to move fairly quickly through this stage, others engage in more discussion, and their exploration process may not seem very different from that of a person-centered or psychoanalytic counselor, except for the emphasis on thoughts.

The third stage is more elaborate in the cognitive approach than in others. The client is instructed to go out and behave differently, either by implementing newly discovered rational thinking or possibly by experimenting with finding – new information about his or her beliefs about others. Scientific problem solving, led by the counsellor but with the client as an active participant, leads to plans of action. As with any new learning experience, new patterns may not be implemented perfectly at first, but reinforcement and refinement are necessary. Cognitive counseling aims to bring about changes in actions in a comparatively short time.

4.5.4 Cognitive Therapy Techniques

Humour is used as a way of helping clients to 'interrupt' their own seriousness and to separate themselves from stuffy, outmoded and dysfunctional beliefs.

Homework to the clients which include self- monitoring and recording of negative thoughts and self- sabotaging beliefs, as well as exercises in critical thinking and questioning.

Written work is sometimes included which may take the form of writing down and disputing personal beliefs which may have caused problems in the past.

Imagery is also used in which clients are sometimes asked to imagine themselves responding in positive ways to situations which have been problematic for them in the past.

Role plays are also used. For example, a client could role play some feared or threatening future event such as public speaking or a job interview.

Modelling is also used. It is not restricted to counseling sessions but may be extended to models of positive behaviour which clients may have observed in others.

The technique of cognitive distraction is used as a means of helping clients deal with anxiety and depression. This means encouraging clients to learn relaxation procedures, yoga or meditation but it also means teaching them how to dispute the irrational beliefs which cause problems for them.

It advocates reading, listening to tapes, attendance at lectures and workshops and generally becoming independent in the search for improvement and change. Hence, this approach is also viewed as self-help approach.

Semantic Correction is another technique used with clients who over generalise or make sweeping statements.

Shame attacking exercises are used with clients who are fearful of exposing personal weakness or those who are inhibited about expressing themselves. They are encouraged to take risks and engage in some form of activity which will

prove to them that their fears are exaggerated. For example, a client may be asked to become more gregarious socially, either in dress, behaviour or manner.

4.6 CLIENTS WHO BENEFIT FROM THIS APPROACH

Clients who lack assertiveness or those who experience problems in relation to negative thinking and depression.

Clients who need specific interventions such as family or marital therapy may also be helped by this approach.

The principles of this approach can be applied to education and child therapy and this flexibility of application is one of its main assets.

4.7 LIMITATIONS OF BEHAVIOUR THEORY OF COUNSELING

Clients who wish to conduct an in – depth study of childhood events and attendant traumas cannot seek this therapy as this approach tends to minimise the past.

The active, directive and action- based nature of the approach may not appeal to some clients and some of them may feel threatened by it.

Self Assessment Questions

1) What are the D and E components that are added to the ABC model of cognitive theory?

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2) What are the different stages of counseling?

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3) Explain different cognitive therapy techniques.

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4) Which are the clients who will benefit from cognitive therapies?

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5) What are the limitations of cognitive behaviour therapy?

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4.8 LET US SUM UP

The behavioural therapy has been effective in shifting attention away from the intensely introspective approach to clients and focuses directly on the client's undesirable behaviour. This approach facilitates relearning and healthy behavioural change through various methods. The rationale of behaviour therapy is that maladaptive and neurotic problems which have been learned can, according to the same principles of acquisition, be unlearned.

A basic aim of behavioural counseling is to enable clients to exercise more control over their own behaviour and the environment. Secondly, to help clients reduce the distress, anxiety and inconvenience central to most behavioural problems.

Some of the behavioural techniques which are frequently used are : Relaxation training, Systematic desensitisation, Client self-monitoring, Practicing and planning behaviour, Assertiveness training, Social skills training, Reinforcement methods, Modeling , Focus on physical exercise and nutrition , Imagery and visualisation.

Cognitive counseling provides a model for understanding and intervening in human behaviour in which the point of entry is through the thinking process. The fundamental assumption is that more effective thinking will result in more satisfactory behaviour and feelings. For certain clients, identifying faulty thinking and learning more effective ways of viewing life experiences can result in rapid improvement. Cognitive counselors regard erroneous thinking as the source of emotional upset and ineffective behaviour.

This is a highly active and directive approach which incorporates elements of teaching, persuasion, debate and even humor within its repertoire. ABC model helps us to understand how the clients can change their irrational thoughts. Cognitive therapy techniques include: Humour, Self- monitoring and recording of negative thoughts and self- sabotaging beliefs, Role plays and modeling, The

technique of cognitive distraction, Reading, listening to tapes, attending lectures and workshops, Semantic Correction and Shame – attacking exercises.

4.9 UNIT END QUESTIONS

1) Discuss some of the behavioural techniques.
2) Construct a hierarchy to desensitise a person suffering from phobia of dogs.
3) Explain ABC model of Counseling.
4) Discuss some of the cognitive therapy techniques.

4.10 GLOSSARY

Systematic desensitisation : It is a technique devised by Joseph Wolpe. It is used in behavioural counseling as a means of helping clients deal with irrational fears and phobias.

Real-life desensitisation : It is the most effective method of dealing with phobias, and is often used following a period of visual or imagery desensitisation.

Assertiveness training : The most important aspect of assertiveness training is to help the clients differentiate between *'submissive', 'aggressive' and 'assertive'* styles of communication.

Semantic Correction : It is a technique used with clients who over generalise or make sweeping statements.

4.11 SUGGESTED READINGS

Geldard, K. & Geldard, D. (2003) *Counselling Skills in Everyday Life.* Palgrave publications.

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UNIT 1 COUNSELLING CHILDREN AND ADOLESCENTS

Structure

1.0 INTRODUCTION

In this unit we are dealing with counseling children and adolescents. We start with the process of counseling children, which includes the environment, the referral process etc. The goals of counseling are then discussed in detail and emphasis on confidentiality of the information and how to terminate a counseling session. The next section in this unit deals with child treatment issues and deals separately with counseling older and younger children respectively. Then we take up the play as the medium, how toys arte important for children to express their feelings etc. we consider the therapeutic activities such as art, music, bibliotherapy Therapeutic Activities include art, music, bibliotherapy, story telling, etc. Then we take up counseling of adolescents, their issues and the cognitive changes that come about and the psychological and social changes that are aimed at in adolescent counseling. Then we discuss the different methods of counseling adolescents, their risk taking behaviour etc. Within this we discuss family counseling, individual counselling and relevant counseling skills.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the process of counseling children;
- Explain the Goals of child counseling;
- Enlist the Play and therapeutic techniques;
- Describe Adolescent issues;
- Explain the goals of counseling adolescents; and
- Analyse the Relevant counseling skills.

1.2 COUNSELLING CHILDREN

Vast advances in information technology have exposed children to various situations and also made us aware of every possible harm that can come to them, giving us insight into the level of complexity that children face today in negotiating every type of developmental milestone. Children are faced with violence and sexually explicit images through television, videos, and the internet that children fifty years ago never dreamed of seeing. Children are being exploited sexually through child pornography.

Counseling children occurs both in school and in clinical settings. Although the process is similar in both settings, there are differences in the environment, referral process, goals, confidentiality, and termination.

1.2.1 The Environment

The school is natural, every day setting in each child's world. Access to educators and peers who interact with the child and the opportunity to observe the child's interactions with others provide the counselor or therapist with rich diagnostic information for both understanding the child and constructing effective interventions. In contrast, in the clinical setting the practitioner is dependent on parental report and observations of the child in early sessions to more fully understand the child and his or her needs.

1.2.2 The Referral Process

Referral for counseling and psychotherapy in clinical settings most often involves parent's seeking treatment for their child for a variety of reasons, some of which maintain the privacy of the family (i.e., behaviours that occur only in the family setting and are not open to other scrutiny). Commitment to the therapeutic process is made by the parent who brings the child for counseling in schools. Referral typically is initiated by the teacher because of behaviours the child is exhibiting that are disruptive to the educational process for the child or for others.

1.2.3 Goals of Counseling

In the clinical setting, goals of counseling derive from goals found within the mental health system (i.e., promoting emotional functioning that allows the child to process normally in all developmental areas); in the school setting, however, such goals frequently are an integration of the goals of both the educational and mental health systems, which often are conflicting. The educational and mental health systems, share the goal of promoting growth in children, but they have different perspectives and priorities about what it means to promote growth in children. Educational systems focus on academic progress, socialisation, and appropriate behaviour; thus counselors and therapists working in school systems must focus on developing emotional, behavioural, and social skills and functioning that will lead to the child's full participation in the educational process.

1.2.4 Confidentiality in Schools

Ensuring confidentiality requires constant vigilance in any setting. However, in schools the pressure to share information with others who work with the child is constant additionally, teachers and other school personnel do not share the ethical codes that govern the professional behaviour of counselors and therapists, and at times they will talk indiscriminately in the halls or teachers lounge about children and their families. The success of treatment efforts requires some communication with those directly involved with the child. Finding ways to share just enough information to ensure the success of a recommended intervention in the classroom without violating the child's confidentiality and privacy is a necessary skill for practitioners working in school setting to develop.

1.2.5 Termination of Counseling

Termination usually occurs when the goals of counseling have been met and the child's emotional functioning is adequate. In schools, however, termination often occurs when the school year ends rather when the child's goals are met. Children who need continued care through the summer months should be referred to community professionals. However, changing counselors can be disruptive to the therapeutic relationship and at times results in the child's resistance to developing new therapeutic relationships.

1.3 CHILD TREATMENT ISSUES

Some aspects of counseling children are different from counseling adults. In addition to noting developmental changes that are ongoing processes with children, Clarisio, and McCoy (1983) summarise three unique aspects of counseling children.

First, children rarely present themselves voluntarily for counseling. In the school setting they typically are referred for counseling by their teachers, parents, or school administrators, and in clinical setting they usually are brought by their parents. However, the effect of involuntary submission for counseling may not be resistance in the same for as it is with many adults who are required to submit to counseling. Behaviours ranging from passive compliance to refusal to go to counseling are possible, but often children will go to counseling because they haven't considered the possibility that they can refuse.

Second, children often lack an explicit understanding of the counseling process, purpose and goals, and of the role they play in developing more functional feelings and behaviours.

Third, children are dependent upon and influenced by their environment, particularly their families and the school. Thus they are vulnerable and in need of protection potentially harmful influences. This condition provides a challenge to counselors to carefully consider information and advice given to children to ensure that it does not lead them to further conflict with their environments However, it also provides an opportunity to enhance children's personality development and influence significant others in children's lives.

1.4 COUNSELING TECHNIQUES FOR OLDER CHILDREN

Counseling or psychotherapy for older children often requires techniques similar to those used with adults. Use of structured games is often effective in the development of the therapeutic relationships for older children, but because language skills have developed, verbal exchanges are meaningful in bringing about positive changes in cognitions.

1.5 COUNSELING TECHNIQUES FOR YOUNGER CHILDREN

Using the play environment as a background for counseling young children allows the counselor or therapist to have increased communication with the child without increasing the amount of language used in the counseling session. Landreth (1982) refers to play as children's language and suggests that play facilitates expression of thoughts and feelings. Additionally, the use of art, music, books, storytelling, and computers as tools for communication of feelings provides the counselor with a wide range of tools for working with children.

1.6 PLAYS AS MEDIUM

A plethora of innovative play therapy techniques have been developed in recent years to implement the therapeutic powers of play. Fifteen techniques are described that are effective, enjoyable, inexpensive, and easy to implement. Included in the description of each technique are the therapeutic rationale, materials needed, step-by-step implementation guide, and applications. The techniques selected are appropriate for 4 to 12 year old children and cover an extensive array of play approaches (e.g., art, fantasy, sensorimotor, and game

play). The chosen techniques address several pertinent presenting problems such as anxiety, depression, impulsivity, distractibility, and noncompliance.

For over 60 years, play therapy has been a well-established and popular mode of child treatment in clinical practice. One reason play therapy has proven to be a particularly useful approach with children is that they have not yet developed the abstract reasoning abilities and verbal skills needed to adequately articulate their feelings, thoughts, and behaviours. For children, toys are their worlds, and play is their conversation.

Play therapy can be defined as an interpersonal process wherein a trained therapist systematically applies the curative powers of play (e.g., relationship enhancement, role-playing, abreaction, communication, mastery, catharsis, attachment formation, etc.) to help the clients resolve their current psychological difficulties and help prevent future ones. Play therapy techniques specify how to use the play materials so as to effectively implement the therapeutic powers of play (Schaefer, 1993).

Described below are 15 clinically useful play therapy techniques. The goals of the chosen techniques include helping children become aware of and express their feelings, manage anger, improve self-control, reduce fear, anxiety, and depression, increase empowerment, and enhance problem solving skills. (Refer to box below)

1) **The Feeling Word Game**

Therapeutic Rationale

Often children have difficulty verbalising their feelings when directly questioned, either because they are guarded or they do not connect with those feelings they find most threatening. When involved in playing a game, children's defenses are reduced, and they are more likely to talk about their feelings. The Feeling Word Game allows children to communicate their feelings in an enjoyable, nonthreatening manner.

Applications

The Feeling Word Game can be successfully used with all children, including those with conduct problems, attention-deficit/ hyperactivity disorder (ADHD), or anxiety problems. This technique is a fun and nonthreatening way for therapists to discuss and question issues that are generally too intimidating for the child to communicate about directly.

2) **Color-Your-Life**

Therapeutic Rationale

Color-Your-Life provides children with a nonthreatening, concrete method of understanding and discussing various affective states. It is critical for children to develop certain skills to successfully manage their affect. Specifically, children need to develop an awareness of numerous affective states, the ability to relate those states to their environmental events, and the skill to verbally express these feelings in an appropriate manner.

Applications

Color-Your-Life is suitable for all children between 6 and 12 years of age. The basic requirement is that the children are able to recognise and name colors as well as various affective states. The technique can be used in an individual or a group format. It is helpful to use the technique at several points throughout the therapy in order to examine what change has occurred.

3) **The Pick-Up-Sticks Game**

Therapeutic Rationale

The Pick-Up-Sticks Game was designed to facilitate affective expression in children. The technique is a fun way for children to express their feelings and pair various affective states with environmental events in a game context. In order for the Pick-Up- Sticks Game to be successful, the children must already be familiar with color–feeling pairs. One way to introduce them to this is by first playing Color-Your-Life, described above.

Applications

The adapted version of the Pick-Up-Sticks Game is applicable for 6–12-year-old children. This technique can be used in an individual or a small group format.

4) **Balloons of Anger**

Therapeutic Rationale

It is crucial to help children understand what anger is and how to release it appropriately. Balloons of Anger is an enjoyable, effective technique that provides children with a visual picture of anger and the impact that it can have upon them and their environment. It allows the children to see how anger can build up inside of them and how, if it is not released slowly and safely, anger can explode and hurt themselves or others.

Applications

Balloons of Anger is effective for aggressive children who have difficulty controlling their anger and for withdrawn children who internalise their anger instead of expressing it. This technique can be used in an individual or a group format.

5) **The Mad Game**

Therapeutic Rationale

The Mad Game was designed to show children that anger is a common, acceptable feeling, and it allows children to verbally and kinesthetically express their anger.

Applications

The Mad Game can be used in an individual or a group format. This technique can be slightly altered to express feelings other than anger, such as sadness or anxiety.

6) **Beat the Clock**

Therapeutic Rationale

Beat the Clock was designed to increase children's self control and impulse control. The goal of this game is for the child to resist distraction, remaining on task and focused for a specified period of time. When the child successfully completes this task, she or he receives poker chips, which can be cashed in for a prise. When the child is successful at the game, the child is filled with a sense of competence and accomplishment.

Applications

Beat the Clock can be used in an individual or a small group format. This technique is useful for any child who has impulse control problems (e.g., children with ADHD).

7) **The Slow Motion Game**

Therapeutic Rationale

It is well known that children learn best by doing. The Slow Motion Game was designed to have children actively practice self-control over their movements in a playful group context.

Applications

The Slow Motion Game is successful with any group of children that has difficulty maintaining self-control. Also, common board games can be effectively used to increase children's self-control.

8) **Relaxation Training: Bubble Breaths**

Therapeutic Rationale

Bubble Breaths is an extremely useful and concrete relaxation technique designed to teach children deep and controlled breathing while helping them become aware of their own mind–body connections. Bubble blowing is fun, inexpensive, and allows nonthreatening interactions between the child and therapist.

Applications

Bubble Breaths can be used in an individual or a group format. It is a simple, inexpensive technique that is extremely engaging and nonthreatening. This technique is especially useful in reducing anger, anxiety, or tension in children.

9) **Worry Can**

Therapeutic Rationale

Children often worry about numerous things that they keep bottled up inside. These worries may be the root of some of their presenting problems, such as fears, peer conflict, temper tantrums, and separation anxiety. Worry Can is an effective method for helping children to identify and then discuss their worries with an adult and/or other children.

Applications

Worry Can may be used in an individual or a group format. It can be adapted to be used as an Anger Can or as a Sad Can. A variation of this technique is The Garbage Bag Technique Two brown sandwich bags may be used as garbage bags one for garbage from home and one for garbage from school. The child is instructed to decorate the garbage bags and then place three strips of paper, each with a separate problem, in each bag. The following session, the child picks out a piece of garbage to play out in miniatures or in role-playing. Often children will develop their own solutions to their problems. If this does not occur, the therapist should be directive and intervene with suggestions in the context of the play. The therapist needs to keep the play in the third person so as to allow the child to maintain enough distance from the problem in order to solve it.

10) **Party Hats on Monsters**

Therapeutic Rationale

Party Hats on Monsters is a drawing strategy designed to enable children to gradually face their fears in a nonthreatening, enjoyable manner. Most children find it more comfortable to express their fears through drawing as opposed to verbalising them. Furthermore, children find it reassuring when they are not required to face their worst fear or anxiety immediately. By experiencing step by step success facing the feared object, the children's confidence and sense of mastery are increased.

Applications

This technique is appropriate for preschool and school-age children. Although it is beneficial for helping children face their common fears, it is especially effective for children who have anxiety disorders. This technique can be slightly altered by providing children with the option of sculpting their fears in clay.

11) **Weights and Balloons**

Therapeutic Rationale

A common challenge in therapy is making abstract therapeutic constructs understandable, meaningful, and concrete to children. Techniques that are enjoyable and "hands-on" are an ideal way to teach children these complex concepts. Weights and Balloons is an easy, effective technique for teaching children the somewhat complicated cognitive behavioural theory of depression.

Applications

Weights and Balloons is an inexpensive technique that transforms a complex idea into something concrete and understandable. This technique is particularly useful for children who are depressed. However, it is useful with all children to illustrate the effect that thoughts have on feelings.

12) **The Power Animal Technique: Internalising a Positive Symbol of Strength**

Therapeutic Rationale

Children who are referred for therapy often have low selfesteem, ineffective problem solving skills, and difficult relationships with peers and adults. Therefore, primary therapeutic goals often include improving the child's positive sense of self and increasing his or her coping skills. However, it is often difficult for children to articulate what strengths they wished they had or what attributes would help them cope more effectively.

Applications

The Power Animal Technique is useful with any child who might profit from a positive introject.

13) **Using a Puppet to Create a Symbolic Client**

Therapeutic Rationale

Puppets serve a crucial role in play therapy. Frequently, children project their thoughts and feelings onto puppets. In this way, puppets allow children the distance needed to communicate their distress. Furthermore, the puppets serve as a medium for the therapist to reflect understanding and provide corrective emotional experiences in the context of the children's play. Most children naturally project their experiences onto the puppets. However, some children are too fearful and withdrawn to become involved in any aspect of therapy. By using the puppet as a symbolic client the therapist is able to engage these children and overcome resistance. The creation of the symbolic client removes the focus from the child, thereby increasing the child's comfort level and allowing him or her to remain at a safe emotional distance.

Applications

This technique is particularly effective for any child between 4 and 8 years of age who is anxious or withdrawn in the beginning stages of therapy. A variation of this technique would be to have the puppet present with the same problem as the child and to enlist the child's help in brainstorming solutions to solve the puppet's problem.

14) **Broadcast News**

Therapeutic Rationale

It is much easier for children to play out their problems than discuss them. Furthermore, children are better able to solve their own problems when they can distance themselves from them. Broadcast News is an enjoyable, nonthreatening technique that enhances children's verbalisation and problem-solving skills.

Applications

Broadcast News is an extremely useful technique for highly verbal children 6 years of age and older. Children who are very outgoing will find this an easy activity, whereas children who are withdrawn or anxious may have

some difficulty. Puppets can be used if the therapist thinks that the child needs more distance from his or her problems. A variation of this technique is to have a talk show where the child is the host. The therapist is the guest and guides what "issues" she or he is going to discuss.

15) **The Spy and the Sneak**

Therapeutic Rationale

The Spy and the Sneak was designed to transform negative family interactions into positive ones, which would increase the family members' enjoyment of each other and improve their self-esteem. Parents begin to see many of their children's positive qualities and start to reward the good behaviour. Children realise that they get more attention by acting in a positive manner than in a negative one.

Applications

The Spy and the Sneak is a fun, engaging technique that involves no cost but results in huge therapeutic gains. This technique is excellent to use with any family that is experiencing negative interactions. After the family has engaged in the technique for a few weeks, the therapist may choose to instruct the parent and child to switch roles, with the child becoming the spy and the parent becoming the sneak.

Play is *"the child's natural medium of self-expression"* and the child learns through play. Therefore, play is an excellent medium for communicating with children during counseling. Children's growth and development in all areas are facilitated by play through exploring their curiosities, developing relationships with others, learning to express their emotions in socially acceptable ways, learning to cooperate and to share, and experimenting with the use of language. The natural progression of play is spontaneous, unstructured play as toddlers, to structured games with rules between the ages of 7 and 11, to games that require higher cognitive skills in adolescence. The Various play therapy techniques are:

1.6.1 Toys as Tools

A variety of toys recommended as staples in the therapeutic playroom, including a dollhouse with furniture and doll family, doll clothes, baby doll with bottle, puppets, building blocks, toy cars and trucks, toy guns, knives, and swords, stuffed animals, play telephones, crayons, paints, scissors, glue and paper, play dough, and clothes for playing dress-up. Toys should be available that allow children to be creative, to release emotion, to develop insight, to test reality, and to express themes from real life, such as anger and aggression, love and nurturing, and sadness when children find it difficult to express their emotions directly. Puppets provide effective stimuli for dramatised, symbolic acting out of emotions. Toy guns, toy soldiers, play dough, doll families, and drawing and coloring pictures can all be used to encourage expression of need for nurturance and love. Several sources provide suggestions for play activities that may be helpful when planning counseling sessions for children. Kaduson, Cangelosi, and Schaefer (1997) provide suggestions for using play therapy with children who have various internalising, externalising, or stress-produced disorders.

1.6.2 Sand and Water Play

Sand and water are natural media that fascinate children. The sand box can symbolise the child's environment, allowing the child to build the world of his fantasy by using toy cars, building-block houses, and doll figures. The child then plays out themes representative of the conflicts he or she is experiencing. Use of dry and damp sand in separate waterproof trays that are painted blue so that a lake is represented when the sand is pushed aside provide stimuli for the changing themes of children's play. Chaos, struggle, and resolution are common stages that recur in children's sand play. Additionally, water play has been used for work with overly active and constricted children, providing an outlet for aggression or for relaxation.

1.7 THERAPEUTIC ACTIVITIES

Many other therapeutic activities can be used effectively when counseling children. They include the use of art, music, books, storytelling, computers, and physical activity.

1.7.1 Art

Art has been used for therapeutic process for over 30 years since the development of this technique for working with children (Kramer,1958). Art therapy includes the use of materials such as crayons, paints, clay and play dough for drawings and sculptures. Techniques used to discover the hidden messages of the child's conflict as revealed through the art include listening to the child's "art talk", observing, intuitive guessing and interpretation of form and content(Orton, 1997).

1.7.2 Music

Music therapy has been used effectively in counseling to reduce stress and anxiety. Music can enhance the counseling programme whether the counselor is musically talented or not.

1.7.3 Bibliotherapy

Bibliotherapy or the use of literary forms in counseling children is used widely by elementary school counselors and psychologists as well as other mental health professionals. It provides a fun and relaxing activity while children gain insight into human behaviour, clarify their values and attitudes, develop understanding of socialisation patterns, increase self –awareness and identify and solve problems.

1.7.4 Storytelling

It is a therapeutic technique in which children are asked to tell a story with a beginning, middle, end, and moral. Story plots and characters of stories children tell have been found to parallel the events of children's lives, thus providing the counselor or therapist with insight into inner conflicts the child is confronting and allowing the child the opportunity to gain insight into the events and resolve the conflicts in new ways. Storytelling can be used in conjunction with drawings the child makes by having the child tell a story about the drawing. Metaphors, which provide a form of symbolic communication, have been found to be effective means of communication when working with young children. Using age - appropriate vocabulary and the therapist goal as a guide, stories can be modified to address specific issues the child must resolve.

1.7.5 Other Techniques

With the dawning of the computer age and videogames, the use of computer art and games has been explored as a therapeutic technique that captures the attention of today's youth. Bowman and Rotter (1983) found that there are computer games that enhance cooperation, allow creative activity and promote social and emotional learning. Additionally, use of physical activity, especially pleasant events, with depressed children has shown therapeutic outcomes when integrated with other interventions.

Self Assessment Questions

1) Explain the goals of counseling children.

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2) Explain the significance of play in child counseling.

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3) Describe the therapeutic activities that can be used effectively when counseling children?

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4) What are the various play therapy techniques that we can use?

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5) What are bibliotherapy and storytelling techniques? Explain

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1.8 COUNSELLING ADOLESCENTS

Adolescents are neither children nor adults but they are in a transition between being a child and being an adult. They are in a process of establishing their own identity and beginning to individuate from the family. As a result many young people are reluctant to express their personal issues in front of the whole family. However, this problem can easily be overcome by offering them individual counseling.

As adolescents have complex cognitive processes and advanced cognitive skills than children, a counselor can employ advanced intervention strategies than those that can be used with children. It is also important for the counselor to respect the young person as an individual who wants to take responsibility for their own decisions rather than someone who wants to be told what to do.

To meet the special counseling needs of young people, a proactive approach for counseling adolescents is proposed by Geldard & Geldard. In the proactive approach for counseling, the counsellor:

- is authentic and open
- is proactive in introducing creative, experiential, cognitive and psycho – educational strategies
- is responsive to the young person's developmental needs
- matches the adolescent style of communication
- uses particular counseling skills

1.8.1 Adolescent Issues

Adolescent moves from being part of the family group towards being part of a peer group and to standing alone as an adult. He moves from dependency to independence, autonomy and maturity. As a consequence, he faces not only biological changes but also cognitive, psychological, social, moral and spiritual challenges.

1.8.2 Cognitive Changes

Adolescents continually explore, challenge and change their constructs about the way they view their world. They develop egocentric thinking to that extent that they believe every one is watching them as though they were on stage. They feel that they are unique, omnipotent, and powerful and they cannot be hurt. However, this is part of a complex process of becoming a unique individual on a journey which leads to adulthood.

1.8.3 Psychological Changes

The most important psychological task for an adolescent is the formation of a personal identity. As they are on a journey of self-discovery, they are continually adjusting to new experiences, encounters and situations while at the same time adjusting to biological, cognitive and psychological changes. These situations are naturally stress and anxiety provoking. As adolescents are characterised by emotional reactivity and a high intensity of emotional response, their relationships will also get affected.

1.8.4 Social Changes

Adolescents are challenged to make changes to their social behaviour as a consequence of the expectations of society, parents, and family and peer groups. As parents are also unprepared for their child's adolescence, unrealistic expectations may develop. This results in tensions within the family which strains family relationships.

1.8.5 Influence of Peer Pressure

Adolescents are subjected to strong social pressures to conform to group behaviours. They navigate the individuation process by first establishing their social identity in the peer group. But if their behaviours are self- destructive or antisocial there are likely to be negative consequences for the adolescent. Parents become anxious when their adolescents make changes to their personal appearance in ways which are not easily acceptable to them. The way adolescents present themselves is subject to fashion and also group membership.

1.8.6 Risk Taking Behaviour

Adolescence is a time of experimentation and trying out new behaviours in response to new situations. This tendency to take risks is increased by the influence of peers who may encourage such behaviour by demonstrating their own ability to take risks or through a desire to obtain vicarious pleasure from observing another adolescent's risk taking behaviour. As adolescents tend to compete for status and attention, there is likely to be strong pressure to participate in life threatening and risk taking behaviour.

1.8.7 Dealing with Sexuality Issues

Adolescents are likely to feel romantic attachments involving sexual attraction mostly in opposite- sex relationships and sometimes with same –sex relationships. But these relationships may be temporary, unstable and vulnerable o change. As most adolescents experience powerful feelings of romantic love they may suffer in self-esteem when rejected by the person they love. In the case of some adolescents, who, because of personality or poorly developed social skills are unable to experience a relationship with someone they find attractive. This can have a negative effect on their self-esteem and may lead to depression.

1.9 WAYS OF COUNSELING ADOLESCENTS

The following approaches can be used in dealing with the relationship problems of the adolescents:

- Family counseling
- Individual counseling
- Subgroup counseling for the adolescent and siblings
- Subgroup counseling for the adolescent and parents.

1.9.1 Family Counseling

Sometimes relationship problems of the adolescents can be resolved through family counseling. In this process, adolescent may be able to openly express the

issues that are troubling for them. This can lead to a dialogue between members of the family about the issues, and decisions will be made which will resolve a relationship problem. However, some adolescents are reluctant to participate openly in a family counseling as they may feel disempowered by other family members.

1.9.2 Individual Counseling

Proactive approach can be used in dealing with counseling adolescents and to maintain their interest and cooperation in the counseling process we can make use of symbolic, creative, cognitive, behavioural and psycho – educational strategies.

1.9.3 Subgroup Counseling for the Adolescent and Siblings

Many adolescents are able to work through issues with their siblings in a counseling environment. Circular questions can be used to engage the participants in conversation so that they can share their point of view. During this conversation, it is helpful if excessive discussion of unsatisfactory past events which have impacted on the relationship can be minimised. Instead, the emphasis is placed on looking at options and finding solutions in the here and now. Sometimes it can be helpful to use role reversal for a short time during such a session.

1.9.4 Subgroup Counseling for the Adolescent and Parents

During the session with parents and adolescents, counselors need to pay careful attention to avoid giving the impression that they are biased towards one party. If either the parent or the adolescent gain the impression that the counselor is taking sides, the counseling process is likely to be comprised. Parents will find it difficult to relinquish their level of control of the adolescent while at the same time the adolescent will be struggling to be in control of his own life by striving for autonomy and freedom from parental control. A psycho educational strategy can be useful in helping to address this issue. The situation can be normalised by explaining the inevitability of the struggle between a parent and adolescent. Moreover, the parties may have difficulty in hearing what each other has to say. In this situation, it may be helpful to address basic communication behaviours based on the need to listen and validate what each other is saying.

Self Assessment Questions

1) Discuss the various methods of counseling adolescents.

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2) How would you bring about cognitive and psychosocial changes? Describe the methods.

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3) What is meant by family counseling?

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4) Differentiate between individual and group counseling.

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1.10 RELEVANT COUNSELLING SKILLS

Apart from basic counseling skills, some skills which are essential when counseling young people with regard to relationships are:

- Transitional questions
- Choice questions
- Guru questions
- Normalising

1.10.1 Transitional Questions

Transitional questions are useful in inviting them to return to a previous topic of discussion. Examples of transitional questions are:

'You were telling me how angry you feel towards your stepfather and I would be interested to know what that anger is about. Would it be helpful for you to tell me about that anger?

1.10.2 Choice Questions

These questions are particularly useful when counseling young people with regard to relationships. These questions make it clear that the young person has a choice about the way they think and behave and may also draw attention to the consequences of decisions.

The counselor might ask the choice questions like:

'What other choices could you make in responding to your step father?'

'What would be the consequence for you if you were to talk to him about what troubles you?

1.10.3 Guru Questions

Young people are keen to give each other advice and to receive advice from their peers. When young people come to counseling, they will often ask a counselor what they should do. Sometimes it may be useful for the counselor to make a suggestion but it should be stated in this way

'I don't know whether this would work for you. What do you think?'

Guru questions invite the client to be their own adviser. For example, if Anil were to ask a counselor, 'Do you think I should apologise to Vijay?', the counselor might invite Anil to get up from his seat, stand in a new position facing his seat and to imagine that he is a Guru, a wise person. The counselor might then say to Anil, who is imagining he is a guru, 'Guru, you are a very wise person and I want you to give Anil some advice. Imagine that he is sitting in that chair (the chair Anil was sitting in) and tell him what to do.'

Many young people will enjoy this approach as it invites them into an advisory position. They often find that in that position they are able to offer themselves useful advice.

1.10.4 Normalising

It is another counseling skill that can be very helpful to an adolescent with a relationship problem**.** Sometimes, young people believe that they are different from other young people and this affects their self-esteem. For example, a young person might say, "I should be able to get on with my mother and I can't. My friends like her but I argue with her all the time.'

In these cases before working on relationship problems between the client and his mother, the counselor should normalise the situation. This can be achieved by explaining to the client that at this stage, it is normal for the young person to want to individuate and it is normal for parents to resist these attempts and so some level of conflict is inevitable. Once this normalisation statement has been absorbed by the client, he would be ready to enter into the relationship counseling with his mother more comfortably.

Self Assessment Questions

1) Explain the issues of adolescents.

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2) What are the different ways of counseling adolescents?

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3) Explain the specific counseling skills used in adolescent counseling.

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1.11 LET US SUM UP

Vast advances in information technology have exposed children to various situations and also made us aware of every possible harm that can come to them, giving us insight into the level of complexity that children face today in negotiating every type of developmental milestone. Children are faced with violence and sexually explicit images through television, videos, and the internet. Counseling children occurs both in school and in clinical settings. Although the process is similar in both settings, there are differences in the environment, referral process, goals, confidentiality, and termination.

Some aspects of counseling children are different from counseling adults. Using the play environment as a background for counseling young children allows the counselor or therapist to have increased communication with the child without increasing the amount of language used in the counseling session. Play is children's language and suggests that play facilitates expression of thoughts and feelings. Additionally, the use of art, music, books, storytelling, and computers as tools for communication of feelings provides the counselor with a wide range of tools for working with children.

Adolescents are neither children nor adults but they are in a transition between being a child and being an adult. They are in a process of establishing their own identity and beginning to individuate from the family. As a result many young people are reluctant to express their personal issues in front of the whole family. However, this problem can easily be overcome by offering them individual counseling.

Adolescent moves from being part of the family group towards being part of a peer group and to standing alone as an adult. He moves from dependency to independence, autonomy and maturity. As a consequence, he faces not only biological changes but also cognitive, psychological, social, moral and spiritual challenges.

The approaches that are used in dealing with the relationship problems of the adolescents are family counseling, individual counseling, sub group counseling for the adolescent and siblings and subgroup counseling for the adolescent and parents. Apart from basic counseling skills, some skills which are essential when counseling young people with regard to relationships are transitional, choice, guru questions and normalising.

1.12 UNIT END QUESTIONS

1) Discuss the different issues encountered by children and adolescents.
2) How do we use play techniques in counseling with children?
3) What are the various play techniques that we can use effectively in counseling children.
4) Specific counseling skills are used in counseling adolescents. Discuss.
5) What are the different ways of counseling adolescents?
6) Describe the therapeutic activities that can be used effectively when counseling Children and adolescents.
7) What is subgroup counseling? Explain

1.13 GLOSSARY

Bibliotherapy : It refers to the use of literary forms in counseling children. It provides a fun and relaxing activity while children gain insight into human behaviour, clarify their values and attitudes, develop understanding of socialisation patterns, increase self –awareness and identify and solve problems.

Storytelling : It is a therapeutic technique in which children are asked to tell a story with a beginning, middle, end, and moral.

Transitional questions : These are useful in inviting the clients to return to a previous topic of discussion.

Choice questions : Young person has a choice about the way he thinks and behaves and may also draw attention to the consequences of decisions.

Guru questions : These questions invite the client to be their own adviser.

Normalising : The facts are explained to the clients and are made to believe that their behaviour and reactions are quite normal.

1.14 SUGGESTED READINGS

Geldard,K. & Geldard,D.(2008). *Counselling Children – A Practical Introduction*. 3rd edition, Sage Publications.

Geldard,K. & Geldard,D.(2009). *Relationship Counselling for Children, Young People and Families*. 1st edition, Sage Publications.

Geldard,K. & Geldard,D.(2010). *Counselling Adolescents: The Proactive Approach for Young People*. 3rd edition, Sage Publications.

Prever,M.(2010). *Counselling and Supporting Children and Young People*: *A Person-centred Approach*. 1st edition, Sage Publications.

UNIT 2 COUNSELING IN FAMILY AREAS

Structure

2.0 INTRODUCTION

This unit deals with counseling in family areas. It starts with developmental models of Family Life. It explains what is family life, what is family life spiral and the family genogram and how they are to be used in counseling. Then we deal with the theoretical antecedents of family counseling in which we deal with conjoint theory, strategic theory and structural theory. This is followed by goals of family counseling and how the process of change is one such goals and how these are achieved in terms of firsgt and second order changes. Then we take upn Intervention Strategies within which we discuss both specific and non specific factors. The conduction of family interview and its importance are taken up followed by techniques of family counseling wherein we list nout the various techniques that are used in family counseling.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain counseling in family areas;

- Describe developmental models of family life;
- Elucidate the theories of family counselling;
- Enumerate the goals of family counseling;
- Explain what is invoved in the process of change; and
- Analyse the effectiveness of various techniques of family counseling.

2.2 DEVELOPMENTAL MODELS OF FAMILY LIFE

The area of marriage and family counseling/therapy has exploded over the past decade. Counselors at all levels are expected to work effectively with couples and families experiencing a wide variety of issues and problems. Structural, strategic, and transgenerational family therapists at times may seem to be operating alike, using similar interventions with a family. Differences might become clear when the therapist explains a certain technique or intervention. Most of today's practicing family therapists go far beyond the limited number of techniques usually associated with a single theory.

Family systems can be seen as a developmental process that evolves over time. Developmental models of family life include the family life cycle, the family life spiral and the family genogram.

2.2.1 The Family Life Cycle

Jay Haley (1993) offered the first detailed description of a family life cycle. He identified six developmental stages, stretching from courtship to old age. He was interested in understanding the strengths families have and the challenges they face as they move through the life cycle. He hypothesised that symptoms and dysfunctions appeared when there was a dislocation or disruption in the anticipated natural unfolding of the life cycle: "The symptom is a signal that a family has difficulty in getting past a stage in the life cycle."

Tension arises in families overtime because of the developmental changes they encounter. Family stress is most intense at those points where family members must negotiate a transition to the next stage of the family life cycle. On one level, this stress may be viewed as part of the family's response to the challenges and changes of life in their passage through time – for example, a couple may encounter tension while making the transition to parenthood with the birth of their first child. On another level, pressures may emerge from the family's multigenerational legacies that define the family's attitudes, taboos, expectations, labels and loaded issues. For example, over several generations a rule that men cannot be trusted to handle the money may impose stress when the female is absent. When stress occurs on both levels, the whole family may experience acute crisis.

2.2.2 The Family Life Spiral

Combrinck Graham (1985) constructed a nonlinear model of family development called the family life spiral. The spiral includes the developmental tasks of three generations that simultaneously affect one another. Each person's developmental issues can be seen in relation to those of the family members. For example, midlife crisis involves the reconsideration of status, occupation and marital state

for adults in the middle years of their lives. This crisis may coincide with their adolescent children's identity struggles and the parent's plans for retirement. Similarly, when a family's childbearing experience is viewed in terms of grandparenthood, the birth of a child "pushes" the older generations along the timeline, whether or not the grandparents are prepared for their new roles.

Centripetal Periods (CP) - The close periods in family life are called centripetal to indicate the many forces in the family system that holds the family tightly together. Centripetal periods are marked by an inner orientation requiring intense bonding and cohesion such as early childhood, child rearing and grand parenting. Both the individual's and the family's life structure emphasise internal family life during these periods. Consequently, the boundaries between members are more diffuse so as to enhance team work among the members. In contrast to diffuse internal boundaries, external boundaries may become tightened as if to create a nest within which the family can attend to itself.

Centrifugal Periods (CF) – By contrast, the distant or disengaged periods have been called "centrifugal" to indicate the predominance of forces that pull the family apart. These periods are marked by a family's outward orientation. Here, the developmental focus is on tasks that emphasise personal identity and autonomy such as adolescence, midlife and retirement. As such, the external family boundary is loosened, old family structures are dismantled and distance between family members typically increases.

Families move between centripetal and centrifugal forces depending on the developmental tasks required of them at various stages of the family life cycle. A family will typically move through one cycle each 25 years. This period is the time required to produce a new generation. Within each family cycle, different members will experience:

- One's own childhood (CP) and adolescence (CF)
- The birth (CP) and adolescence (CF) of one's children
- The birth (CP) and development (CF) of one's grandchildren

These developmental shifts have been called "oscillations" that provide opportunities for family members to practice intimacy and involvement in the centripetal periods and individuation and independence in the centrifugal periods.

Neither centripetal nor centrifugal directions define a pathological condition. These directions describe the relationship styles of the family at particular stage of the family life spiral. Symptom formation often occurs when the family is confronted with an event that is out of phase with the anticipated development of the family life spiral. Such events include untimely death, birth of a disabled child, chronic illness or war. For some families, stress will develop around typical developmental demands, such as children's needs for dependency as infants or adolescents demands for more autonomy. The intensity and duration of family anxiety will affect the family's ability to make the required transitions. The purpose of family therapy is to help the family past the transitional crisis so that they can continue toward the next stage of family life.

2.2.3 The Family Genogram

Genograms give family therapists another useful way to conceptualise family development. These are used to chart the progression of a particular family through the life cycle over at least three generations. It is like a family tree that includes information about birth order, family members, their communications and issues of relationships. Genograms provide the basis of clinical hypothesis in family work and offer a culturally sensitive method for understanding individual or family clients.

Self Assessment Questions

1) Define the concept family life spiral.

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2) Describe centripedal and centrifugal directions of family pathology.

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3) What is family genogram?

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2.3 THEORETICAL ANTECEDENTS OF FAMILY COUNSELING

There are various ideas that led to the development of a systems approach to counseling and psychotherapy.

2.3.1 Conjoint Theory

Virginia Satir is among the best – loved of all theorists in the field of family therapy. Her family therapy model reflects a growth perspective rather than a medical model for assessing and working with families. According to her, illness is an appropriate communicative response to a dysfunctional system or family

context. Health is developed when the system is changed so as to permit healthy communication and responses.

Satir defined *congruence* as the use of words that accurately match personal feelings. When using congruent communication, the person is alert, balanced and responsive to any question or topic without needing to hold back. In contrast, *incongruence* is seen as communication wherein the nonverbal and verbal components do not natch. Examples of incongruent communication include double messages, assumptions, ambiguous messages and incomplete communication.

According to Satir, self-esteem is the basis for family emotional health. She felt there is a correlation between self-esteem and communication. Low self- esteem is associated with poor communication because low self esteem affects behaviour and interactions among the members of the system. She held that maladaptive communication can be both learned and unlearned.

Satir believed that a functional family is an open system wherein there is a clear exchange of information ad resources both within the system and with the others outside the family. In contrast, a closed system is rigid and maladaptive.

She observed that family pain is symptomatic of dysfunction. She did not feel that the problems the family brought to her were the real difficulty. Rather, she saw the methods of coping within the family and rules for behaviour that were fixed, arbitrary and inconsistent decreased the family's ability to cope over time. Her approach involves the following treatment stages:

- Establish trust.
- Develop awareness through experience.
- Create new understanding of members and dynamics.
- Have family express and apply their new understandings with each other.
- Have the family use their new behaviours outside therapy.

2.3.2 Strategic Theory

Haley(1991) and Madanes (1981) asserted that a family's current problematic relational patterns were at some point useful because they organised family members in a concerted way to solve an existing problem. These patterns persisted because they protected the family from the threat of disintegration. Haley held that therapeutic change occurs when a family's dysfunctional protective patterns are interrupted. He noted that the role of family therapists, through the use of directives, is to provoke such interruptions. Haley offered the Rapist provocations such as the following:

A husband and wife with sexual problems may be required to have sexual relations only on the living room floor for a period of time. This task changes the context and so the struggle.

A man who is afraid to apply for a job may be asked to go for a job interview at a place where he would not take the job if got it, thereby practicing in a safe way.

Therapist directives serve three purposes

- Facilitates change and make things happen
- Keep the therapist's influence alive during the week
- Stimulate family reactions that give the therapist more information about family structure, rules and system.

Haley stated that the goal is not to teach the family about their malfunctioning system but to change the family sequences so that the presenting problems are resolved. His ideas help the family therapist who is using the strategic approach in the following way –

First, a strategic family therapist attends to what is defined by the family members experiencing the problem as the "nature of the problem."

Second, the therapist focuses on how the family is responding in attempting to resolve the problem. The assumption is that it is often the very ways in which families are defining a problem and responding to it that may "keep it going" in a vicious problem-solution cycle.

2.3.3 Structural Theory

Structural family therapists do not "sit on the sidelines" during therapy. Rather, they become involved with family members, pushing and being pushed. Minuchin emphasised on the action of the family therapist. His belief was that "if both I and the family take risks within the constraints of the therapeutic system, we will find alternatives for change." He stated "In families that are too close, I artificially create boundaries between members by gestures, body postures, and movement of chairs. My challenging maneuvers frequently include a supportive statement: a kick and a stroke are delivered simultaneously. My metaphors are concrete: Your father stole your voice. I rarely remain in my chair for a whole session. I move closer when I want intimacy, kneel to reduce my size with children, or spring to my feet when I want to challenge. These operations occur simultaneously and represent my psychological fingerprint."

According to Minuchin, family therapy techniques are uniquely integrated in the person of the counselor or therapist who goes 'beyond technique' to wisdom concerning 'knowledge of the larger interactive system'.

2.4 GOALS OF FAMILY COUNSELING

Family therapy represented a watershed in the history of counseling. Before family therapy, the focus of counselors and therapists had been solely on the individual. The goal of counseling was always to change some cognitive, affective or behavioural component of an individual. In contrast, family therapists aim to change systems within which individuals reside. The goal is to introduce family members a broader way of conceptualising and experiencing their problems. This approach typically achieves the following:

- Primary problems in family functioning are delineated.
- Scapegoating is neutralised.
- Guilt and blame decrease.

- Empathy for differences increases.
- Family myths and nonfunctional rules are challenged.
- New agreements for living together can be formed

As the therapist monitors a family's struggle over time, covert rules of family life become overt and the family experiments with different ways of relating, communicating, and living together. Openly discussing issues and exposing family secrets often brings great relief and reduces tension.

Self Assessment Questions

1) What are the treatment stages as suggested by Satir?

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2) What are the main assumptions of strategic theory?

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2.4.1 The Process of Change

Family therapist differentiate between first-order change and second - order change. Lyddon (1990) succinctly defined these different types of changes as follows: "First – order change is essentially 'change without change' – or any change within a system that does not produce a change in the structure of the system. In contrast, second –order change is 'change of change' – a type of change whose occurrence alters the fundamental structure of the system." At any given moment, counselors and psychotherapists can only bring about one or the other type of change in their clients.

2.4.2 First -Order Change

It occurs when a family modifies problem behaviours yet maintains its present structure. An example of a first – order intervention is a family therapist's instructing parents when they can fight with their son over bedtime. By this intervention, the family therapist hopes to give the family relief from their problem behaviour; radical change of present family system is not a goal. Family therapists call this process of bringing about this type of change *"negative feedback."*

2.4.3 Second- Order of Change

It refers to transformations in either the structure or the internal order of a system. Family therapists often seek to generate or amplify change processes that will

alter the basic structure of a family system. This goal embodies second –order change. An example of a second – order intervention is a family therapist's directing the more passive parent to take over bedtime compliance responsibility with the goal of changing the power dynamics in the marital dyad. Family therapists call this process of bringing about this type of change *"positive feedback."*

2.5 INTERVENTION STRATEGIES

Two factors which are important in family therapy applications are:

i) understanding the significance of nonspecific factors in family therapy outcomes and

ii) how to structure the first session so that family therapy can get of to a good start.

2.5.1 Specific vs. Nonspecific Factors

Specific factors are those counseling activities that are specific to a particular counseling approach – for example, a strategic family therapist's use of a "proscribing the symptom" intervention.

Nonspecific factors are those change – producing elements present in counseling regardless of theoretical orientation. Many non specific factors have been proposed and one such factor is *working alliance* which is a best – known predictor of counseling outcomes.

Edward Bordin (1994) posited that there were three components of working alliance – task, goal and bond. Three components are conceptualised as follows:

Task: It refers to the in-therapy activities that form the substance of the therapeutic process. In a well -functioning relationship, both parties must perceive these tasks as relevant and effective. Furthermore, each must accept the responsibility to perform these acts.

Goal: It refers to the counselor and the client mutually endorsing and valuing the aims (outcomes) that are the target of the intervention.

Bond: It embraces the complex network of positive personal attachments between client and counselor, including issues such as mutual trust, acceptance and confidence.

Thus, Bordin's working alliance model emphasised 'the role of the client's collaboration with the therapist against the common foe of the client's pain and self- defeating behaviour.

2.6 FAMILY INTERVIEW

Haley (1991) advocated brevity and clarity in counseling work with families. He stated that "if therapy is to end properly, it must begin properly – by negotiating a solvable problem and discovering the social situation that makes the problem necessary."

He outlined a structured family interview for use during an initial session. The five stages of this structured family interview are as follows:

Social: The interviewer greets the family and helps family members feel comfortable.

Problem: The interviewer invites each person present to define the problem.

Interaction: The interviewer directs all members present to talk together about the problem while the interviewer watches and listens.

Goal setting

Family members are invited to speak about what changes every one – including the "problem" person – wants from the therapy.

Ending: Directives are given and the next appointment is scheduled.

The information gained from the first interview helps the family therapist form hypothesis about the function of the problem within its relational context. This information can also help the family therapist to generate directives to influence change. According to Haley, "the first obligation of a therapist is to change the presenting problem offered. If that is not accomplished, the therapy is a failure.'

2.7 TECHNIQUES OF FAMILY COUNSELLING

When a family seeks treatment, the initial question for the therapist is what the problem is and what does having the problem do to the family? The family is then assessed as a whole with the therapist observing how members work together, discovering problems other than the presenting problems, and assessing the family's developmental stage cycle (Klimek & Anderson, 1988). In general, the therapist is less concerned with "why" than with "who, where, and what."

The following select techniques have been used in working with couples and families to stimulate change or gain greater information about the family system. Each technique should be judiciously applied and viewed as not a cure, but rather a method to help mobilise the family. The when, where, and how of each intervention always rests with the therapist's professional judgment and personal skills.

1) **The Genogram:** The genogram, a technique often used early in family therapy, provides a graphic picture of the family history. The genogram reveals the family's basic structure and demographics. (McGoldrick & Gerson, 1985). Through symbols, it offers a picture of three generations. Names, dates of marriage, divorce, death, and other relevant facts are included in the genogram. It provides an enormous amount of data and insight for the therapist and family members early in therapy. As an informational and diagnostic tool, the genogram is developed by the therapist in conjunction with the family.

2) **The Family Floor Plan:** The family floor plan technique has several variations. Parents might be asked to draw the family floor plan for the family of origin. Information across generations is therefore gathered in a nonthreatening manner. Points of discussion bring out meaningful issues related to one's past.

   Another adaptation of this technique is to have members draw the floor plan for their nuclear family. The importance of space and territory is often inferred

as a result of the family floor plan. Levels of comfort between family members, space accommodations, and rules are often revealed. Indications of differentiation, operating family triangles, and subsystems often become evident. Used early in therapy, this technique can serve as an excellent diagnostic tool (Coppersmith, 1980).

3) **Sequencing:** Ask questions like who does what, when? When kids are fighting, what is mother doing? or father doing ?

4) **Hypothetical Questions:** Who would be most likely to stay home if mother got sick? Which child can you visualise living at home as an adult?

5) **Scaling Reports:** On a scale of most-least, compare one another in terms of anger, power, neediness, happiness.

6) **Reframing:** Most family therapists use reframing as a method to both join with the family and offer a different perspective on presenting problems. Specifically, reframing involves taking something out of its logical class and placing it in another category (Sherman & Fredman, 1986). For example, a mother's repeated questioning of her daughter's behaviour after a date can be seen as genuine caring and concern rather than that of a nontrusting parent. Through reframing, a negative often can be reframed into a positive.

7) **Tracking:** Most family therapists use tracking. Structural family therapists (Minuchin & Fishman, 1981) see tracking as an essential part of the therapist's joining process with the family. During the tracking process the therapist listens intently to family stories and carefully records events and their sequence. Through tracking, the family therapist is able to identify the sequence of events operating in a system to keep it the way it is. What happens between point A and point B or C to create D can be helpful when designing interventions.

8) **Communication skill-building techniques:** Communication patterns and processes are often major factors in preventing healthy family functioning. Faulty communication methods and systems are readily observed within one or two family sessions. A variety of techniques can be implemented to focus directly on communication skill building between a couple or between family members. Listening techniques including restatement of content, reflection of feelings, taking turns expressing feelings, and nonjudgmental brainstorming are some of the methods utilised in communication skill building.

   In some instances the therapist may attempt to teach a couple how to fight fair, to listen, or may instruct other family members how to express themselves with adults. The family therapist constantly looks for faulty communication patterns that can disrupt the system.

9) **Family Sculpting:** Developed by Duhl, Kantor, and Duhl (1973), family sculpting provides for recreation of the family system, representing family member's relationships to one another at a specific period of time. The family therapist can use sculpting at any time in therapy by asking family members to physically arrange the family. Adolescents often make good family sculptors as they are provided with a chance to nonverbally

communicate thoughts and feelings about the family. Family sculpting is a sound diagnostic tool and provides the opportunity for future therapeutic interventions.

10) **Family Photos:** The family photos technique has the potential to provide a wealth of information about past and present functioning. One use of family photos is to go through the family album together. Verbal and nonverbal responses to pictures and events are often quite revealing. Adaptations of this method include asking members to bring in significant family photos and discuss reasons for bringing them, and locating pictures that represent past generations. Through discussion of photos, the therapist often more clearly sees family relationships, rituals, structure, roles, and communication patterns.

11) **Special days, mini-vacations, special outings:** Couples and families that are stuck frequently exhibit predictable behaviour cycles. Boredom is present, and family members take little time with each other. In such cases, family members feel unappreciated and taken for granted. "Caring Days" can be set aside when couples are asked to show caring for each other. Specific times for caring can be arranged with certain actions in mind (Stuart, 1980).

12) **The Empty Chair:** The empty chair technique, most often utilised by Gestalt therapists (Perls, Hefferline, & Goodman, 1985), has been adapted to family therapy. In one scenario, a partner may express his or her feelings to a spouse (empty chair), then play the role of the spouse and carry on a dialogue. Expressions to absent family, parents, and children can be arranged through utilising this technique.

13) **Family Choreography:** In family choreography, arrangements go beyond initial sculpting; family members are asked to position themselves as to how they see the family and then to show how they would like the family situation to be. Family members may be asked to reenact a family scene and possibly resculpt it to a preferred scenario. This technique can help a stuck family and create a lively situation.

14) **Family Council Meetings:** Family council meetings are organised to provide specific times for the family to meet and share with one another. The therapist might prescribe council meetings as homework, in which case a time is set and rules are outlined. The council should encompass the entire family, and any absent members would have to abide by decisions. The agenda may include any concerns of the family. Attacking others during this time is not acceptable. Family council meetings help provide structure for the family, encourage full family participation, and facilitate communication.

15) **Strategic Alliances:** This technique, often used by strategic family therapists, involves meeting with one member of the family as a supportive means of helping that person change. Individual change is expected to affect the entire family system. The individual is often asked to behave or respond in a different manner. This technique attempts to disrupt a circular system or behaviour pattern.

16) **Prescribing Indecision:** The stress level of couples and families often is exacerbated by a faulty decision-making process. Decisions not made in

these cases become problematic in themselves. When straightforward interventions fail, paradoxical interventions often can produce change or relieve symptoms of stress. Such is the case with prescribing indecision. The indecisive behaviour is reframed as an example of caring or taking appropriate time on important matters affecting the family. A directive is given to not rush into anything or make hasty decisions. The couple is to follow this directive to the letter.

17) **Putting the client in control of the symptom:** This technique, widely used by strategic family therapists, attempts to place control in the hands of the individual or system. The therapist may recommend, for example, the continuation of a symptom such as anxiety or worry. Specific directives are given as to when, where, and with whom, and for what amount of time one should do these things. As the client follows this paradoxical directive, a sense of control over the symptom often develops, resulting in subsequent change.

18) **Paradoxical Intervention:** Instruct a family to do something they don't expect and observe how the family then changes by rebellion or noncompliance. This approach is not appropriate in crisis situations such as violence, grief, or suicide, or for families with minimal resistance. It is reserved for highly resistant and rigid families and is clearly an advanced therapeutic skill (Papp, 1981).

19) **Unbalancing:** Support an individual or subsystem at the expense of others. This modifies family structure and introduces the possibility for alternative ways of living together.

The techniques suggested here are examples from those that family therapists practice. Counselors will customise them according to presenting problems. With the focus on healthy family functioning, therapists cannot allow themselves to be limited to a prescribed operational procedure, a rigid set of techniques or set of hypotheses. Therefore, creative judgment and personalisation of application are encouraged.

2.8 EVALUATION OF FAMILY COUNSELLING

Hampson & Beavers (1996) studied family and therapy characteristics in relation to treatment success. They reported the following predictors of successful treatment:

- Number of family therapy sessions attended.
- Third party ratings of family competence.
- Self ratings of family competence.
- Therapist's ratings of working alliance.

Hampson and Beavers's measure of family competence included items on family affect, parental coalitions, problem – solving abilities, autonomy and individuality, optimistic versus pessimistic views and acceptance of family members. They also noted that family size, family income, family structure, family ethnicity and therapist gender did not predict outcome.

Self Assessment Questions

1) Explain some of the techniques of family counseling?

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2.9 LET US SUM UP

The area of family counseling/therapy has exploded over the past decade. Counselors at all levels are expected to work effectively with couples and families experiencing a wide variety of issues and problems. Structural, strategic, and transgenerational family therapists at times may seem to be operating alike, using similar interventions with a family. Differences might become clear when the therapist explains a certain technique or intervention. Most of today's practicing family therapists go far beyond the limited number of techniques usually associated with a single theory.

Family systems can be seen as a developmental process that evolves over time. Developmental models of family life include the family life cycle, the family life spiral and the family genogram. There are various ideas that led to the development of a systems approach to counseling and psychotherapy – conjoint theory, strategic theory and structural theory.

The goal of family counseling is to change systems within which individuals reside. The aim is to introduce family members a broader way of conceptualising and experiencing their problems.

The process of change includes first-order change and second - order change. The techniques of family counselling are genogram, the family floor plan, sequencing, hypothetical questions, scaling reports, reframing, tracking, communication skill-building techniques, family sculpting, family photos, special days, mini-vacations, special outings, the empty chair, family choreography, family council meetings, strategic alliances, prescribing indecision, putting the client in control of the symptom, paradoxical intervention and unbalancing.

2.10 UNIT END QUESTIONS

1) What are the goals of family counseling?

2) Explain any two theories of family counseling?

3) Discuss the process of change in family counseling?

4) Explain the concept of family interview.

5) Discuss the techniques of family counseling.

2.11 GLOSSARY

Family life cycle : It includes six developmental stages, stretching from courtship to old age.

Family life spiral : It includes the developmental tasks of three generations that simultaneously affect one another.

Genograms : It is like a family tree that includes information about birth order, family members, their communications and issues of relationships.

Centripetal Periods (CP) : The close periods in family life are called centripetal to indicate the many forces in the family system that holds the family tightly together.

Centrifugal Periods (CF) : The distant or disengaged periods have been called "centrifugal" to indicate the predominance of forces that pull the family apart.

First Order Change : It is essentially 'change without change' – or any change within a system that does not produce a change in the structure of the system.

Second Order Change : It is 'change of change' – a type of change whose occurrence alters the fundamental structure of the system."

2.12 SUGGESTED READINGS

Coppersmith, E. (1980). *The Family Floor Plan: A Tool of Training, Assessment, and Intervention in Family Therapy*. Journal of Marital & Family Therapy, 6, 141-145.

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UNIT 3 COUNSELLING IN SCHOOLS

Structure

3.0 INTRODUCTION

In this unit we will be dealing with counseling in schools. We start with giving an introduction to school counseling and the factors that would influence school counseling. Then we deal with the principles of school counseling and delineate the role and functions of a school counsellor. Then we discuss counseling in different part of the school in that at elementary level, middle level, secondary level and in a school which has faced a trauma through some violent activities.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Delineate the factors influencing school Counselling;
- Describe the Principles of school Counselling;
- Elucidate the Role and functions of the school counsellor;
- Describe what is involved in Counselling in elementary school;
- Describe the Characteristics of the elementary student;
- Explain the functions of a counsellor in the middle/ junior high school;

- Analyse the role of a counsellor in a trauma laden situation in schools; and
- Describe the role of a counsellor in the secondary school counsellor.

3.2 FACTORS INFLUENCING SCHOOL COUNSELLING

The primary objective of every guidance and counseling programme is to adjust the perceptions and ambitions of the target (the client) to match the expectations of the deliverer (the counselor or guidance professional).

Guidance and counselling are normalisation mechanisms, designed to eradicate non-standard / undesirable / anomalous behaviours and attitudes from the recipient group.

The School Counseling Program is comprehensive in scope, developmental in nature, proactive in design, and differentiated in order to address individual and societal needs.

The role of the school counselor is multidimensional. School counselors ascribe to the ASCA Code of Ethics and participate in on-going professional development. School counselors incorporate leadership, advocacy, counseling, consultation, coordination, collaboration and teaming, and the use of data to ensure students' success in the domains of academic, career, and personal/social development.

School counselors are shared stakeholders working in collaboration and partnership with students, families, educators, and community members in a variety of settings at a building, district and community level.

School counselors, in collaboration with stakeholders, are invested in helping students make the transition from school to school, school to work, or school to higher education or career and technical training.

All students benefit from an interdisciplinary delivery system, which includes a school guidance curriculum, individual student planning, responsive services, and system support.

The ongoing use of a variety of data sets, including process, perception and results data, is integral to ensure that every student receives the benefits of the School Counseling Program. The data is used to identify and address individual student needs and issues, examine current practices, and determine the best ways to make systemic changes in order to seek continuous improvement.

The School Counseling Program delineates a framework of specific, measurable outcomes in the three domains of academic, career and personal/social development. These outcomes must align with each student's developmental needs and must answer the question, "How are students different as a result of the School Counseling Program?"

The School Counseling Program fosters an environment that encourages students to develop self-awareness, as well as understanding, tolerance and acceptance of others' diverse qualities, backgrounds, beliefs and aptitudes. The School

Counseling Program enables our students to become productive members of the global community.

The School Counseling Program, using a variety of tools, assists all students in identifying and cultivating their intellectual strengths and personal attributes as they explore their higher education and/or career options.

The School Counseling Program will help students develop the skills of critical thinking, problem solving, decision making, self reflection and effective communication.

The School Counseling Program promotes life-long learning for all students.

Guidance

Guidance is the act of making decisions for another person to help students and clients get somewhere or help them to have a better future by showing them how to do it themselves. Counselling is the act of steering anothers thoughts till they come up with the correct answer or behaviour themselves. Neither is foolproof.

Guidance is different than counseling because guidance is mainly meant for simple and uncomplicated issues as for instance if a person wants to improve himself or herself on certain areas of behaviour etc. or the availability of various careers in a particular area or subject. In counseling however , it is mainly for major issues like how to deal with a trauma and its consequences, how to deal with Post Traumatic Stress Disorder, how to deal with the shock sustained in witnessing a murder of one's own close friend or relative. An issue of such a magnitude that the person is unable to sleep for days on end, cries incessantly, depressed and extremely anxious, then this needs counselling. A divorce, a separation from the spouse, break up of a family due to sudden natural calamity etc. may require counseling rather than guidance.

Counselling and guidance programs in schools are an educational development of the 20th century. School counseling increases student's ability to concentrate, study, and ultimately learn. It decreases classroom disturbances. Counseling services support teachers in the classroom in order to enable teachers to provide quality instruction designed to assist students in achieving high standards. School counselors are trained to recognise "early warning signs" in at-risk youth. School counselors work with principals, teachers, and other staff to develop and implement school safety, and to prevent school violence. Students who have counseling programs reported being more positive, and having greater feeling of belonging and safety in their schools.

Role of school counselors

In the United States, the school counseling profession began as a vocational guidance movement at the beginning of the 20th century. In 1907, Jesse B. Davis became the principal of a high school and encouraged the school English teachers to use compositions and lessons to relate career interests, develop character, and avoid behavioural problems. From that grew systematic guidance programs, which later evolved into comprehensive school counseling programs that address three basic domains: academic development, career development, and personal/social development.

In North Carolina, one has to complete an approved master's degree in school counseling program in a regionally accredited college or university in order to be a licensed school counselor. Within these counselor education programs, several standards are studied such as the professional identity of school counseling, cultural diversity, human growth and development, and career development. Also required are the core components for helping relationships, group and individual work, assessment, research and program evaluation, knowledge and requirements for school counselors, contextual dimensions of school counseling, foundations of school counseling and an internship under a highly qualified school counselor.

School counselors are expected to apply their professional training in schools in order to support student academic success. Through comprehensive school counseling programs of developmental, preventive, remedial, and responsive services, school counselors address academic development, career development, and personal/social development of students. This job description is a guide for the implementation of such comprehensive school counseling programs in the public schools of North Carolina.

Professional school counselors, formerly referred to as "guidance counselors," are professional educators who have a master's degree or higher in school counseling (or the substantial equivalent), and are certified or licensed by the state in which they work. Professional school counselors possess the qualifications and skills necessary to address the full array of student's academic, personal, social, and career development needs.

Professional school counselors advocate for and care for students, and are important members of the educational team. They consult and collaborate with teachers, administrators and families to help all students be successful academically, vocationally and personally.

The role and function of school counselors may be based on how they spend their time. Individual counseling, guidance activities, consultation and group counseling are major activities as measured by time commitments. It is noted that for senior high counselors, paper work, scheduling and administrative tasks are seen as significant time robbers that deter counselors from allotting more time for individual and group counseling.

The variety in school settings will also account for some differences in the ways counselors may carry out their roles. However, some common influences determine the role and function of counselors regardless of the setting. These influences are:

i) Professional constants or determinants: These indicate what is appropriate and not appropriate to the counselor's role. These include guidelines and policy statements of professional organisations, licensing or certification limitations, accreditation guidelines and requirements, and the expectancies of professional training programs.

ii) Personal factors: These factors involve the interest of the counselor such as what he or she likes to do, what the counselor gets encouraged to do and is rewarded for doing by the school, community or his peers, what the counselor has resources to do, what the counselor perceives as the appropriate role and function for a given setting and finally how life in general is going for the counselor. The counselor's attitudes, values and experiences both on and off the job can influence how he or she views the job.

3.3 PRINCIPLES OF SCHOOL COUNSELING

Principles of Guidance:

1) Parents and teachers have guidance responsibilities.

2) Take time to solve problems and make decisions.

3) Let the counselee develop his own insights.

4) Problems arise from situations.

5) Guidance is a life long process.

6) Guidance service should be extended to all, not simply to the maladjusted.

7) Guidance workers should rigorously observe a code of ethics.

8) Guidance places emphasis on the dignity, worth and individuality of the child as a means of promoting the democratic way of life.

9) Guidance is concerned with the choices and decisions to be made by the student.

10) Guidance is primarily concerned with prevention rather than cure.

11) Guidance is concerned with the "whole" students not with the intellectual life alone.

12) Guidance is a continuous process throughout the school life of each student.

School counseling is based on some principles which suggest how counseling programs can make their contributions more effectively –

- School counseling and guidance programs are designed to serve the developmental and adjustment needs of all youth.
- The school counseling program should be concerned with the total development of the student it serves.
- This program also recognises that individual development is a continuous, ongoing process and so school counseling programs must themselves be developmental.
- People guidance is viewed as a process that is continuous throughout the child's formal education.
- Trained professional counseling personnel are essential for ensuring professional competencies, leadership and direction.
- Certain basic activities are essential to program effectiveness and these must be specifically planned and developed if they are to be effective.
- The school counseling program must reflect the uniqueness of the population it serves and the environment in which it seeks to render this service.
- The school counseling program should base its uniqueness on a regular, systematic assessment of the student clientele's needs and the characteristics of the program's environmental setting.

- Teacher understanding and support of the school counseling program is significant to the success of such programs.
- The school counseling program is accountable. It recognises the need to provide objective evidence of accomplishments and the value of those accomplishments.
- The school counselor is a team member. The counselor shares a concern and programs for youths with psychologists, social workers, teachers, administrators and other educational professionals and staff.
- The school counseling program must recognise the right and capability of the individual to make decisions and plans.
- The school counseling program must respect the worth and dignity of every individual.
- The school counseling program must recognise the uniqueness of the individual and the individual's right to that uniqueness.
- The school counselor should be a role model of positive human relations of unbiased, equal treatment.

3.4 ROLE AND FUNCTIONS OF THE SCHOOL COUNSELLOR

The school counselor conducts various activities for the elementary, secondary and higher secondary students. They are:

- Individual Counselling
- Organising and conducting counseling groups
- Classroom and other group guidance activities
- Standardised test administration and interpretation
- Nonstandardised assessment (i.e. case studies, observation, information gathering interviews, questionnaires)
- Needs assessment (to determine the priority needs of the target population)
- Consultation activities
- Providing career guidance and information
- Providing educational guidance and information (including scholarships, college placement, student scheduling)
- Prevention planning and implementation activities
- Developmental activities
- Administrative activities

Self Assessment Questions

1) Explain the significance of school counseling.

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2) What are the factors which influence school counseling?

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3) Elucidate the principles of school counseling.

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4) What are the roles and functions of school counselors?

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5) Differentiate between guidance and counseling.

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3.5 COUNSELLING IN ELEMENTARY SCHOOL

Elementary schools are a powerful socialising force in a human development. Every individual carries important imprints for their elementary school experiences throughout their lives. In this setting, the young pupil is expected not only to acquire knowledge but also to learn to meet the school's behaviour and social expectancies. Failure to learn generates behavioural problems, inappropriate behaviours and social skills handicap learning.

As a basis for guidance in the elementary school, two needs have to be considered – *those basic needs which continuously demand satisfaction* and *those developmental needs which must be met during different life stages.* According to Maslow's theory, as the teacher and counselor view the elementary pupil and the ability to become self – actualised and develop potential, the teacher or counselor must be concerned with the degree to which the pupil's lower – order needs are being met.

The developmental needs of human kind have been presented by Havighurst as *"developmental tasks"* in his life stage theory. Counselors and teachers in the elementary school should focus on the following developmental tasks for middle childhood:

- Learning physical skills necessary for ordinary games.
- Learning to get along with age mates.
- Developing fundamental skills in reading, writing and calculating.
- Learning appropriate gender – specific roles.
- Developing concepts necessary for every day living.
- Developing conscience, morality and a scale of values.

Maslow and Havighurst focus both the personal and the cultural nature of the needs of children as they grow and develop. There is also an implied developmental task for educational programs – *the task of providing learning experiences appropriate to the needs, both basic and developmental of the elementary school child.*

3.6 ROLE OF ELEMENTARY SCHOOL COUNSELOR

Counsellors and other elementary school specialists must work closely and effectively with classroom teachers. Their major focus should be on guidance activities which are usually classroom oriented. This naturally leads to an emphasis on consultation and coordination.

In addition to counseling, consulting and coordination functions, the elementary school counselor has responsibilities for people's orientation, assessment and career and other development needs as well as significant attention to the prevention of undesirable habits and behaviours.

3.6.1 Counsellor

He should be available to meet individually or in groups with children referred by teachers or parents or identified by the other helping professionals in need of counseling. Counsellors can anticipate individual pupils coming to the counseling offices for assistance, advice or support. Current social issues like substance abuse, child abuse, divorce and discrimination are a frequent basis for individual counseling in the elementary school.

3.6.2 Consultant

The counselor may confer directly with teachers, parents, administrators and other helping professionals to help the student in school setting. He also helps others to assist the student – client in dealing more effectively with developmental or adjustment needs.

3.6.3 Coordinator

Elementary school counselors have a responsibility for the coordination of the various guidance activities in the schools. Coordinating these with ongoing classroom and school activities is also desirable.

3.6.4 Agent for Orientation

As a human development facilitator, the elementary school counselor recognises the importance of the child's orientation to the goals and environment of the elementary school. The counselor may plan group activities and consult with teachers to help children learn and practice the relationship skills necessary in the school settings.

3.6.5 Agent of Assessment

The school counselor while assessing the students should also understand the impact of culture, environment of the school and other environmental influences on people's behaviour.

3.6.6 Agent of Prevention

In the elementary school, there are early warning signs of future problems for young children like learning difficulties, general moodiness and acting – out behaviours (fights, quarrels, disruptions, restlessness, impulsiveness and obstinacy). There is research evidence that children who cannot adjust during their elementary school years are at high risk for a variety of later problems. Further, substance abuse, violence among peers, vandalism has increased among elementary school pupils raising concern for preventive efforts.

3.7 CHARACTERISTICS OF THE ELEMENTARY STUDENT

While planning for counseling programmes for the elementary school children, the counselor should focus on the following characteristics of the student:

- The elementary school student is experiencing continuous growth, development and change.

- The elementary school student is relatively limited in the ability to verbalise.
- The reasoning powers of the elementary school pupil are not fully developed.
- The ability of the elementary school pupil to concentrate over long periods of time is limited.
- The elementary school pupil displays feeling more or less openly.

Any successful programme in the elementary school that focuses on the student must have not only the approval but also significant involvement of the faculty. It must be teacher – centered. Close and frequent contact with parents must be anticipated in primary years. The counseling process in elementary school must be activity oriented. As the elementary school years are noted as developmental years, the elementary school guidance program must respond accordingly with a developmental rather than a remedial emphasis.

Self Assessment Questions

1) Explain the significance of counseling in elementary school.

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2) What are the characteristics of elementary student?

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3.8 THE MIDDLE/ JUNIOR HIGH SCHOOL COUNSELLOR

The middle/ junior high school focuses on providing the orientation and transitional needs and the educational and social – developmental needs of their populations. The counselors working in a middle or junior high school will be involved in the following roles –

1) Student Orientation: The counselor would orient the students and their parents to the programs, policies, facilities and counseling activities at this school level and later, their pre – entry orientation to the high school they will attend.
2) Appraisal or Assessment Activities: Apart from school record and standardised test data, counselors involved in the use of observation and

other techniques to identify emerging traits of individual students during this critical development period.

3) Counseling: At this school level, both individual and group counseling would be used by the counselors. It is observed that in middle or junior high school, group counseling is used more frequently than individual counseling.

4) Consultation: Another role of counselor is to provide consultation to faculty, parents and also to school administrators regarding the developmental and adjustment needs of individual students.

5) Student Development: At this middle school level, school counselors, faculty and other helping professionals should focus on student development. This refers to understanding the developmental characteristics of this age group and their attending developmental tasks and planning programs that are appropriately responsive.

3.9 THE SECONDARY SCHOOL COUNSELLOR

The roles and functions of the secondary school counselor are in no way different from those of counselors in the elementary and middle high schools. The only difference is in how counselors in the secondary school discharge their role and function and in various emphases appropriate to secondary school testing. For instance, the emphasis at the secondary school level shifts slightly from the preventive to the remedial in dealing with many common counseling concerns. Many of these issues are serious life problems such as addiction to drugs and alcohol, sexual concerns and interpersonal relationship adjustments.

Further, there is less client emphasis on preparing for decisions and more emphasis on making decisions. These include immediate or impending career decisions or further education decisions, decisions relevant to relationships with the opposite sex and perhaps marriage and decisions involved in developing personal value systems.

One of the thrust areas of secondary school counseling is *guidance programs*. The goals of guidance programmes are:

- To help students with their academic achievement in high school.
- To help students plan and prepare for postsecondary schooling.
- To help students with personal growth and development.
- To help students plan and prepare for their work roles after high school.

The secondary school counselor should focus on the following characteristics of adolescents while providing counseling:

- It is a period of continuous physical growth and arousal of sexual impulses.
- It is a period of movement toward maturity with focus on independence, responsibility and self – discipline.
- Many adolescents exaggerate their ability to solve the problems of the world and those that are personal for them. Many become critical of adult solutions to social problems, life styles and values and deny that adults can evaluate life of the adolescents.

Self Assessment Questions

1) Explain the role of junior high school counselor.

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2) Explain the role of secondary school counselor.

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3.10 ROLE OF A COUNSELLOR IN A TRAUMA LADEN SITUATION IN SCHOOL

The Therapeutic Intervention

Phase1 of Intervention: Initial Contact with the School

This first contact with the school will highlight the fact that when entering a system such as a school, one must let oneself be guided by the needs of the clients as they emerge and be flexible enough to respond to them as they arise. One can almost speak of an element of "therapeutic flexibility" which is necessary when working with a large system. If one's initial plans are too rigid and too prescriptive they may not be adequate to address the wide range of needs of the clients and may eventually be rejected. Knox and Roberts (2005) also argue for the fact that each school incident is unique and one cannot possibly anticipate all the effects that the traumatic event is going to have on the school.

Phase 2 of Intervention: Group Debriefing with Children

The day after the meeting with the school teachers the team went to the school in groups of must address the classes of the children who had actually witnessed the shocking or traumatic incident. As group debriefing is an accepted manner of trauma work (Udwin, 1993) this would be the most effective manner to reach all the children who had directly witnessed the event.

The intervention should aim at the following:

a) Allowing the children to express their feelings regarding the traumatic incident in a non-threatening context,

b) Allowing them to regain some sense of control over their environment and,

c) Normalising the experience as a group by allowing them to see that their classmates had experienced similar feelings of fear and anxiety.

Allowing the children to develop an increased sense of security, competence and mastery following a traumatic event is regarded as desirable goal of trauma work with children.

Also one could use a developmentally appropriate technique such as drawings which would allow the children to express their feelings around the traumatic event in a non-threatening manner. Children quite often cannot express verbally what they felt or feel, but can express through drawing and painting.

Each child should be given the opportunity to draw a picture of what had happened and given a chance to talk about his/her picture to the rest of the class. Team members should provide each child with a lot of positive reinforcement throughout the process. After this each child may be asked to draw a picture describing what he or she would do if he/she were given the responsibility as director of the school to make the school safer for the children. Such an exercise would provide the children with a sense of empowerment, as they would feel involved in the decision-making about safety in schools. The teachers can also be assisted during this process and the team can give them a lot of positive reinforcement for the very quick way in which they had reacted in order to protect the children.

The teachers may in fact be also much shaken after the incident, as they might have feared for their own as well as the children's safety.

Phase 3 of Intervention: Individual Assessment of Children

The next step is to ask teachers to identify children in the other classes whom they felt were experiencing particularly negative feelings around the traumatic incident. This offer may also be made to the children who had been the target of the group intervention as certain children might need further therapeutic inputs.

Following the incident a number of children also refused to come to school and parents had contacted us for advice as to how address the problem.

Phase 4 of Intervention: Group Intervention with Teachers

The next part of the intervention is to address the needs of the teachers at the school. As mentioned earlier the teachers seemed to have experienced a serious crisis surrounding their roles as caregivers. Moreover they may also experience their place of work as no longer safe. Hence group sessions could be held with teachers led by two co-therapists. The value of group therapy is widely recorded in the literature, for example Yalom (1995) was considered important for teachers to share their own feelings with one another and ultimately to normalise their own experiences of the event.

The groups should be so organised that each teacher or a member of the group should be able to open up and discuss issues related to the traumatic incident. The level of emotional intensity will of course differ from group to group.

Phase 5 of Intervention: Exiting the School System

The next step is to exit from the system. This process is quite difficult for many persons. A number of the therapists may feel that felt that they could not leave the clients or children without further therapeutic interventions.

The above case of traumatic incident in a school describe two important aspects, which are given below:

a) There is a very strong needs in schools to have adequate therapeutic support preferably with a therapist who is well versed in the principles of counseling.

b) The therapist or a counsellor must be sensitive to a large number of factors in that situation where a traumatic event had taken place. Some of the questions to be resolved here include the following:

   i) How does a therapist enter a school system after a traumatic event in a manner that is respectful and does not create further trauma?

   ii) What is the role of the therapist in a school context following a traumatic event?

   iii) How does a therapist include the families in this therapeutic process?

   iv) What are the implications of a traumatic event for the relationship between school and parents?

3.11 LET US SUM UP

School counseling increases student's ability to concentrate, study, and ultimately learn. It decreases classroom disturbances. Counseling services support teachers in the classroom in order to enable teachers to provide quality instruction designed to assist students in achieving high standards. School counselors are trained to recognise "early warning signs" in at-risk youth. School counselors work with principals, teachers, and other staff to develop and implement school safety, and to prevent school violence. Students who have counseling programs reported being more positive, and having greater feeling of belonging and safety in their schools.

Professional school counselors, formerly referred to as "guidance counselors," are professional educators who have a master's degree or higher degree in school counseling (or the substantial equivalent), and are certified or licensed by the state in which they work. Professional school counselors possess the qualifications and skills necessary to address the full array of student's academic, personal, social, and career development needs.

Professional school counselors advocate for and care for students, and are important members of the educational team. They consult and collaborate with teachers, administrators and families to help all students be successful academically, vocationally and personally.

The factors which influence school counseling are professional constants or determinants and personal factors. Professional determinants include guidelines and policy statements of professional organisations, licensing or certification limitations, accreditation guidelines and requirements, and the expectancies of professional training programs. Personal factors involve the interest of the counselor, the encouragement that he gets from the school, community or his peers and resources of the counselor. The counselor's attitudes, values and experiences both on and off the job also influence how he or she views the job.

Elementary schools are a powerful socialising force in a human development. Every individual carries important imprints for their elementary school

experiences throughout their lives. In this setting, the young pupil is expected not only to acquire knowledge but also to learn to meet the school's behaviour and social expectancies. Failure to learn generates behavioural problems, inappropriate behaviours and social skills handicap learning. Elementary school counseling should focus on two needs - those basic needs which continuously demand satisfaction and those developmental needs which must be met during different life stages.

The counselors working in a middle or junior high school will be involved in the following roles such as that of student orientation, appraisal or assessment activities, counseling , consultation and student development.

The roles and functions of the secondary school counselor are in no way different from those of counselors in the elementary and middle high schools. The only difference is in how counselors in the secondary school discharge their role and function and in various emphases appropriate to secondary school testing. For instance, the emphasis at the secondary school level shifts slightly from the preventive to the remedial in dealing with many common counseling concerns. Many of these issues are serious life problems such as addiction to drugs and alcohol, sexual concerns and interpersonal relationship adjustments. Further, there is less client emphasis on preparing for decisions and more emphasis on making decisions. These include immediate or impending career decisions or further education decisions, decisions relevant to relationships with the opposite sex and perhaps marriage and decisions involved in developing personal value systems. One of the thrust areas of secondary school counseling is guidance programs.

3.12 UNIT END QUESTIONS

1) Explain the principles of school counseling.
2) Discuss the role and functions of the school counselor.
3) Explain the significance of counseling in elementary school.
4) Explain the difference between the roles of junior high school and secondary school counselor.

3.13 GLOSSARY

School Counsellors : Professional school counselors, formerly referred to as "guidance counselors," are professional educators who have a master's degree or higher in school counseling (or the substantial equivalent), and are certified or licensed by the state in which they work. Professional school counselors possess the qualifications and skills necessary to address the full array of student's academic, personal, social, and career development needs.

Guidance Programmes : These are designed to help students with their academic achievement in high school and to help them in planning and preparing for postsecondary schooling.

3.14 SUGGESTED READINGS

Gibson, R. L. & Mitchell, M .H. (1995). *Introduction to Counseling and Guidance*. Prentice –Hall, New Jersey.

Rogers, Carl (1951). *Client-Centered Therapy: Its Current Practice, Implications, and Theory.* Boston: Houghton Mifflin.

UNIT 4 COUNSELLING FOR HIV / AIDS

Structure

4.0 INTRODUCTION

In this unit we will be dealing with counselling for HIV / AIDS. We start the unit with Nature and Definition of HIV Counselling in which we discuss the epidemiology of HIV both abroad and India. We also discuss who all to be offered the test and how often and which tests. An emphasisis placed on ante natal test which can prevent HIV being passed on to the progeny. Then we discuss the routine test results and the bodily fluids which spread HIV. This is followed by goals of HIV counselling and the emphasis is on the aims of such counselling and what should be the focus etc. This is followed by HIV Counselling

programmes and services and the counselling process. Then we delineate the conditions necessary for HIV counselling and have a discussion on pretest for HIV as to its nature and context. Then we discuss the HIV counselling programmes and services and the intricacies involved in counselling process. The next section deals with counselling during combination antiretroviral therapy and the coping strategies. Then we take up the psychological issues related to HIV AIDS counselling especially when the test results are positive. In the counselling process we discuss how counselling patients and partners together has to be undertaken in which we discuss the worried well, and their characteristics and coping strategies.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the nature of HIV counselling;
- Delineate the epidemiology of HIV AIDS both abroad and in India;
- Elucidate the aspects related to HIV Testing;
- Describe goals of HIV counselling;
- Explain the various programmes and services for HIV counselling;
- Describe the Nature and goals of HIV counselling;
- Delineate the Conditions necessary for HIV counselling;
- Analyse the Psychological Issues in HIV counselling; and
- Present the techniques for Counselling Patients and Partners together.

4.2 NATURE AND DEFINITION OF HIV COUNSELLING

There have been significant developments in the treatment of HIV in recent years. This progress and up to date knowledge about HIV and the epidemiology of HIV infection has informed new guidelines on counselling and testing for HIV.

New guidance is prefaced by a number of important assertions:

It is possible with the advent of new and improved treatment for the majority of those living with HIV to remain fit and well on treatment.

A significant number of people in the United Kingdom are unaware of their HIV infection and thereby put at risk their own health and the health of others by transmitting infection unknowingly.

Late diagnosis is the most important factor associated with HIV-related morbidity and mortality in the UK. For example in the UK 24% of deaths in HIV-positive patients in 2006 were directly attributable to late diagnosis of HIV.

Patients should therefore be offered and encouraged to accept HIV testing in a wider range of settings than is currently the case.

Patients with specific indicator conditions should be routinely recommended to have an HIV test.

The consensus is that doctors, nurses and midwives should be able to obtain informed consent for an HIV test in the same way that they currently do for any other medical investigation.

4.2.1 Epidemiology

Some of the following points may be of value to the patient:

Men having sex with men (MSM) remain the group in the UK at highest risk of acquiring HIV with evidence that transmission is continuing at a substantial rate.

The estimated number of people infected through heterosexual contact within the UK has increased from 540 new diagnoses in 2003 to 960 in 2007, and has doubled, from 11% to 23%, as a proportion of all heterosexual diagnoses during this period.

In 2005, 70% of diagnoses were in people aged 15 to 39 and 73% of heterosexual cases were in people of African origin or were acquired there.

The Health Protection Agency estimates that 77,400 people were living with HIV in the UK at the end of 2007, of whom over a quarter (28%) were unaware of their infection.

In 2005, 34% of newly diagnosed patients were diagnosed late with serious immunosuppression and 11% had progressed to AIDS. The figure for late diagnosis was 31% in 2008.

4.2.2 HIV in India

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV. There was recognition, though, that this would not be the case for long, and concerns were raised about how India would cope once HIV and AIDS cases started to emerge.

Later in the year, India's first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers, and as HIV screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks.

In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among Injecting Drug Users (IDUs) in Manipur, Mizoram and Nagaland – three north-eastern states of India bordering Myanmar (Burma).

At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992 the government set up NACO (the National AIDS Control Organisation), to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan, the National AIDS Control Programme (NACP) for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS Control Societies (SACS) in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety.

By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as *'low-risk'*, such as housewives and richer members of society.

In 1999, the second phase of the National AIDS Control Programme (NACP II) came into effect with the stated aim of reducing the spread of HIV through promoting behaviour change. During this time, the prevention of mother-to-child transmission (PMTCT) programme and the provision of free antiretroviral treatment were implemented for the first time. In 2001, the government adopted the National AIDS Prevention and Control Policy and former Prime Minister Atal Behari Vajpayee referred to HIV/AIDS as one of the most serious health challenges facing the country when he addressed parliament. Vajpayee also met the chief ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention.

The third phase (NACP III) began in 2007, with the highest priority placed on reaching 80 percent of high-risk groups including sex workers, men who have sex with men, and injecting drug users with targeted interventions. Targeted interventions are generally carried out by civil society or community organisations in partnership with the State AIDS Control Societies. They include outreach programmes focused on behaviour change through peer education, distribution of condoms and other risk reduction materials, treatment of sexually transmitted diseases, linkages to health services, as well as advocacy and training of local groups. The NACP III also seeks to decentralise the HIV effort to the most local level, i.e. districts, and engage more non-governmental organisations in providing welfare services to those living with HIV/AIDS.

As for current estimates, in 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. In 2008 the figure was estimated to be 2.31 million. In 2009 it was estimated that 2.4 million people were living with HIV in India, which equates to a prevalence of 0.3%. While this may seem low, because India's population is so large, it is third in the world in terms of greatest number of people living with HIV. With a population of around a billion, a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million.

4.2.3 Who Should be Offered a Test?

Universal HIV testing (where all individuals are offered and recommended an HIV test routinely but can refuse testing) is recommended in all the following:

1) Sexual health clinics
2) Antenatal services
3) Termination of pregnancy services
4) Drug dependency programmes
5) Healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma.
6) HIV testing should be routinely offered and recommended to the following patients:
7) All patients presenting for healthcare where HIV, including primary HIV infection, enters the differential diagnosis (see article on primary HIV infection)
8) All patients diagnosed with a sexually transmitted infection
9) All sexual partners of men and women known to be HIV positive
10) All men who have disclosed sexual contact with other men
11) All female sexual contacts of men who have sex with men
12) All patients reporting a history of injecting drug use
13) All men and women known to be from a country of high HIV prevalence (>1%*)
14) All men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence (see up to date UN AIDS list in Internet and Further REading section below)
15) HIV testing should also be routinely performed in the following groups in accordance with existing Department of Health guidance:
16) Blood donors
17) Dialysis patients
18) Organ transplant donors and recipients.

An HIV test should be considered more widely when there is a particularly high HIV prevalence in the local population. Local PCT data should be consulted. If the HIV prevalence exceeds 2 in 1000 population then testing should be offered to all registered patients. The introduction of universal HIV testing should be considered in such circumstances.

4.2.4 How Often to Test?

Repeat testing should be provided for the following:

All individuals who have tested HIV negative but where a possible exposure has occurred within the window period (the time between infection and a positive test result).

Men who have sex with men (MSM) – annually (more frequently if clinically suspect seroconversion or ongoing high risk exposure).

Injecting drug users – annually (more frequently if clinically suspect seroconversion).

4.2.5 Antenatal Care

If HIV test at booking is refused a further offer of testing should be made.

If they decline again a third offer of a test should be made at 36 weeks.

Women presenting to services for the first time in labour should be offered a Point Of Care Test (POCT).

A POCT test may also be considered for the infant of a woman who refuses testing antenatally.

In areas of higher seroprevalence, or where there are other risk factors, women who are HIV negative at booking may be offered a routine second test at 34–36 weeks' gestation.

4.2.6 Which Test to Use?

Testing including confirmation should follow the standards laid out by the Health Protection Agency. All acute healthcare settings should expect to have access to:

Urgent HIV screening assay result within eight hours (definitely within 24 hours), to provide the best support for exposure incidents.

4.2.7 Routine Results within 72 hours

There are two methods in routine practice for testing for HIV involving either venepuncture and a screening assay where blood is sent to a laboratory for testing or a rapid Point Of Care Test (POCT).

Blood tests

The recommended first-line assays:

Fourth generation assay tests for HIV antibody and p24 antigen simultaneously and have the advantage of reducing the time between infection and testing HIV positive to one month.

Third generation assay detects antibody only and has the disadvantage of giving a positive result after a longer (6 to 7 week) interval.

The better fourth generation tests are not offered by all primary screening laboratories.

HIV RNA quantitative assays (viral load tests):

These are not recommended as screening assays because of the possibility of false positive results. They offer only marginal advantage over fourth generation assays for detecting primary infection.

HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus is passed from one person to another through blood to blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Most of these people will develop AIDS as a result of their HIV infection.

4.2.8 Body Fluids that Spread HIV

The body fluids that have been proven to spread HIV are given below:

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Other body fluids containing blood
- These are additional body fluids that may transmit the virus that health care workers may come into contact with:
- Cerebrospinal fluid surrounding the brain and the spinal cord
- Synovial fluid surrounding bone joints
- Amniotic fluid surrounding a fetus.

The HIV and AIDS pandemic in many low-and middle-income countries is growing, and it is estimated that fewer than 20 per cent of people living with HIV and AIDS know their status. Most people have a test too late, often only finding out their positive status when they already have an AIDS-related illness. People who do not know their positive status may not be able to take sufficiently early action to mitigate the effects of the disease. They will also not be aware of the need to alter their behaviour to avoid the risk of infecting others or reinfecting themselves.

Provider Initiated Testing and Counselling (PITC) has been suggested as a possibility for dramatically scaling up testing. This is opt out, rather than opt in testing. For example, everyone attending a GP's surgery could be tested unless they requested otherwise (opted out) if it were part of a full package of HIV and AIDS services. PITC would mean a much higher percentage of people living with HIV and AIDS would be aware of their status and would therefore be able to access treatment, care, support and prevention information and services.

It refers to a process where in support and strength is provided to individuals, couples, families or groups by competent persons to help them cope with the knowledge that they are infected or affected by HIV. It is an ongoing process that allows the individuals to develop a sense of responsibility in meeting challenges posed by their infection. Counselling should also be given to HIV negative individuals to promote behaviour change and condom use.

One of the core elements in a holistic model of health care is counselling in HIV and AIDS. In counselling HIV and AIDS, psychological issues are recognised as integral to patient management. HIV and AIDS counselling has two general aims: (1) *the prevention of HIV transmission and* (2) *the support of those affected directly and indirectly by HIV.*

HIV counselling should have these dual aims because the spread of HIV can be prevented by changes in behaviour. One to one prevention counselling has a particular contribution in that it enables frank discussion of sensitive aspects of a patient's life. Such discussion may be hampered in other settings by the patient's concern for confidentiality or anxiety about a judgmental response. Also, when patients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through a fear of rejection, social stigma, disease progression, and the uncertainties associated with future management of HIV.

Good clinical management requires that such issues be managed with consistency and professionalism, and counselling can both minimise morbidity and reduce its occurrence. All counsellors in this field should have formal counselling training and receive regular clinical supervision as part of adherence to good standards of clinical practice.

4.3 GOALS OF HIV COUNSELLING

The goals of HIV counselling are mainly on prevention of the disease and to provide support to those affected with disease. An overview of the goals of HIV counselling can be understood from the following.

4.3.1 Aims of Counselling in HIV Infection

Prevention

Determining whether the lifestyle of an individual places him or her at risk

Working with an individual so that he or she understands the risks

Helping to identify the meanings of high risk behaviour

Helping to define the true potential for behaviour change

Working with the individual to achieve and sustain behaviour change

Support

Individual, relationship, and family counselling to prevent and reduce psychological morbidity associated with HIV infection and disease

4.4 HIV COUNSELLING PROGRAMMES AND SERVICES

The different HIV counselling programmes and services that are organised for the target group can be seen in the following:

- Counselling before the test is done
- Counselling after the test for those who are HIV positive and HIV negative
- Risk reduction assessment to help and prevent transmission
- Counselling after a diagnosis of HIV disease has been made
- Family and relationship counselling
- Bereavement counselling
- Telephone "hotline" counselling

- Outreach counselling
- Crisis intervention
- Structured psychological support for those affected by HIV
- Support groups

Se1f Assessment Questions

1) Define HIV counselling.

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2) Explain the goals of HIV counselling.

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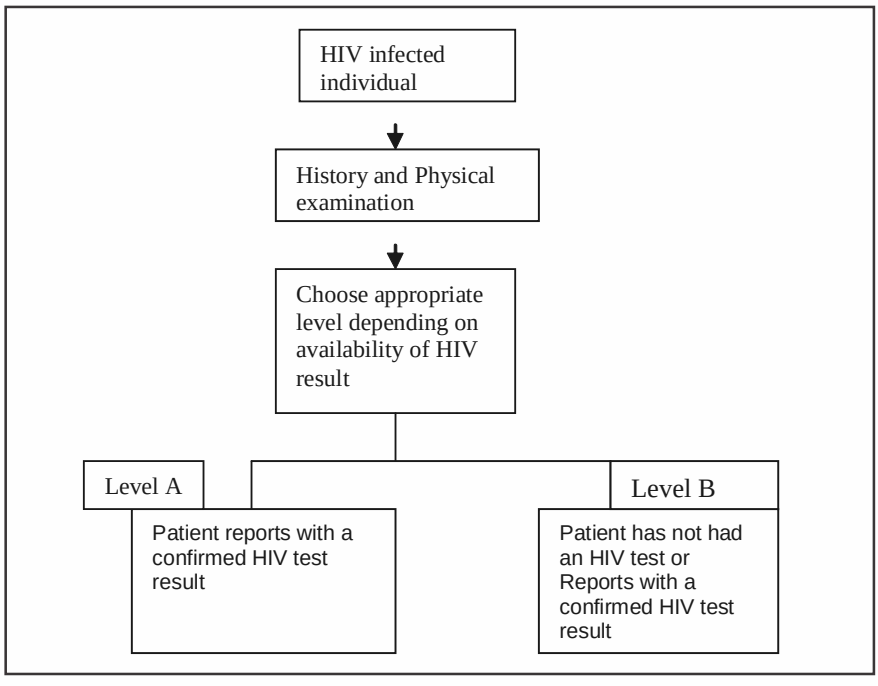
4.5 HIV COUNSELLING PROCESS

The individual suspected of having HIV infection should be referred to the appropriate level for counselling depending on the availability of the HIV test result. If it is available then counselling can be given at level A, if not then referral to a testing facility at level B is recommended. This can be understood from the following figure



4.5.1 Conditions Necessary for HIV Counselling

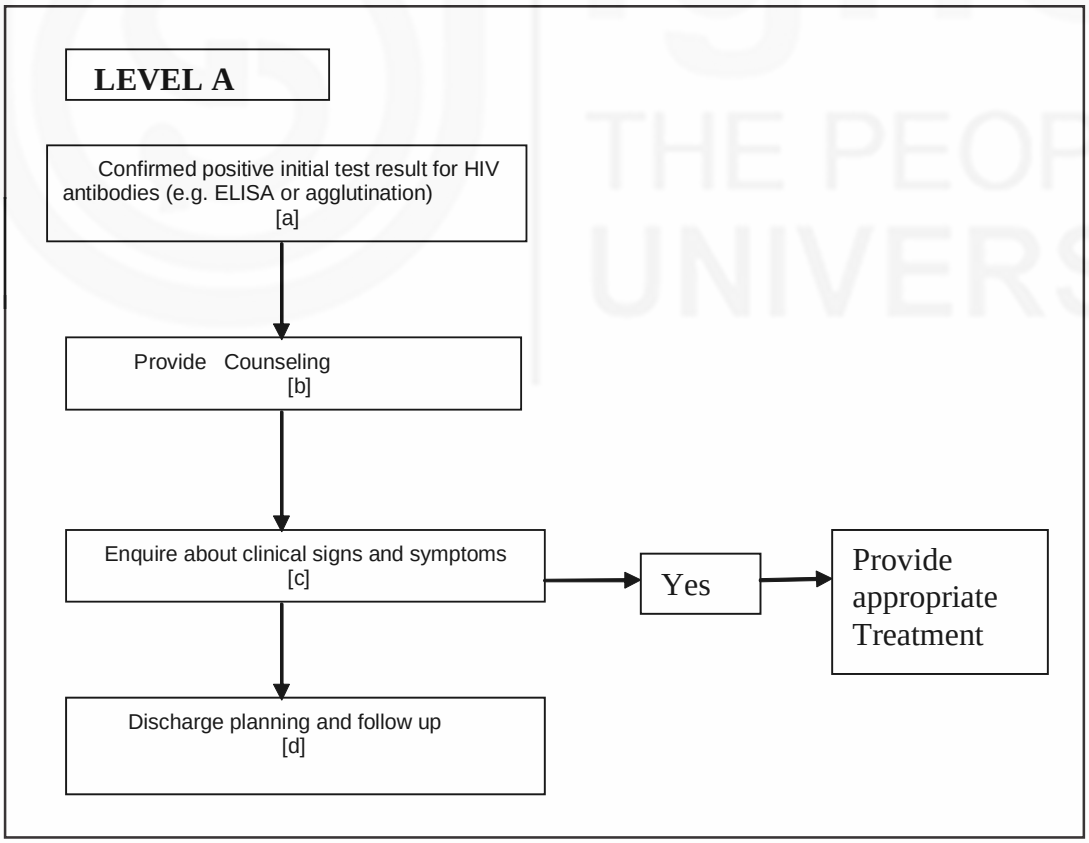
a) An individual attending a health center with a confirmed HIV positive result will require information on the HIV result and its implications.

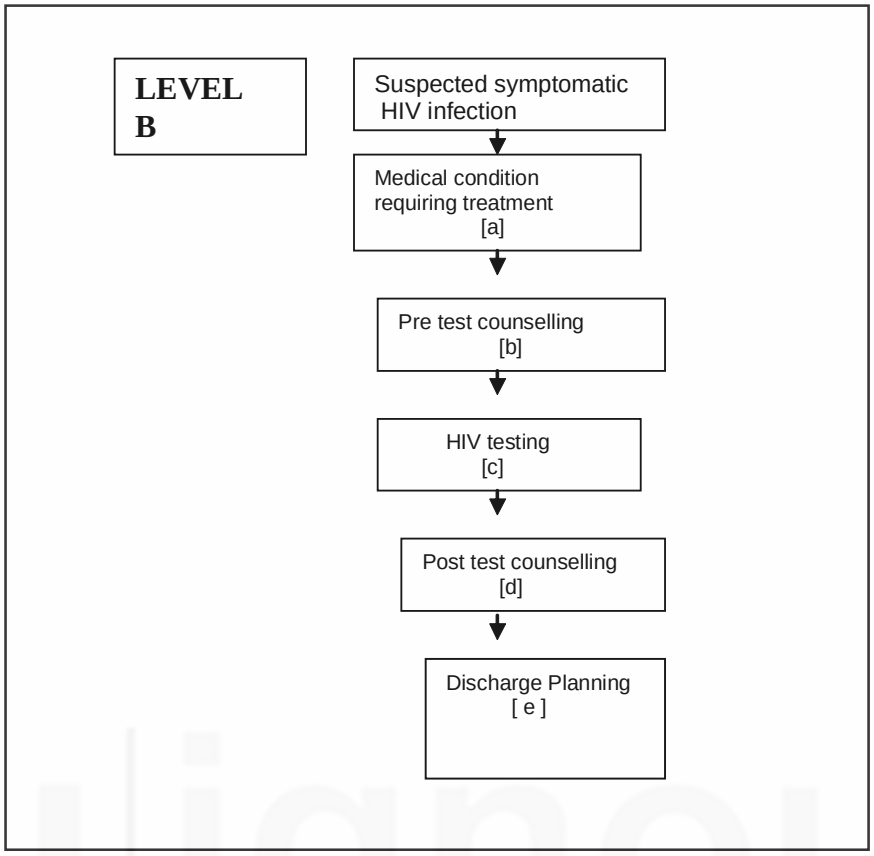
b) The attending clinician may wish to follow up the individual or may delegate this responsibility to a trained counsellor. The patient needs to be involved in this decision so that issues of confidentiality are dealt with. Follow up of the patient may be in the out patient clinic or in the ward. During the initial meeting an assessment to determine the circumstances that lead to an HIV test being performed should be done. Based on the outcome of this the individual can then be provided supportive or problem solving counselling or a combination of both.

c) If there is an underlying medical condition that requires treatment, this should be attended to first before HIV counselling is offered.

d) Whether admitted or reviewed in the clinic, the counsellor should take the opportunity to plan with the patient how follow up counselling will be provided. With the patients consent relatives may be involved in the counselling process. Based on the patients needs, plans for referral to other health and social services can be made. Home-based care as a complement to hospital care should be considered if it is available.

This can be seen in the following figure -





The above figure reflects the following process -

a) An individual with suspected HIV infection is admitted to the hospital with a medical condition requiring treatment. The medical condition should be attended to without discrimination before HIV testing is done. Appropriate treatment is given according to the presenting condition.

b) The patient is offered pre-test counselling by the attending clinician, or a trained counsellor. This involves the giving of information on the technical aspects of HIV testing and possible personal, medical, social, psychological and legal implications of being found either HIV positive or HIV negative. The information is given in a manner that the individual understands and feels he/she can make an informed decision about taking the HIV test. The issue of confidentiality surrounding test results and subsequent counselling and follow up is also covered.

c) If the outcome of pretest counselling is favourable the individual is then tested using the approved testing procedure.

d) Post-test counselling is given by the clinician or a trained counsellor. This involves discussing the interpretation of an HIV result and whether it was expected or not. The focus of the discussion will depend on whether the result is positive, negative or equivocal.

e) Whether admitted or reviewed in the clinic, the counsellor should take the opportunity to plan with the patient how follow-up counselling will be provided. With the patients consent, relatives may be involved in the counselling process. Based on the patients needs, plans for referral to other health and social services can be made. Home-based care as a complement to hospital care should be considered if it is available.

4.5.2 Pre-test Discussion

A discussion of the implications of HIV antibody testing should accompany any offer of the test itself. This is to ensure the principle of *informed consent* is understood and to assist patients to develop a realistic assessment of the risk of testing HIV antibody positive. This process should include accurate and up to date information about transmission and prevention of HIV and other sexually transmitted infections.

Patients should be made aware of the *"window period"* for the HIV test that a period of 12 weeks since the last possible exposure to HIV should have elapsed by the time of the test.

Given below is the discussion checklist of a pre test of HIV and the factors that necessitate counselling the patients:

1) Pre-test discussion checklist
2) Indications for further counselling and referral to counsellor
3) People who have been sexually active in areas of high HIV prevalence
4) Men who have sex with men
5) Current or previous sexual partners HIV positive
6) Client presenting with clinical symptoms of HIV infection
7) High risk sexual behaviour
8) High risk injecting drug practices
9) Learning or language difficulties
10) Points for counsellor and/or physician to cover
11) What is the HIV antibody test (including seroconversion)
12) The difference between HIV and AIDS
13) The window period for HIV testing
14) Medical advantages of knowing HIV status and treatment options
15) Transmission of HIV
16) Safer sex and risk reduction
17) Safer injecting drug use
18) If the client were positive how would the client cope: personal resources, support network of friends/partner/family
19) Who to tell about the test and the result
20) Partner notification issues
21) HIV status of regular partner: is partner aware of patient testing?
22) Confidentiality
23) Does client need more time to consider?
24) Is further counselling indicated?
25) How the results of the test are obtained (in person from the physician or counsellor)?

Patients may present for testing for any number of reasons, ranging from a generalised anxiety about health to the presence of HIV related physical symptoms. For patients at minimal risk of HIV infection, pre-test discussion provides a valuable opportunity for health education and for safer sex messages to be made relevant to the individual. For patients who are at risk of HIV infection, pre-test discussion is an essential part of post-test management. These patients may be particularly appropriate to refer for specialist counselling expertise. In genitourinary medicine clinics where HIV antibody testing is routinely offered as a part of sexual health screening, health advisers provide counselling to patients who have been identified as high risk for testing HIV positive.

The importance of undertaking a sensitive and accurate sexual/and or injecting drug risk history of both the patient and their sexual partners cannot be overstated. If patients feel they cannot share this information with the physician or counsellor then the risk assessment becomes meaningless; patients may be inappropriately reassured, for example, and be unable to disclose the real reason for testing.

Counselling skills are clearly an essential part of establishing an early picture of the patient and his/her history and of how much intervention is needed to prepare him or her for a positive result, and to further reinforce prevention messages. It is at this stage that potential partners at risk are identified which will become an important part of the patient's management if HIV positive.

4.5.3 Post-test Counselling

HIV results should be given simply, and in person. For HIV negative patients this may be a time where the information about risk reduction can be "heard" and further reinforced. With some patients it may be appropriate to consider referral for further work on personal strategies to reduce risks for example one to one or group interventions. The window period of 12 weeks should be checked again and the decision taken about whether further tests for other sexually transmitted infections are appropriate.

4.5.4 Causes of Uncertainty

Following are the causes of uncertainty:

- The cause of illness
- Progression of disease
- Management of dying
- Prognosis
- Reactions of others (loved ones, employers, social networks)
- Effects of treatment
- Long term impact of antiretroviral therapy
- Impact of disclosure and how this will be managed

HIV positive patients should be allowed time to adjust to their diagnosis. Coping procedures rehearsed at the pre-test discussion stage will need to be reviewed in the context of the here and now; what plans does the patient have for today, who can they be with this evening? Direct questions should be answered but the focus is on plans for the immediate few days, when further review by the counsellor

should then take place. Practical arrangements including medical follow up should be written down. Overloading the patient with information about HIV should be avoided at this stage. Sometimes this may happen because of the health professional's own anxiety rather than the patient's needs. Counselling support should be available to the patient in the weeks and months following the positive test results.

Self Assessment Questions

1) Explain pre test and post test counselling.

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2) What are the points to be covered by physician or a counsellor during the discussion with HIV patient?

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4.6 COUNSELLING DURING COMBINATION ANTIRETROVIRAL THERAPY

Significant developments in combination antiretroviral therapy have led to a surge of optimism about long term medical management of HIV infection, and people are now living much longer with HIV. Patient adherence is an important factor in the efficacy of drug regimens. However, taking a complicated drug regimen often taking large numbers of tablets several times a day is a constant reminder of HIV infection. The presence of side effects can often make patients feel more unwell than did the HIV and some may be unable to cope with the side effects. Counselling may be an important tool in determining a realistic assessment of individual adherence and in supporting the complex adjustment to a daily routine of medication.

4.6.1 Coping Strategies

- Using counselling
- Problem solving
- Participation in discussions about treatment
- Using social and family networks
- Use of alternative therapies, for example relaxation techniques, massage

- Exploring individual potential for control over manageable issues
- Disclosure of HIV status and using support options.

4.7 PSYCHOLOGICAL RESPONSES TO HIV POSITIVE RESULT

Many reactions to an HIV positive diagnosis are part of the normal and expected range of responses to news of a chronic, potentially life threatening medical condition. Many patients adjust extremely well with minimal intervention. Some will exhibit prolonged periods of distress, hostility, or other behaviours which are difficult to manage in a clinical setting. It should be noted that serious psychological maladjustment may indicate pre-existing morbidity and will require psychological/psychiatric assessment and treatment. Depressed patients should always be assessed for suicidal ideation.

Effective management requires allowing time for the shock of the news to sink in; there may be a period of emotional "ventilation", including overt distress. The counsellor should provide an assurance of strict confidentiality and rehearse, over time, the solutions to practical problems such as who to tell, what needs to be said, discussion around safer sex practices and adherence to drug therapies. Clear information about medical and counselling follow up should be given. Counselling may be of help for the patient's partner and other family members.

4.7.1 Psychological Issues in HIV/AIDS Counselling

1) Shock of diagnosis
2) Recognition of mortality
3) Of loss of hope for the future
4) Fear and anxiety
5) Uncertain prognosis
6) Effects of medication and treatment/treatment failure
7) Of isolation and abandonment and social/sexual rejection
8) Of infecting others and being infected by them
9) Of partner's reaction
10) Depression due to adjustment to living with a chronic viral condition
11) Depression over absence of a cure
12) Depression over limits imposed by possible ill health
13) Possible social, occupational, and sexual rejection if treatment fails
14) Anger and frustration over becoming infected
15) Anger and frustration over new and involuntary health/lifestyle restrictions
16) Anger and frustration in over incorporating demanding drug regimens, and possible side effects, into daily life
17) Guilt interpreting HIV as a punishment; for example, for being gay or using drugs
18) Guilt at anxiety caused to partner/family

4.8 COUNSELLING PATIENTS AND PARTNERS TOGETHER

This should only take place with the patient's explicit consent, but it may be important for the following reasons:

Adjustments to sexual behaviour and other lifestyle issues can be discussed and explained clearly to both.

If the patient's partner is HIV negative (i.e. a serodiscordant couple) particular care and attention must be paid to emotional and sexual consequences in the relationship.

Misconceptions about HIV transmission can be addressed and information on safer sex given.

The partner's and the patient's psychological responses to the diagnoses or result, such as anxiety or depression, can be explained and placed in a manageable perspective

There may be particular issues for couples who have children or who are hoping to have children or where the woman is pregnant.

Partners and family members sometimes have greater difficulty in coming to terms with the knowledge of HIV infection than the patients do themselves. Individual counselling support is often required to manage this, particularly role changes within the relationship, and other adjustment issues that may lead to difficulties. This is part of a holistic approach to the patient's overall health care.

In many cases the need for follow up counselling may be episodic and this seems appropriate given the long term nature of HIV infection and the different challenges a patient may be faced with. The number of counselling sessions required during any of these periods largely depends on the individual presentation of the patient and the clinical judgment of the counsellor.

4.8.1 Worried Well

Patients known as the "worried well" present with multiple physical complaints which they interpret as sure evidence of their HIV infection. Typically, fears of infection reach obsessive proportions and frank obsessive and hypochondriacal states are often seen. This group shows a variety of characteristic features, and they are rarely reassured for more than a brief period after clinical or laboratory confirmation of the absence of HIV infection. A further referral for behavioural psychotherapy or psychiatric intervention may be indicated, rather than frequent repetition of HIV testing.

4.8.2 Characteristics of the Worried Well

1) Repeated negative HIV tests
2) Low risk sexual history, including covert and guilt inducing sexual activity
3) Poor post adolescence sexual adjustment
4) Social isolation

5) Dependence in close relationships (if any)

6) Multiple misinterpreted somatic features usually associated with undiagnosed viral or post viral states (not HIV) or anxiety or depression

7) Psychiatric history and repeated consultation with general practitioners or physicians

8) High levels of anxiety, depression, and obsess ional disturbance

9) Increased potential for suicidal gestures

4.8.3 Coping Strategies

The importance of encouraging and working towards coping strategies involving active participation (to the extent the patient can manage) in planning of care and in seeking appropriate social support has been demonstrated clinically and empirically. Such an approach includes encouraging problem solving, participation in decisions about their treatment and care, and emphasising self worth and the potential for personal control over manageable issues in life.

Many patients diagnosed with HIV some years ago are now feeling well enough to return to work and to study and are, paradoxically, learning to readjust to living, as they had formally adjusted to the possibility of dying. Patients also have to deal with the uncertainty which remains about the long term efficacy of current medical treatment, and there are some who will fail on combination therapy. Even with the significant medical advances in patient management, counselling remains an integral part of the management of patients with HIV, and their partners and family.

Self Assessment Questions

1) What are the psychological responses to an HIV positive result?

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2) What are the characteristics of worried well?

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4.9 LET US SUM UP

HIV/AIDS counseling is confidential communication between a client and a care provider aimed at enabling the client to cope with stress and take personal decision relating to HIV / AIDS. The counseling process includes the evaluation of personal risk transmission, the facilitation of preventive behaviours and evaluation of coping mechanisms when the client is confronted with a positive result.

The aims of counseling are to help each individual to take charge of his life by developing the ability to make wise and realistic decisions, altering own behaviour to produce desirable consequences providing information.

Counselling micro skills are essential for effective communication and the development of a supportive client counselor relationship. These skills facilitate pre-test and post – test counseling effectively.

4.10 UNIT END QUESTIONS

1) Explain the concept of HIV counselling and discuss the goals of HIV Counselling.
2) Explain the pre –test discussion checklist during HIV counselling.
3) Discuss the coping strategies suggested during HIV counselling.
4) What are the psychological responses to an HIV positive result?
5) What are the characteristics of worried well?

4.11 GLOSSARY

HIV : HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact.

Coping strategies: coping refers to a process of using some techniques to manage taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimise, reduce or tolerate stress or conflict.

Worried well : Patients known as the "worried well" present with multiple physical complaints which they interpret as sure evidence of their HIV infection. Typically, fears of infection reach obsessive proportions and frank obsessive and hypochondria cal states are often seen.

Window period : The "window period" is the time it takes for a person who has been infected with HIV to react to the virus by creating HIV antibodies. This is called *seroconversion.* During the window period,

people infected with HIV have no antibodies in their blood that can be detected by an HIV test, even though the person may already have high levels of HIV in their blood, sexual fluids, or breast milk.

4.12 SUGGESTED READINGS

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UNIT 1 FAMILY COUNSELING

Structure

1.0 INTRODUCTION

This unit deals with family counseling. The unit starts with evolution of family counseling in terms of how developments in psychoanalysis, child guidance movement, marriage and group counseling etc. This is followed by concepts of family life cycle, in which there is a discussion about communication within families. Then we take up different approaches tom family counseling and types of family counseling. This is followed by family counseling in relation to individual counseling. Then we deal with family counseling processes. Then we deal with do's and don'ts in family counseling.

1.1 OBJECTIVES

After reading this unit, you should be able to:

- Define family counseling;
- Describe the historical evolution of family counseling;
- Understand the concept of family life cycle;
- Understand the concept of adaptive and dysfunctional communication patterns;
- Familiarise with the different approaches to family counseling;

- Understand the different types of family counseling;
- Describe the process of family counseling in terms of laying down its aims and objectives, process of assessment and the intervention process in family counseling;
- Describe the indications and contraindications for applying family counseling; and
- Critically analyse or evaluate the entire family counseling process.

1.2 EVOLUTION OF THE CONCEPT OF FAMILY COUNSELING

Family counseling is a program of providing information and professional guidance to members of a family concerning specific health matters, such as the care of a severely retarded child or the risk of transmitting a known genetic defect. Family is a group of people related by heredity, such as parents, children, and siblings. The term is sometimes broadened to include related by marriage or those living in the same household, who are emotionally attached, interact regularly, and share concerns for the growth and development of the group and its individual members.

Family counseling, is a program that consists of providing information and professional guidance to members of a family concerning specific health matters

Legal Definition of family counselling

Family counselling is a process in which a family counsellor helps:

Family counseling is a process in which

a) one or more persons to deal with personal and interpersonal issues in relation to marriage; or

b) one or more persons (including children) who are affected, or likely to be affected, by separation or divorce to deal with either or both of the following:

   i) Personal and interpersonal issues;

   ii) Issues relating to the care of children.

Family therapy provides a safe environment and temporary structure for people during these difficult times. People can re-build and create new ways of being that are more effective for their current life.

I think relationship counseling should be tailored to each person's or family's goals by using a combination of techniques and styles that best suit their personality and needs. All facets of an individual or a family are important to consider: mind, body, relationships, spirituality, and culture. I always look at a client's struggle in the context of their relationships. I help clients alter negative thinking and behaviour patterns, and use relaxation techniques to relieve stress and anxiety.

Most people already know what they need to do, but need the motivation, support, and feedback of a compassionate counselor to do it.

Family therapy is generally conducted by a therapist or team of therapists who are trained and experienced in family and group therapy techniques. Therapists

may be psychologists, psychiatrists, social workers, or counselors. Family therapy involves multiple therapy sessions, usually lasting at least one hour each, conducted at regular intervals (for example, once weekly) for several months. Typically, family therapy is initiated to address a specific problem, such as an adolescent with a psychological disorder or adjustment to a death in the family. However, frequently, therapy sessions reveal additional problems in the family, such as communication issues. In a therapy session, therapists seek to analyse the process of family interaction and communication as a whole and do not take sides with specific family members. Therapists who work as a team can model new behaviours for the family through their interactions with each other during a session.

Family therapy is based on family systems theory, in which the family is viewed as a living organism rather than just the sum of its individual members. Family therapy uses systems theory to evaluate family members in terms of their position or role within the system as a whole. Problems are treated by changing the way the system works rather than trying to fix a specific member. Family systems theory is based on several major concepts.

Concepts in Family Therapy

1) **The identified client**

The identified client is the family member with the symptom that has brought the family into treatment. Children and adolescents are frequently the indentified client in family counseling.

The concept of the identified clinet is used by family counselors to keep the family from scapegoating the client or using him or her as a way of avoiding problems in the rest of the system.

2) **Homeostasis (Balance)**

Homeostasis means that the family system seeks to maintain its customary organisation and functioning over time, and it tends to resist change. The family counsellor can use the concept of homeostasis to explain why a certain family symptom has surfaced at a given time, why a specific member has become the client, and what is likely to happen when the family begins to change.

3) **The extended family field**

The extended family field includes the immediate family and the network of grandparents and other relatives of the family. This concept is used to explain the intergenerational transmission of attitudes, problems, behaviours, and other issues. Children and adolescents often benefit from family counseling that includes the extended family.

4) **Differentiation**

Differentiation refers to the ability of each family member to maintain his or her own sense of self, while remaining emotionally connected to the family. One mark of a healthy family is its capacity to allow members to differentiate, while family members still feel that they are members in good standing of the family.

5) **Triangular relationships**

Family systems theory maintains that emotional relationships in families are usually triangular. Whenever two members in the family system have problems with each other, they will "triangle in" a third member as a way of stabilising their own relationship. The triangles in a family system usually interlock in a way that maintains family homeostasis. Common family triangles include a child and his or her parents; two children and one parent; a parent, a child, and a grandparent; three siblings; or, husband, wife, and an in-law.

In the early 2000s, a new systems theory, multisystemic therapy (MST), has been applied to family counseling and is practiced most often in a home based setting for families of children and adolescents with serious emotional disturbances. MST is frequently referred to as a "family-ecological systems approach" because it views the family's ecology, consisting of the various systems with which the family and child interact (for example, home, school, and community).

Several clinical studies have shown that MST has improved family relations, decreased adolescent psychiatric symptoms and substance use, increased school attendance, and decreased re arrest rates for adolescents in trouble with the law. In addition, MST can reduce out of home placement of disturbed adolescents.

6) **Preparation**

In some instances the family may have been referred to a specialist in family therapy by their pediatrician or other primary care provider. It is estimated that as many as 50 percent of office visits to pediatricians have to do with developmental problems in children that are affecting their families. Some family doctors use symptom checklists or psychological screeners to assess a family's need for counselling. For children and adolescents with a diagnosed psychological disorder, family therapy may be added to individual therapy if family issues are identified as contributing factors during individual therapy.

Family therapists may be either psychiatrists, clinical psychologists, or other professionals certified by a specialty board in marriage and family therapy. They usually evaluate a family for treatment by scheduling a series of interviews with the members of the immediate family, including young children, and significant or symptomatic members of the extended family. This process allows the therapist(s) to find out how each member of the family sees the problem, as well as to form first impressions of the family's functioning. Family therapists typically look for the level and types of emotions expressed, patterns of dominance and submission, the roles played by family members, communication styles, and the locations of emotional triangles. They also note whether these patterns are rigid or relatively flexible.

Preparation also usually includes drawing a genogram, which is a diagram that depicts significant persons and events in the family's history. Genograms include annotations about the medical history and major personality traits of each member. Genograms help uncover intergenerational patterns of behaviour, marriage choices, family alliances and conflicts, the existence of family secrets, and other information that sheds light on the family's present situation.

Precautions: Individual therapy for one or more family members may be recommended to avoid volatile interaction during a family therapy session. Some families are not considered suitable candidates for family therapy. They include:

- families in which one, or both, of the parents is psychotic or has been diagnosed with antisocial or paranoid personality disorder
- families whose cultural or religious values are opposed to, or suspicious of, psychotherapy
- families with members who cannot participate in treatment sessions because of physical illness or similar limitations
- families with members with very rigid personality structures (Here, members might be at risk for an emotional or psychological crisis.)
- families whose members cannot or will not be able to meet regularly for treatment.

Risks: The chief risk in family therapy is the possible unsettling of rigid personality defenses in individuals or relationships that had been fragile before the beginning of therapy. Intensive family therapy may also be difficult for family members with diagnosed psychological disorders. Family therapy may be especially difficult and stressful for children and adolescents who may not fully understand interactions that occur during family therapy. Adding individual therapy to family therapy for children and adolescents with the same therapist (if appropriate) or a therapist who is aware of the family therapy can be helpful.

Normal Results: Normal results vary, but in good circumstances, they include greater insight, increased differentiation of individual family members, improved communication within the family, loosening of previously automatic behaviour patterns, and resolution of the problem that led the family to seek treatment.

Read more: http://www.answers.com/topic/family-therapy-2#ixzz1GXyBxJtV
When a member of a family develops a problem, everyone in the family is affected as human beings have their existence integral to the family unit they belong to. In many such instances, professional help is essentially recommended in the form of a counseling process that involves the entire family so as to be able to grapple with the indefinite transitions and changes that families have to go through during the course of its life cycle.

Family counseling is a therapeutic endeavour that seeks to alter interactions between family members and role performance within families and aims, at the same time, to improve the functioning of an individual member, for instance, a child who is referred and identified as the principal client (Bentovim & Kinston, 1978). The approach usually involves working with the family as a group although it can proceed with a subgroup of the family with one person as the index client.

The current practice of family counseling has its roots in a variety of theoretical, practical and research approaches to helping children, married couples, and individuals with psychological problems. In understanding family counseling as it is now, it will be essential to acknowledge the contributions of analytic therapists, child guidance clinics, marriage counseling movement and studies on communication patterns within families in helping families cope with the problems.

Thus, the actual initiation of family counseling movement dates back to 1950s with the development of two important events— an influential book by Ackerman (1958) called *The psychodynamics of family life*, and the work on communication by Bateson and his colleagues mentioned below. Thus, to summarise, the following different factors and developments influenced the emergence of family counseling as an independent and specialised approach within the domain of counseling and psychotherapy:

1.2.1 Developments in Psychoanalysis

Psychoanalytic therapists began to extend their approach to include family orientation in the late 1940s. Infact, Freud (1909) was the first to include a parent in the psychoanalysis of a child. He worked indirectly with 'Little Hans' phobic problems by communicating with the boy's father and also seeing them together. Beginning with Sigmund Freud who specifically focused on intra-psychic processes during early childhood and started involving parents in the psychoanalysis of adolescent cases, Alfred Adler too emphasised the development of social interest within the family and initiated child guidance clinics in Vienna. Harry Stack Sullivan (1953) was concerned not only with intra-psychic factors but also interpersonal relationships within the family and with significant others. The works of Klien (1948) and Winnicott (1965) have also been of specific significance in this regard. Eventually it was Nathan Ackerman, a child psychiatrist who was trained in psychoanalysis and is considered as an initiator of family counseling movement, who started involving the entire family in the process of diagnosis and treatment. He was aware of conscious and unconscious issues within the individual and the family, as well as the issues that affected the family as a whole. His writings, particularly his book *The Psychodynamics of Family Life*, had an immense influence and many therapists thence forth were drawn towards his engaging style and active approach to counseling.

1.2.2 Growth of Child Guidance Movement

A new pattern of treatment emerged with the evolution of the child guidance clinic in the 1920s and 1930s—— weekly sessions with the child in conjunction with regular case work with one or the other parent initiated. Child guidance clinics, whose origins were based in Adlerian theory, concentrated on both the treatment and prevention of emotional disorders in children through an interdisciplinary approach. Parents, as well as children, were traditionally being worked with in clinics by teams of specialists from the fields of psychiatry, psychology, and social work. Although early research in this area tended to focus on such parental behaviour as maternal over protectiveness (Levy, 1943), clinicians eventually began to concentrate on the family as a whole.

1.2.3 Emergence of Marriage Counseling Movement

Sometime during 1950s, conjoint therapy, in which both the members of the couple were seen together by one counselor became a common practice. As marriage counseling developed, it focused more and more on attending to and working with the marriage relationship and less on the individual issues of each client. Paul Popenoe and Emily Mudd, the early pioneers in marriage counseling focused on the marital issues from a couple perspective and emphasised that there are three entities in a marital discord that one needs to work with: the husband as an individual, the wife as an individual and the couple as a unit.

These pioneers in the field also established the American Association of Marriage Counsellors in 1942 also set the precedent for seeing couples and family members together in conjoint sessions.

1.2.4 Initiation of Group Counseling

The innovative ideas of the 1940s and 1950s that emerged from small group behaviour laboratories, such as the National Training Laboratory (NTL) in Bethel, Maine, and the Tavistock Institute of Human Relations in London, England were especially important to the development of marriage and family counseling. Some practitioners even started treating families as a group and began the practice of couple and family group counseling, an approach that was found promising and yielding the desired results (Corey & Corey, 1987; Ohlsen, 1979, 1982).

1.2.5 Influence of General Systems Theory

The general systems theory, as developed by Ludwig Von Bertalanffy (1968), a biologist, viewed all living organisms, including couples and families, as interacting components that mutually affect one another. The focus is on how the interaction of parts influences the operation of the system as a whole. When his theoretical tenets were applied to psychological problems, it indicated that a family cannot be understood without knowing how the family functions as a whole. For example, if one person in the family is not functioning up to the capacity, the entire system has difficulty in carrying out its tasks. One of the main concepts introduced by this theory is c*ircular causality*, the idea that events area related to each other through a series of interacting feedback loops. By viewing family operations in this way, the focus for family dysfunction is shifted from an individual to the family unit itself.

1.2.6 Researches on Schizophrenia and Family Communication

Three main researchers conducted pioneer studies in the family dynamics and the etiology of schizophrenia: the Gregory Bateson group (Bateson, Jackson, Haley & Weakland, 1956) at the Mental Research Institute in Palo Alto, California; the Theodore Lidz group (Lidz, Cornelison, Fleck & terry, 1957) at Yale; and the Murray Bowen and Lyman Wynne groups (Bowen, 1960; Wynne, Ryckoff, Day & Hirsch, 1958) at the National Institute of Mental Health (NIMH). All observed how couples and families functioned when a family member was diagnosed as schizophrenic. Bateson and his group focused on the communication patterns within families of persons with schizophrenia and specifically pointed towards the pattern of *double bind* communication that involved providing contradictory messages to the child. Theodore Lidz and his research team observed that when marriage partners fail to meet each other's psychological and emotional needs, one partner may form a pathological alliance with the child, ultimately precipitating the child's schizophrenia. Bowen (1960) too observed the schizophrenic patients who lived with their parents in the ward for sustained period of time and concluded that not just the patient but the entire family unit had pathogenic features. Ackerman (1958, 1966) reached similar conclusions. These works had been important not only from the point of view that they provide insight into the etiology of schizophrenia but also provided direct impetus and direction to the family counseling movement.

1.3 CONCEPTS OF 'FAMILY LIFE CYCLE' AND 'COMMUNICATION PATTERN WITHIN FAMILIES'

Family Life Cycle

The *family life cycle* is the name given to the stages a family goes through as it evolves over the years. Family life and the growth that take place within it and complement those in an individual's life as those suggested by Erikson, 1959; Levinson, 1978 in their theories discussing the stages of development within an individual's life. Those families that attain the stage-critical tasks in time that are essential for individual as well as the family growth attain a better sense of well-being and grow with greater adaptability to the inevitable transitions of life (Carter & Mc Goldrick, 1988).

Table 1.1: Stages of the family life cycle

	Stage	Emotion	Stage-critical tasks
1.	Unattached adult	Accepting parent offspring separation	a) Differentiation from family origin, b) Development of peer relations, c) Initiation of career.
2.	Newly married	Commitment to the marriage	a) formation of marital system, b) Making room for spouse, c) Adjusting career demands.
3.	Childbearing	Accepting new members into the system	a) Adjusting marriage to make room for the child, b) Taking on parental roles, c) Making room for parents who have turned grandparents.
4.	Pre-school age child	Accepting the new personality	a) Adjusting to the specific needs of the child, b) Coping with energy drain and lack of privacy, c) Taking time out to be a couple.
5.	School age child	Allowing child to establish relationships outside the family	a) Extending family/ society interactions, b) Encouraging the child's educational progress, c) Dealing with increased activities.
6.	Teenage child	Increasing flexibility of family boundaries to allow independence	a) Shifting the balance in parent child relationship, b) Refocusing on mid-life career and marital issues, c) Dealing with increasing concerns for older generation.
7.	Launching center	Accepting exits from and entries into the family	a) Releasing adult children into college, work, & marriage, b) Maintaining supportive home base, c) welcoming children's spouses.
8.	Middle aged adult	Letting go of children and facing each other	a) Rebuilding the marriage, b) Welcoming grandchildren into family, c) Dealing with aging or demise of ones own parents.
9.	Retirement	Accepting retirement and old age	a) Maintaining individual and couple functioning, b) Supporting middle generation, c) Coping with death of parents or spouse, d) Closing or adapting family home.

Regardless of nature or type of family, all families have to invariably deal with family cohesion (i.e. emotional bonding) and family adaptability (i.e. ability to be flexible and change) (Olson, 1986). These two dimensions both with their four levels, as represented by Olson (1986) in what is known as the 'Circumplex Model of Marital and Family Systems' are *curvilinear*, that is to say, the families that are apparently very high or very low on these dimensions seem dysfunctional, whereas families that are balanced seem to function more adequately (Maynard & Olson, 1987). Families that are most successful, happy, and strong, are not only balanced but according to researchers (Stinnett & DeFrain, 1985), they are: 1) committed, 2) appreciate each other, 3) spend time together, 4) have good communication patterns, 5) have a high degree of religious orientation, and 6) are able to deal with crisis in a positive manner.

Thus, counselors are required to be sensitive to the current stage of development of a *family life cycle* and be concurrently attuned to the developmental tasks and individual growth of each of its individual family members in understanding the pathology of a particular family member or that of the family constellation as a whole. A comprehensive assessment of the same should be done in a comprehensive manner. Consequently, they can be more inclusive in their intervention plan.

Communication Pattern within Families

From the time of its origins in the work on schizophrenia in 1950s, family counseling has emphasised *communication patterns* within families. From this work emerged the concepts that describe dysfunctional ways of relating within a family: the double bind, marital schism, marital skew, and pseudomutuality.

1) **Double bind:** Various researchers (Bateson, Palo Alto, Jackson, Haley, 1956) while working with the families of persons with schizophrenia observed a pattern of communication in which a person receives two related but contradictory messages. One may be relatively clear and the other may be unclear, creating a "no-win" paradox. For example, a father might encourage his child to always stand for his rights or whatever is considered as right and justified, and the same father may often curb the child's expression by telling him "Don't question my authority".

2) **Marital schism and marital skew:** In their work with individuals who had been hospitalised with schizophrenia, Lidz and his colleagues found unusual patterns of family communications between parents and their children which they termed as marital schism and marital skew.

   In *marital schism*, one parent would undermine the worth of the other parent by competing for support and sympathy from children. That is to say, one parent would form an alliance with one of the children and would indulge in frequent criticism, rejection and argumentation with the other parent. For example, if the father did not value the mother, he would be afraid that the child would grow up like the mother, so he would often despise and criticise her in front of the children and involve them in the same process.

   In *marital skew*, one of the parents dominate the family dynamics and decision making process of the home so much so that it involves complete neglect of the other parent's perspective and wishes. However, the neglected parent

accepts the situation, and indicates to the children that everything is fine and the home is normal, thus distorting reality to the children.

In both of these situations, a pressure is being placed on the children to normalise the family dynamics. A child is in a state of bind, particularly in marital schism as by pleasing on parent, he would be invariably displeasing the other.

3) **Pseudomutuality:** Lyman Wynne (1958) and his colleagues observed that in families of children with schizophrenia, there was often a conflict between the child's need to maintain a separate identity and to maintain intimate relationships with family members. There is lack of open, authentic interactions between family members along with heightened emotional expression and reactivity at times. Family members may relate in limited or superficial ways to each other and may perceive their relationships as open that would invariably conceal the distant pattern in relationships within the family.

1.4 APPROACHES TO FAMILY COUNSELING

a) **Psychodynamic Approach:** Psychoanalytically oriented family counseling focuses on object relations. *Object relations* is concerned with the way people form attachments to others and things around them. The theory assumes that the basis of preferences for certain objects as opposed to others is developed in early childhood in parent-child interactions. Individuals bring these unconscious forces into a relationship with other members in the family. Skynner (1991) emphasised ways in which the childhood experiences of a parent affects the ways that they relate to their own children; for example, a mother who received no adequate mothering or neglect may develop a 'projective system', i.e. expectations from the child shaped by her own childhood experiences rather than current reality and needs of her own child. Projective systems affect the parents' ways of relating to one another as well as to the children. By identifying these systems, the counselor helps the family resolve conflicts. In doing so, the counselor helps the family members to gain *insight* into their own unconscious conflicts and help them understand how their own problems interact with those of other members in the family. The fundamental goals are insight, integration, and adaptive functioning. Thus, in other words, the focus is laid on both the *family members as individuals* with their early attachment patterns (Byng-Hall, 1991) and underlying conflicts and also on to the *family group* with its typical mode of functioning (Zinner & Shapiro, 1974) and continuing conflict stemming from a common traumatic experience.

b) **Systemic Approach:** Under the rubric of general systems theory, the concepts were originally developed by Von Bertalanffy (1962) in response to dissatisfaction with reductionism that saw events confined to *cause and effect* chain like that in psychodynamic model that saw past events as causal of subsequent ways of behaving. Von Bertalanffy's work in biology and medicine explored the inter-relationships of parts to each other and to the whole system. According to him, a family cannot be understood without knowing how the family functions as a whole unit as each family is a part of a larger system, a neighbourhood, which is again a part of a larger system, a

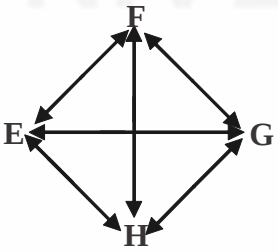
town and so forth. Individuals themselves are wholes that comprise smaller systems as organs, tissues, cells and so forth. If any part of the system changes, the whole system reflects a change. Important concepts in understanding the systemic perspective is through understanding the *communication pattern* within the family system. This implies that the pathology is typically seen as a failure of communication among family members. The emphasis is not on the past experiences or on purported intrapsychic conflicts of each member or that of the family a whole but on present functioning of the family system in terms of the communication pattern and manner of *feedback* among the family members as a unit thereby facilitating the attainment of homeostasis within the system.

Thus, in order to understand the concept of systems approach to family counseling, one must familiarise with the concepts of *feedback* and *homeostasis*, which deals with ways in which family systems and their units function.

***Feedback*:** Feedback, in this context, refers to the communication pattern within the units of a system. There are two basic patterns of communication: linear and circular. The linear approach shows that the communication occurs in a single direction, moving from A to B to C to D. In a system with circular feedback, each unit may change and thus affect any of the other units. For example, in a family context, a mother may feel her alcohol dependence is caused by son's insolent behaviour and the son may feel that his reactive behaviour towards his mother is due to her alcohol abuse. In this way, the feedback of the mother affects the feedback of the son and the feedback of the son affects the feedback of the mother. Thus, in family systems theory, a circular feedback interaction is observed and the blame is not placed on either mother or son. In other words, the emphasis is on the process rather than the content.

Linear Causality

Circular Causality



Homeostasis: In general, systems have a tendency to seek stability and equilibrium referred to as homeostasis (Goldenberg & Goldenberg, 2004). For example, a thermostat is being used to regulate the temperature so that the room does not become too hot or too cold. Likewise, the family system attempts to regulate itself so that stability and equilibrium can be maintained through positive and negative feedback interaction. Thus, the positive and negative feedback are related to changing the system or maintaining stability in the system. In *positive feedback*, change occurs in the system; in *negative feedback*, equilibrium is achieved. For example, if a parent talks to the child about the undesired behaviour pattern on the child's part and works with him to bring about the desired change without getting accusative, then the *negative feedback* interaction is said to be operational to bring about the

equilibrium. While in this particular example, if the parent chooses to be more aggressive and accusative with the child, the child may choose to stay out late more often and not participate in the family functioning, then in that case *positive feedback* may be said to be operational that might change the functioning of the system but in a destructive manner. However, depending upon the nature of the problem, the positive feedback processes might create the desired change in the family system as well.

One influential systemic approach to family counseling is Milan's approach. In *Milan approach* (Palazzoli, 1978), *circular questioning* is often used to assess the conflicting views among members in the family. Following approach is applied in this technique, a) one person is asked to comment on the relationships of others, for example, the mother may be asked how her husband relates to their son and others are asked to comment on her response, b) based on this, a hypothesis may be constructed about the dysfunctional pattern within the family and is presented to the family, c) finally, the family may be asked to adopt newer adaptive ways of communicating and behaving with each other.

The limitation of Milan's approach is that it refutes the impact of past traumatic experiences that the family might have gone through and also ignores the effects of certain realistic and social concerns such as unemployment and poverty.

c) **Bowen's Intergenerational Approach:** Murray Bowen's (1960) approach to family counseling is rooted in systems approach to family counseling. However, it substantially differs from other systemic approaches in terms of its emphasis on family's emotional system and the history of this system as it may be traced through the dynamics of the parents' families and even grand parents' families. His theory laid specific emphasis on how families projected their own emotionality onto a particular family member, that member's reaction to other family members and how individuals cope with stress put on them by the way other family members cope with their anxieties. He is particularly concerned with the ways children distance themselves emotionally and physically from their families. Finally, one of the most significant aspects of Bowen's theory is how families transmit psychological characteristics that affect the interaction over several generations. Important concepts emanating from Bowen's theoretical perspective are: enmeshment, triangulation, family projection process, emotional cut off, multigenerational transmission process, sibling position and societal regression.

- **Enmeshment** refers to family environment where members are overly dependent on each other or have undifferentiated roles and ego boundaries. One should be able to differentiate one's intellectual processes from one's feelings. When thoughts and feelings are not distinguished, fusion occurs. In a family conflict, people who are able to differentiate their own emotions and intellects are able to stand up for themselves and not be dominated by the feelings of others, whereas those whose feelings and thoughts are fused may express a pseudo-self rather than their own values and opinions. If two enmeshed people, that is, with low level of differentiation marry, it is likely that as a couple they will become highly fused, as will their family when they have children.

- **Triangulation** refers to family fusion situations where a third person or family member is pulled in to resolve conflict between some two members in the family. For Bowen, a two person system is unstable, and when there is stress, joining with a third person reduces the tension in the relationship between the original two people. However, bringing a third person into a conflict (triangulation) does not always reduce the tension, and depends, in part, on the differentiation level of the members involved.

- **Family projection process** refers to the parents' tendency to project their own stress onto one child, particularly if they have low levels of differentiation within themselves.

- ***Emotional cut off*** refers to the child's tendency to emotionally and physically withdraw from the family due to excessive stress caused by emotional overinvolvement. Their interaction with the parents is likely to be brief and superficial. In general, higher the level of anxiety and dependence, the more likely children are to experience an emotional cut off in a family.

- Bowen contended that not only the current family but the enmeshment among family members or their differentiation levels at previous generations may play an important role in family pathology, a concept referred to as *multigenerational transmission process.*

- In *sibling position*, Bowen emphasised that the birth order and the way child functioned in the family with respect to other siblings, determined how one functions as a parent.

Bowen extended his model of family systems to societal functioning to develop the concept to *societal regression* and suggested that certain societies that are regressed with enmeshed identities of its inhabitants may move towards mature differentiation through the development of differentiated selves of its members.

Techniques used in this approach focus on ways to differentiate one's self from one's extended family of origin. In the process, there is an attempt to create an individuated person with a healthy self concept who does not experience undue anxiety every time the relationship becomes stressful. Ways of achieving this goal include assessment of self through the use of a genogram (a three generational family tree) and a focus on cognitively evaluating events and interactions (Bowen, 1976). The sequencing and pacing of this process differs from family to family and the exact nature of problem of concern being experienced by the family members.

d) **Structural Approach:** Structural approach, developed by Salvador Minuchin, helps families by dealing with problems as they affect current interactions of family members. To Minuchin, the term family structure refers to a set of unspoken rules that organise the ways in which family members relate to one another and the rules that determine the hierarchy of authority, responsibility and cooperation among family members. Of particular interest are *boundaries* between family members and the *permeability* in boundaries of systems and subsystems within the family.

Permeability refers to the level of permissibility in a family or a family system with regard to other people or members seeking expression or alignment with it. High permeability would be found in enmeshed families whereas non-permeability or rigid boundaries would be found in disengaged families.

In responding to crises or dealing with daily events, families may have typical ways that subsystems within the family react. *Alignments*, according to this approach, refer to the ways in which the family members join each other or oppose each other in dealing with an activity. *Coalitions* refer to alliances between family members against one another. Sometimes, they are flexible and sometimes they are fixed, such as when a mother and daughter work together to control a disruptive father. Minuchin uses the term *triangle* more specifically than does Bowen to describe a coalition in which "each parent demands that the child side with him against the other parent". Thus, the power within the family shifts, depending upon alignments and coalitions.

The goal of this kind of counseling is to alter the current family structure by working on the coalitions and alliances within the family based on the hypotheses about the structure and the nature of the problem. Families are helped to develop communication and social skills. They also work to establish boundaries within the family that are neither too rigid nor too flexible. By supporting the parental subsystem as the decision-making system that is responsible for the family, counselors work to help the family system use power in a way that functions well. The techniques that family counselors use in this kind of an approach are: *family mapping* that involves using diagrams to describe current ways in which the families relate, *enactment* of the conflict, *intensity* involves altering the way and content of the messages that are given to each other in the family, *changing boundaries* that involves marking boundaries between members in the family and *reframing* involves altering the perception of a given event or situation in the family thereby altering the reaction pattern associated with it. These techniques are active and highly attuned to family functioning.

Minuchin (1974) and his colleagues have deployed their methods for behavioural problems and psychosomatic states such as diabetes, asthma, and anorexia nervosa. The aim in this approach has always been to restructure a family's rigid patterns that both trigger and maintain damaging patterns and even potentially threatening states.

e) **Strategic Approach:** Concerned with treating symptoms that families present, Haley (1973) and his colleagues developed an approach that emphasises problem solution rather than generating an insight about the nature of problem or developing any hypothetical constructs around it.

Haley's work with Minuchin was important in developing his theoretical approach to family counseling, although, his work is not as developed as that of Minuchin. Thus, what differentiates strategic from structural approach is the attention given by strategic family counselors to symptoms. For Haley, symptoms are an unacknowledged way of communicating within the system, usually when there is no other solution to a problem.

In his approach, Haley observes the interaction among family members focusing particularly on power relationships and to the ways parents deal with power. Viewing relationships as power struggles, Haley (1976) is interested in understanding how relationships are defined. Thus, a communication from one person to another is an act that defines the relationship (Haley, 1963). Important to Haley, as well as to Minuchin, is the concept of hierarchy, in which the parents are in a superior position to the children in terms of making decisions and adhering to family responsibilities. Like Minuchin, he is concerned with family triangles such as those in which one parent is over involved with the child and the other is under involved.

The goal in strategic approach to family counseling is to reduce anxiety and balance the power dynamics within the family system by stating concrete intermediate and final goals to the counseling process. There must be sufficient information available to the counselor to plan strategies to reach goals. For each goal, specific methods for accomplishing them are designed by the counselor.

Since, the presenting problem is the focus of strategic counseling, tasks to alleviate the problem or symptom are its cornerstone. While working with the family, the counselor must select and design tasks that are appropriate to the family and to the nature of its problems, and also help the family complete them. Generally, tasks are of two types: *straightforward tasks*, where the counselor makes directions and suggestions to the family, and *paradoxical tasks*, for families that may resist change.

Each strategic family counseling intervention is different, depending on the counselor's observation of the family structure. Interventions whether using straightforward technique or paradoxical technique are thought out and executed clearly and carefully with the ultimate purpose of correcting the family's power struggle and coalitions.

f) **Behavioural and Cognitive Behavioural Approach:** Some counselors and researchers (Liberman, 1970; Patterson, 1971) have viewed family relations in terms of reinforcement contingencies. The role of the counselor is to generate a behavioural analysis of family problems. This analysis helps identify the behaviours whose frequency should be increased or decreased as well as the rewards that are maintaining undesirable behaviours or that will enhance undesired behaviours. Behavioural family counseling then becomes a process of inducing family members to dispense the appropriate reinforcements to one another for the desired behaviours. Indeed, some counselors (Stuart, 1969) even have family members use tokens for this purpose. For example, a husband might earn four tokens if he does not watch television the whole day on a week end and instead helps his children with their home assignments and take them for an outing. Likewise, other family members may also earn tokens for exhibiting the desired behaviours that is fulfilling for other family members and contributes towards the growth of the family as a unit. Of course, the tokens so earned, may later be exchanged for the desired rewards that should have been decided in advance. The principle underlying is that the desired behaviours initially performed to earn tokens and rewards are later replaced by choicefully taken up

conscious behaviour patterns that would ensure integrity, harmony and growth in the family.

Given the recent developments in cognitive behavioural counseling, it is not surprising that this approach has found its way into the family counseling enterprise. Similar to cognitive behavioural counseling for the individual, the family approach also involves teaching individual family members to self monitor problematic behaviours and patterns of thinking, to develop new skills (communication, problem resolution, negotiation, managing conflict), and to challenge interpretations of family events and reframe these interpretations if necessary (Carlson, Sperry, & Lewis, 1997; Epstein, Schlesinger, & Dryden, 1988).

1.5 TYPES OF FAMILY COUNSELING

a) **Conjoint family counseling:** In *conjoint family counseling*, the entire family is seen at the same time by one counselor. In some varieties of this approach, the counselor plays a rather passive, non-directive role while in certain others he might take the role of an active force, direct the conversation, assign tasks to various family members, impart direct instruction regarding human relations, and so on. Satir (1967) used such an approach and regarded the family counselor as a resource person and a communicator who observes the family process in action and then becomes a model of communication to the family through clear and crisp communication, thus illustrating the family members how to communicate better and bring about more satisfying relationships.

b) **Concurrent family counseling:** In *concurrent family counseling,* one counselor sees all family members but in individual sessions. The overall goal is the same as that in conjoint family counseling. In some instances, the counselor may conduct traditional psychotherapy with the index client and might also see other family members intermittently.

c) **Collaborative family counseling:** In collaborative family counseling, each family member sees a different counselor. The counselors then get together to discuss their respective clients and the family as a whole. In variation of this approach, a counselor might assign his collaborates as co-therapists who then deal with specific family members under the supervision of the principal counselor and each member as well as the family is being discussed to work out the intervention goals and strategies.

1.6 FAMILY COUNSELING IN RELATION TO INDIVIDUAL COUNSELING

Certain aspects of family counseling differentiate it from the customary individual counseling as it involves dealing with a group of people instead of an individual who are otherwise related to each other and yet have difficulty in connecting with each other adequately. At the same time, the family counseling involves a group of individuals who have by and large shared a frame of reference, a common history, and a shared language of connotations for whatever transpires among them. The counselor has to understand the *roles* of various family members within

the family unit, their *liaisoning* and *relatedness* with each other, level of *expression* and *communication* within the family and also about the *idiosyncratic subculture* of the family.

At the same time, it is essential that the counselor must remain detached and does not become overly identified with one section of the family at the expense of another. This can be difficult and challenging as the family members would often try to involve the counselor in their power struggle or in their defenses against open communication.

1.7 FAMILY COUNSELING PROCESS

In most cases of family counseling, the families themselves often do not enter in the process of counseling to seek intervention for the family as a whole rather they often land up with a problem behaviour in the child or an adolescent member to be dealt with that is a matter of concern for the whole family. Or in certain cases, a family counselor may be approached if there is an adult family member with a known psychopathology or disorder that is interfering with the family functioning, or in few other cases, there could be an apparent dispute or conflict among the family members that is causing significant distress to one or more of the family members and affecting the functioning of the family as a whole. Thus, under most instances of family counseling, the family has to be psychoeducated about the need for family counseling, and therefore, has to be adequately prepared and encouraged for involvement in the process so as to grapple with the entire problem and the issue of concern.

Aims and objectives of family counseling

In a family counseling process, irrespective of who all constitute the family and its socio-cultural and educational background, and whosoever be the index client and the nature of problem concerned, the goal of the counseling process is to improve family functioning, and so to help the identified client. Whatever their method, family counselors have the following goals for family counseling:

- Improved communication,
- Improved autonomy for each member,
- Improved agreement about roles,
- Reduced conflict, and
- Reduced distress in the index client

Assessment in family counseling

The history taking and assessment process is a typical part of family counseling. A family counselor needs to understand a particular family with regard to its socio-cultural and educational background. The counselor also needs to be aware of the underpinnings, beliefs and values that are rooted in different cultural contexts.

The entire process of assessment and history taking begins with taking a brief account of the *current concerns* or, so to say, the *presenting problem*. The presenting problem must be clearly understood and concretely stated by the counselor. It is often interesting and important to see how different family members construe the same problem in quite divergent ways.

As a part of the assessment process, it is essential to analyse and assess further:

A) **Structure and History of the Family**

- **Structure and configuration of the family:** The basic structure and configuration of the family needs to be explored as it has existed in the past and also as it exists in the present. Structure recorded in the genogram includes information regarding single parent, a step parent, number and ages of the siblings etc. For this, usually a family history has to be taken at a three-generational level depicted through a *family genogram* using conventional symbols.

- **Transitional events in family cycle:** Changes and events such as births, deaths, departures, and financial problems that have taken place in the past or recent past and divergent *reactions* of various family members to all these transitions or crises situations in the family life need to be discussed and recorded in detail.

- **Nature of relationship/s:** The counselor always explore the nature of relationships within the family structure such as being close, distant, loving, conflictual, reserved etc. which is necessary to understand the overall family atmosphere and cohesion within the family.

- **Boundaries:** As mentioned earlier, families consist of subsystems divided by boundaries that is to say, the boundaries between egos and self concepts. In a well functioning family, these are permeable enough to facilitate easy communication between subsystems but yet sufficiently intact to allow their autonomy. The counselor needs to assess, if in a given family, the boundaries between family members are so *enmeshed* that they are overly involved with each other and fail to maintain individual thought processes and reaction patterns or if the boundaries are too *rigid* that the members act as totally separate persons who merely seem to share the same household.

- **Family atmosphere:** Every family has a distinct atmosphere: authoritative, chaotic, panicky, over-excited, apathetic, critical, aggressive, humorous or balanced. Although many of these listed may occur in a family atmosphere at given points in time but a constellation usually tends to predominate that is essential for a counselor to understand.

B) **Roles, Functioning and Pathological Trends in a Family**

- **Role performance:** Counselors need to explore the different *roles* being taken up, assigned or enforced on different family members; the level of efficacy with which the roles are performed by each member, the level of burden perceived by each member with regard to his/ her role to be performed in the family and their levels of satisfaction with regard to their duties and contributions made towards other family members.

- **Decision making and power struggle:** Families have different trends with regard to decision making and expression of right and authority. Some families are balanced wherein members have the right to express and make choices for themselves in various matters. In fact, all members

are involved in the process of decision making of common interest. While certain other families have skewed patterns, that is, the power and the right to take decisions rests in the hands of one or two members while others have to simply follow or obey that. A family counselor needs to identify the trend that exits in a given family and its impact on other family members before planning any intervention.

- **Pattern of communication and exchange of information:** The family members communicate with one another both verbally and non-verbally, the latter often exerting the greater impact. Communication varies greatly in terms of whether it actually occurs or not, how clear, how open and direct, and how responsive family members are to one another. Pattern of interaction involving two or more family members usually varies from being expressive, selectively expressive or unexpressive; being overly critical or being overly involved or guiding. Often, an incongruity between what is stated and what is expressed non-verbally is an obvious indicator of family dysfunction.

- **Emotional reactivity:** Pattern of emotional reaction among family members that might involve some members being too impulsive, aggressive, irritable or frustrated in their reactions, some might be too docile or emotionally unreactive, some might expect undue pampering or dependence on others while some family members appear to be overly involved with enmeshed ego boundaries with others and would always keep worrying about others or trivial issues in the family, and would remain overly anxious thereby contributing to the family's problems and pathology.

- **Cohesiveness:** Every family has its own unique sense of solidarity, belongingness, and loyalty— a sense of members working together to enhance their welfare. Cohesiveness is threatened when alliances form which exclude some members, when discord develops between two or more members, and a child or a parent is typically scapegoated or blamed for anything or everything that goes wrong in the family. The family also respects the rules that govern relationships between subsystems and the internal process of each of them.

- **Family operations:** Every family has a pattern of operating to resolve conflicts, to reach decisions, to face problems, and to deal with changes inherent in the family life cycle. Some families are adaptive and may deal with transitions, conflicts and changes in an appropriate and mutually supportive manner while other families may show dysfunctional patterns.

- **Liabilities and pattern of individual growth of family members:** Certain families may have a pattern of posing excessive demand/s on one or two family member/s for the interest of others. The counselor needs to explore if the family pattern is adaptive and places appropriate levels of liabilities and burdens on every individual member and encourages the individual growth of each of its members or it creates impediments in the individual growth and development of a particular member or members that might become frustrating for those member/s thereby creating dysfunctional trend in the long run.

C) **Value System, Socialisation and Recreation Pattern within the Family**

A family counselor must also explore with adequate clarity:

- Nature and pattern of value and moral system of a family
- Pattern and level of religious and spiritual orientation within a family
- Pattern and level of socialisation accepted and encouraged in a family
- Pattern of seeking entertainment and recreation within a family.

Several kinds of questioning may be used: circular questioning; questions about the roles of the members such as who takes care of the others, who worries most, who decides etc.; questions about triadic relationships such as what does A do when B criticises C; and about responses to a previous change e.g. the death of a grand parent or an important family member.

Through the entire process of history taking and exploration, the counselor must try to derive answers to two questions: a) *how does the family function and performs its various operations and roles,* and b) *are family factors involved in the index client's problems* that is, are the family members overly reactive, overly critical, overly involved or supportive to the client with regard to his/ her problem behaviour?

The answers to these questions lead to a hypothesis about what should and can be changed in the family structure, its current functioning, relatedness pattern as well as the factors that might be contributing to its pathology.

Intervention process in family counseling

The counselor encourages the family to describe the presenting problem in substantial detail in order to arrive at an understanding and formulation about the nature of the current problem. The counselor also elicits the family's own explanations of the problem which helps him understand maintaining factors. During the initial few sessions, he also gets an opportunity to observe directly the ways in which problem behaviours manifest, like: what provokes a child's angry outburst, what sets off an argument between siblings or between parents, what alliances exist and so on. He may discreetly provoke characteristic ways of relating by directing group discussion, instructing the family to perform certain tasks, or issuing a paradoxical injunction that would simply show the characteristic ways of behaving and reacting to challenging or undesirable life situations by different family members.

In addition to this, it is important to note that seeking the detailed family history in the presence of all family members during which the family problem is placed in the larger context of information about the parents' origins and their early life and marriage, children can often attain better understanding and insight into what circumstances and distresses their parents, grand parents or other elders in the family have gone through in the course of their lives. Laying out the entire panorama of family history—its extended members and their goals, aspirations, fear, and frailties can lead to deeper understanding, empathy, and tolerance. This larger context can promote a shred frame of reference and a platform for each member to understand the other in his/ her individual life context independent of being a part to the family.

In a family counseling process, the counselor must focus on altering the *communication pattern and exchange of information in the family, emotional expression and reactivity of various family members, general atmosphere and cohesiveness within the family, the pattern of boundaries within the family and the family operations in terms of the tasks or roles being taken up by each family member*. The counselor should also focus on and encourage healthy socialisation and recreation pattern to be developed and adopted by the family as a unit. Simultaneously, the family counselor should also work on rectifying the dysfunctional communication and behaviour patterns adopted by various family members.

Techniques to be used may involve expression through dialogue, writing or drawing; role playing; enactment of distressful situations; forming alliances and performing tasks with family sub units; and taking up paradoxical injunctions.

The time interval between sessions and duration of intervention depends largely on the model adopted, the pattern of intervention planned beforehand, and the nature of the problem to be grappled with. Usually a convenient timing that suits all or most family members with weekly follow up sessions is encouraged in a typical family counseling venture. Though, with the achieving targets and goals set for a family, the counselor may increase the time interval between follow up sessions.

Depending on his approach, the family counselor has a choice of working solo or with a co-therapist, ideally of an opposite sex as it provides the advantage of each member conveniently disclosing personal issues and concerns with the counselor of the same sex. The group of counselors involved in dealing with a family may then share impressions and reflections with each other while progressing with the process of counseling.

Termination is usually smoother when the counselor/s and his co-therapist are clear about the final and intermediate objectives and goals of the counseling process to be attained, the target problems to be ameliorated and the techniques to be used. If the counselor has negotiated a specific number of sessions with the family at the outset, the termination is relatively straightforward. He might, however, need to constantly encourage certain family members, in particular, about the need and plan for the sessions to follow. If the family has shown commitment in maintaining regular follow-ups, the counselor should regularly review the goals to be achieved in planning the final phase. The termination process should always be followed by the booster sessions and intermittent review with the family together or open for any of the members to seek session as per need.

1.8 INDICATIONS AND CONTRAINDICATIONS FOR FAMILY COUNSELING

Though, there are no hard and fast rules as to when family counseling is appropriate and when it is not, most of the times, family counseling begins with an adolescent as the index client for intervention or in dealing with the problems of young people living with their parents. These problems are often related to difficulties in communication between members of the family, their role conflicts

and associated problems, or other behavioural problems related to substance or alcohol abuse, liaisoning with anti-social people or social misconduct by the young family member. In many such cases without involving the entire family in the process of counseling, adequate intervention may not be planned.

In other cases, the client's problems have so involved or threatened the fabric of family that it seems wise to counsel the family as a whole. Sometimes, family crises, such as the death of a family member, propel the entire family unit into pathology. While in some other families, there are conflicts over values as to what and how much is permissible to children and what is acceptable to children from the parents. In such cases as well, family counseling is a logical course. Finally, certain marital conflicts and issues between married couples with children also need to be dealt with through the process of family counseling.

However, family counseling is not a cure-all, and it is not always appropriate. It sometimes happens that a family is so disrupted that such intervention would clearly be doomed to fail. In some instances, it may also happen, that one or more family members may simply refuse to cooperate. In some cases, where family violence or sexual abuse have occurred, family counseling is contra-indicated since the presence of other family members may impede or restrict an open expression on the part of the child or the person abused. Likewise, in infantile autism, intellectual handicap and disability in which biological factors contribute to the child's problem, a family approach is unlikely to be relevant. Moreover, in certain instances, families simply do not possess the psychological strength or resources to cope with the emotionally charging and mutually accusing material that is expressed during the sessions. Thus, deciding when to use family counseling and when not to is often a difficult matter that requires careful assessment and a great deal of sensitivity.

1.9 LET US SUM UP

Family counseling has developed substantially since the 1950s. Many different models have existed for family counseling and compete for their attention till date. A number of research on family counseling and therapy have found family counseling to be useful for a variety of problems and to be at least as effective as other types of counseling approaches (Friedlander & Tauson, 2000; Henggeler, Borduin, & Mann, 1993; Nicholas & Schwartz, 2001). Trainers and novice counselors need to familiarise themselves with these models and select one they can apply comfortably. Whatever approach they choose to conform to, they should try to be open and not restrict themselves by setting up rigid theoretical boundaries. Integrative approaches to family counseling are becoming increasingly common, and several counselors and therapists have described ways to incorporate them (Scharf, 2000). Thus, typically integrative approaches are theoretically sound, show efficacious results and can be conveniently adopted for practice.

1.10 UNIT END QUESTIONS

1) Discuss family counseling as an intervention approach in psychological counseling.

2) Describe the crucial events that led to the development of family counseling movement.

3) Describe the concept and stages of family life cycle and its significance in family counseling process.

4) Discuss the concept of adaptive and dysfunctional communication patterns within families in the light of research work done in the context of schizophrenia.

5) Discuss in detail the tenets behind different approaches to family counseling.

6) Discuss the process of assessment and intervention in family counseling.

7) Critically evaluate the entire family counseling process and discuss its application in terms of indications and contraindications for applying family based approach to counseling.

1.11 SUGGESTED READINGS

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UNIT 2 COGNITIVE BEHAVIOUR APPROACH TO COUNSELLING

Structure

2.0 INTRODUCTION

In this unit we start with the definition of cognitive behavioural counselling. We describe this method and put forward the basic tenets of cognitive behavioural counselling. This includes objecives, process of counselling and therapeutic relatiosnhip. This is followed by techniques of cognitive behavioural counselling which includes cognitive techniques and beehavioural techniques. The next section deals with recent research and advances in cognitive behaioural counselling and the computer assisted counselling. How a person can use the computer for getting their problems attended to. Then we deal with the indicators for cognitive behavioural counselling and then there is a section dealing with the critical appraisal of the entire technique.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Define cognitive behavioural counseling;
- Describe the historical background of cognitive behavioural counseling;
- Explain the basic tenets of cognitive behavioural counseling;
- Explain the process of cognitive behavioural counseling;
- Describe the techniques used in cognitive behavioural counseling;

- Explain the recent advances in the field; and
- Critically analyse cognitive behavioural counseling.

2.2 DEFINITION OF COGNITIVE BEHAVIOURAL COUNSELLING

The modern roots of Cognitive Behavioural Counseling can be traced to the development of behaviour therapy in the early 20th century, the development of cognitive therapy in the 1960s, and the subsequent merging of the two.

Behaviour therapy, one of the earliest of the psychotherapies, is based on the clinical application of extensively researched theories of behaviour, such as learning theory. It was during the period of 1950 to 1970 that behavioural therapy became widely utilised, with researchers in the United States, the United Kingdom and South Africa who were inspired by the behaviourist learning theory of Ivan Pavlov, John B. Watson and Clark L. Hull. The wide use and acceptance of behaviourist model can be attributed to its success in treating anxiety disorders, and in being cost and time effective and often replicable, objective and "science-like".

However, early behavioural approaches were unable to effectively treat common disorders such as depression. Behaviourism was also losing in popularity due to the so-called "cognitive revolution". The therapeutic approaches of Albert Ellis and Aaron T. Beck gained popularity among behaviour therapists, despite the earlier behaviourist rejection of "mentalistic" concepts like thoughts and cognitions.

Behaviourist approaches did not directly investigate the role of cognition and cognitive processes, such as thinking, problem solving, appraisal of situations by each individual etc., in the development or maintenance of emotional disorders, although their role was gradually recognised as being of utmost importance.

In a sense, the present blending of behavioural and cognitive methods was stimulated by the limitations of both psychodynamics and radical behaviourism. This blending was also facilitated by the presence of several theoretical models that incorporated cognitive variables along with the scientific and experimental rigor so precious to behaviourists.

This paved way for Cognitive therapy which is based on the clinical application of the more recent, but now also extensive research into the prominent role of cognitions in the development of emotional disorders. However, focusing only on cognitions, and with the isolation of behaviours was seen as unfeasible and impractical.

The merging of these two schools of Behaviour and Cognitive Therapy led to the formation of the school of Cognitive-Behavioural Therapy (CBT) or Cognitive Behavioural Counseling. The theoretical structure and basic method for CBT were outlined by Aaron Beck in a classic series of papers published in the 1960s.

It is variously used to refer to behaviour therapy, cognitive therapy, and to therapy based on the pragmatic combination of principles of behavioural and cognitive theories. New Cognitive Behavioural Counseling interventions are keeping pace with developments in the academic discipline of psychology in areas such as attention, perception, reasoning, decision making.

Cognitive behaviour counseling is an action oriented form of counseling that assumes that maladaptive or faulty thinking patterns cause maladaptive behaviour and "negative" emotions. The treatment focuses on changing the individual's thoughts (cognitive patterns) in order to change their behaviour and emotional state.

The cognitive component in the cognitive-behavioural counseling refers to how people think about and create meaning about situations, symptoms and events in their lives and develop beliefs about themselves, others and the world.

During times of mental distress, people think differently about themselves and what happens to them. Thoughts can become extreme and unhelpful. This can worsen how a person feels. They may then behave in a way that prolongs their distress.

Cognitive behavioural counseling uses techniques to help people become more aware of how they reason, and the kinds of automatic thought that spring to mind and give meaning to things. The practitioners help each person identify and change their extreme thinking and unhelpful thoughts and subsequently, behaviour. In doing this, the result is often a major improvement in how a person feels and lives.

It is a way of talking about:

- how one thinks about oneself, the world and other people
- how what one does affects ones thoughts and feelings.

Unlike some of the other counseling approaches, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of distress or symptoms in the past, it looks for ways to improve ones state of mind now.

Cognitive Behavioural Counseling helps in making the client recognise that one's thoughts, emotions, physical responses and actions, do not exist in isolation of each other. Rather, the connection between each of them is explained and if required, demonstrated.

Each of these areas can affect the others. How one thinks about a problem can affect how s/he feels physically and emotionally. It can also alter what one does about it. There are helpful and unhelpful ways of reacting to most situations, depending on how one thinks about them.

E.g. an individual goes to a party and meets and greets many people. However, an old friend doesn't return the individuals smile and walks past him. an unhelpful thought in such a case may be that "He ignored me, which probably means that he doesn't like me". This thought may lead to emotions of sadness, dejection and feeling low, probable physical problems such as low energy, low appetite, sleep difficulties etc. This may lead to Action in the form of leaving the party immediately, avoiding meeting that friend further etc.

In the same situation, if one thinks a helpful thought such as, "probably my friend did not notice me, was absorbed or thinking about something else", it will lead to no maladaptive emotions or physical problems in the individual. He will be able to continue enjoying the party and may even approach his friend and speak to him, if given a chance.

The same situation, thus can lead to two very different results, depending on how one thinks about the situation. How one **thinks** has an affect on how one **feels** and what one **does**. In the example, in the first case, the individual jumps to a conclusion without very much evidence for it leading to:

- a number of uncomfortable feelings
- an unhelpful behaviour.

This can be understood with the help of a diagram:

Dobson and Block (1988) suggested that Cognitive Behaviour therapies share three propositions:

1) Cognitive activity affects behaviour
2) Cognitive activity may be monitored and altered
3) Desired behavioural change is achievable through cognitive change

Thus, Cognitive Behavioural Counseling can help the client to break the vicious circle of altered thinking, feelings and behaviour. When the client is able to see the parts of the sequence clearly, s/he can change them - and so change the way s/he feels.

Hawton et al. (1989) offered a process-oriented definition proposing that Cognitive Behaviour therapies are typified by their:

- Expression of concepts in operational terms
- Empirical validation of treatment
- Specification of treatment in operational terms
- Evaluation of treatment with reliable and objective measures
- Emphasis on “here and now”
- Objective to help clients bring about desired changes in their lives
- Focus on new learning and changes outside the clinical setting
- Explicit description of therapeutic procedures to the client
- Collaboration of the client and counsellor to deal with identified problems
- Use of time limits and explicitly agreed goals.

Self Assessment Questions

1) Describe the historical background of Cognitive Behavioural Counseling.

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2) Define Cognitive Behavioural Counseling.

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3) According to practitioners of Cognitive Behavioural Counseling, what is the role of maladaptive cognitions in mental disorders?

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2.3 BASIC TENETS

2.3.1 Objectives of Cognitive Behavioural Counseling

The aims of cognitive behavioural counseling are twofold:

1) To reduce distress by teaching skills to recognise, evaluate and change relevant cognitive processes.

2) In later phases, to engender an understanding of themes in maladaptive cognitions in order to modify enduring sets of attitudes and beliefs that are the basis of the client's vulnerability.

The approach to a problem involves the following steps:

- Eliciting automatic thoughts
- Testing their accuracy and viability
- Developing realistic alternatives
- Identifying and challenging underlying maladaptive schemata.

Three types of cognitive phenomena determine mental problems, especially those which are emotional in nature:

Automatic thoughts, cognitive distortions, and schemata

Automatic thoughts are the more autonomous, often private cognitions that flow rapidly in the stream of everyday thinking and may not be carefully assessed for accuracy or relevance. Since many people are unaware of them, they become difficult to desist or change. E.g. in depression, thoughts about loss, defeat, rejection or hopelessness are common. An important component of treatment is to make clients aware of their negative automatic thoughts. Often, clients are so accustomed to having negative thoughts, and the thoughts come to them so quickly, that they are not even aware of having them. Furthermore, clients rarely come into treatment having a clear understanding of the ways in which negative

thoughts impact affective, physiological, and behavioural processes. Therefore, a first step in treatment is to help clients to become more aware of their thoughts, primarily through self-monitoring exercises.

Cognitive distortions refer to misinterpretations of reality that lead to negative conclusions. These include over-generalisation (a single instance is taken as an example of a wide range of situations), dichotomous thinking (only extreme points of view are considered), personalising (assuming oneself to be the cause of an event or problem) etc.

Schemas are fundamental rules or templates for information processing that are shaped by developmental influences and other life experiences. Information about oneself and one's environment is perceived, stored, and recalled through schemata which are assumed to evolve with repeated experiences. Once a schema is activated by a congruent mood state or event, it dominates perceptions of current and future situations. Because they play a major role in regulating self-worth and behavioural coping strategies, schemas are a frequent target of CBT interventions.

2.3.2 The Process of Counseling

In the process of counseling, the counselor aims to blend empathy with an active and a problem-focused approach. This active approach is also seen to be the responsibility of the client. The client is expected to develop a curious and questioning attitude towards their condition, trying to form hypotheses or links between their thoughts and feelings. The client is also expected to participate actively with the counselor so that both of them reach an understanding of his problems.

An important part of the process of counseling is assigning of Homework by the counselor and the client being responsible for its timely completion. Homework exercises usually are given in order to ensure generalisation of skills acquired during the counseling sessions. Completion of these exercises is associated with better outcomes. Homework also helps structure counseling by serving as a recurrent agenda item that links one session with the next.

Psycho education is another key feature of cognitive behavioural counseling. When possible, the therapist uses illustrations from the client's own experiences to demonstrate counseling principles and procedures. For example, if a client exhibited a "mood shift" (a sudden appearance of a strong emotion suggesting that he or she had just had an outpouring of intense automatic thoughts) early in counseling, the therapist might pause to help the client identify the automatic thoughts. Material gleaned from this process can then be used to explain the basic cognitive model (the relationship between cognitions and emotions) and to introduce the client to the concept of automatic thoughts. Readings and other educational aids are also used extensively. Typically, clients are asked to read self-help books, pamphlets, or handouts during the beginning phases of counseling. Workbooks can be used for specific problems such as depression, obsessive-compulsive disorder, and other anxiety disorders.

In a typical counseling session, an active, problem-focused style is followed. It usually begins with a review of homework tasks followed drawing up an agenda for the session in order of importance. Only a limited number of issues can be addressed in a single session. The counselor seeks to identify salient cognitive

and behavioural dimensions of the problem. Specifically, the counselor tries to differentiate between objective reality and the client's subjective appraisal of the same. When the target maladaptive cognitions and behaviours are identified, a range of strategies are used to evaluate their addictiveness, and to develop more realistic and useful alternatives. At the end of the session, the counselor reviews the material covered in the session, seeks the clients feedback, and gives a homework assignment to be completed before the next appointment.

2.3.3 Therapeutic Relationship

The counsellor assumes the role of educator, teaching the client about cognitive models that have been developed to understand the etiology and, more importantly, the maintenance of the client's specific problems. The counsellor is also responsible for teaching clients the cognitive and behavioural techniques designed to alleviate their problems. The client is considered to be the expert on his or her personal experiences, and the two of them work together to overcome the client's difficulties.

As in other counseling approaches, the counsellor-client relationship is important in cognitive counseling and provides the medium for improvement. Counselor function as guides to enable their clients to acquire the understanding that will help them to cope better with their problems—the process of guided discovery—and also as catalysts to promote the kind of corrective experiences outside of counseling that will enhance the clients' adaptive skills. The counsellor plays an active role in helping to pinpoint present problems, focusing on important areas, proposing and rehearsing specific cognitive and behavioural techniques, planning homework assignments, and re-evaluating the experiences during counseling.

Most of the therapist's verbal statements are in the form of questions, reflecting the basic empirical orientation and the immediate goal of converting the client's closed belief system into an open system. The counsellor actively engages the client in working out the agenda for each session and elicits feedback from the client regarding the counsellor's suggestions and behaviour during the session.

The term collaborative empiricism is often used to describe the therapeutic relationship in Cognitive Behavioural Counseling. A highly collaborative relationship is established in which counsellor and client work together as a team to identify maladaptive cognitions and behaviour, test their validity, and make revisions where needed. A principal goal of this collaborative process is to help clients effectively define problems and gain skills in managing these problems. As in other effective counseling approaches, cognitive behavioural counseling also relies on the nonspecific elements of the therapeutic relationship, such as rapport, genuineness, understanding, and empathy.

2.4 TECHNIQUES

Several Cognitive and Behavioural techniques are used by the counselor in order to arrive at maladaptive cognitions and also to help replace them with more adaptive ones.

2.4.1 Cognitive Techniques

i) **Cognitive Rehearsal:** In this technique, the client is asked to recall a problematic situation of the past. The counsellor and client work together to find out the solution to the problem or a way in which the difficult situation if occurs in the future may be sorted out. e.g. a shy person may rehearse how to approach a shopkeeper and ask for his required things.

ii) **Validity Testing:** The counsellor tests the validity of beliefs or thoughts of the client. Initially, the client is allowed to defend his viewpoint by means of objective evidence. The faulty nature or invalidity of the beliefs of the client is exposed if he is unable to produce any kind of objective evidence.

iii) **Daily Record of Dysfunctional Thoughts (DRDT):** It is the practice of maintaining a diary to keep an account of the situations that arise in day-to-day life. The thoughts which are associated with these situations and the behaviour exhibited in response to them are also mentioned in the diary. The counsellor along with the client reviews the diary/journal and finds out the maladaptive thought pattern and how do they actually affect the behaviour of an individual.

iv) **Modeling:** It is one of the cognitive behavioural counseling techniques in which the counsellor performs role-playing exercises which are aimed at responding in an appropriate way to overcome difficult situations. The client makes use of this behaviour of the therapist as a model in order to solve the problems he comes across.

v) **Homework:** The homework is actually a set of assignments given by counselor to clients. The client may have to take notes while a session is being conducted, review the audiotapes of a particular session or he may have to read article/books that are related to the counseling.

vi) **Aversive Conditioning:** Among the different techniques used by counselors, the aversive conditioning technique makes use of dissuasion for lessening the appeal of a maladaptive behaviour. The client while being engaged in a particular behaviour or thought for which he has to be treated, is exposed to an unpleasant stimulus. Thus, the unpleasant stimulus gets associated with such thoughts/behaviours and then the client exhibits an aversive behaviour towards them.

vii) **Systematic Positive Reinforcement:** The systematic positive reinforcement is one of the techniques in which certain (positive) behaviours of a person are rewarded with a positive reinforcement. A reward system is established for the reinforcement of certain positive behaviours. Just like positive reinforcement helps in encouraging a particular behaviour, withholding the reinforcement deliberately is useful in eradicating a maladaptive behaviour.

viii) **Evidence Record:** When people feel upset about something, they may have thoughts that they believe confirm their feelings. People may also have negative thoughts about themselves, such as “I am a loser” or “Nobody likes me.” Persons, Davidson and Tompkins suggest using an Evidence Record to test the validity or truthfulness of these thoughts. List everything that supports the thought and everything that disproves the thought to create this record. This can help determine if negative thoughts are the result of a mood, or if they’re based on truth.

ix) **Positive Data Log:** Thoughts can contribute to distress and affect behaviour. Persons, Davidson and Tompkins developed a Positive Data Log to help change thoughts that contribute to distress into thoughts that help people reach their goals. Choose one thought that contributes to distress, such as "Nobody likes me." Then, pick a mood-enhancing thought, such as "I am likable." In the Positive Data Log, record all evidence that supports the helpful thought. For example, a bank teller smiling at you may be evidence of likability. Therefore you would record this in the Positive Data Log.

The most important and frequently used cognitive technique is the use of questions that encourage the client to break through rigid patterns of dysfunctional thinking and to see new perspectives. The two terms most often used to describe this form of inquiry are *Socratic questioning* (asking questions that guide the client to become actively involved in finding answers) and ***guided discovery*** (a series of questions that help the client explore and change maladaptive cognitive processes). Examples of some of the specific techniques that might be included in guided discovery are examining the evidence exercises and two-column analyses of the advantages and disadvantages of holding a core belief.

2.4.2 Behavioural Techniques

Activity and pleasant event scheduling are commonly used to help depressed clients reverse problems with low energy. These techniques involve obtaining a baseline of activities during a day or week, rating activities on the degree of mastery and/or pleasure, and then collaboratively designing changes that will reactivate the client, stimulate a greater sense of enjoyment in life, or change patterns of social isolation or procrastination.

Graded task assignments, in which problems are broken down into pieces and a stepwise management plan is developed, are used to assist clients in coping with situations that seem especially challenging or overwhelming.

Some of the most useful behavioural methods for treating anxiety disorders are hierarchical exposure to feared stimuli, relaxation training, and breathing training. Exposure protocols can be either rapid or gradual. Typically, a hierarchy of exposure experiences is developed, with sequential increases in the degree of anxiety provoked. Clients are encouraged to expose themselves gradually to these stimuli until the anxiety response dissipates and they gain a greater sense of control and mastery. Progressive relaxation and breathing exercises may be used to reduce levels of autonomic arousal and support the exposure protocol. These techniques also may be used alone to help manage panic attacks or other symptoms of anxiety disorders.

One particularly useful way to encourage the client to use behavioural skills learned in counseling sessions is to develop a coping card. Key elements of a coping strategy or management plan—typically including both behavioural and cognitive strategies—are recorded on a small card that the client carries at all times. Coping cards might contain, for example, antisuicide plans detailing what to do if suicidal thoughts return, strategies for coping with critical remarks from a spouse, or specific ideas for combating procrastination at work. Coping methods that are generated and rehearsed in counseling sessions are then carried out with the help of coping cards in real-life situations.

2.5 RECENT RESEARCH AND ADVANCES

2.5.1 The Evidence Base for Cognitive Behavioural Counseling

Treatment interventions have demonstrated the effectiveness of cognitive behavioural counseling in the treatment of common mental health problems, including the anxiety disorders, generalised anxiety, panic, phobias, obsessive-compulsive disorder, posttraumatic stress disorder, bulimia and depression.

It has also been developed for use in an increasing range of mental health and health difficulties including severe and enduring mental health problems, such as psychosis, schizophrenia, bi-polar disorder, anger control, pain, adjustment to physical health problems, insomnia and organic syndromes, such as early stage dementia.

There is an extensive research base around this approach in working with children and people with learning disabilities, severe and enduring mental health problems and "difficult behaviour" generally.

Research into the contribution of psychological factors to physical health problems (such as low back pain, chronic fatigue, recovery from surgery for example) is growing and has led to the development of Cognitive behavioural approaches in these areas.

Developments in cognitive-behavioural counseling research, theory and practice are occurring rapidly. Its application of is happening in many fields other than mental health, eg. education and training, public health, organisational psychology, forensic psychology, management consultancy, sports psychology for instance.

2.5.2 Computer Assisted Counseling

One of the newest and most interesting methods of conducting cognitive behavioural counseling is through computer-assisted counseling. Multimedia software has been shown to be effective in the treatment of depression, and innovative multimedia programs using virtual reality have been developed for exposure counseling for anxiety disorders. In one study, a computer-assisted counseling software program was shown to be superior to standard counseling in helping clients acquire knowledge about the counseling sessions and in reducing maladaptive cognitions. Computer programs are typically combined with the human elements of counseling in an integrated treatment package. There are cognitive behavioural counseling sessions in which the user interacts with computer software (either on a computer, or sometimes via a voice-activated phone service), instead of face to face with a therapist. This can provide an option for clients, especially in light of the fact that there are not always therapists available, or the cost can be prohibitive. For people who are feeling depressed and withdrawn, the prospect of having to speak to someone about their innermost problems can be off-putting. In this respect, computerised counseling can be a good option.

Computer-assisted counseling can be used to decrease the amount of clinician time required for effective counseling, provide stimulating psychoeducational experiences, and offer engaging alternatives to standard treatment.

2.6 INDICATIONS FOR COGNITIVE BEHAVIORAL COUNSELING

Cognitive behavioural counseling can be used to:

1) Remove or moderate the symptoms of the disorder as a sole treatment or in combination with medication;

2) Reduce the likelihood of relapse or recurrence;

3) Increase adherence to recommended medication treatment;

4) Address specific psychosocial difficulties (e.g., marital discord, low self-esteem) that may either have preceded or been caused by the problem; or

5) Modify underlying beliefs (schemas) that contribute to dysfunctional personality trends or disorders.

The indications for cognitive behavioural counseling are determined more by client and counsellor variables than by the nature of the problem.

Clients: The ideal clients are psychologically minded; able to recognise and label their emotions; to become aware of their automatic thoughts; and to see the connection between thoughts, feelings, and behaviours. The degree of fit between the client's own personal notions of psychology and the basic cognitive model is important. Clients who adhere to such popular notions as the relation between stress and psychological disorders and the importance of self-control seem to benefit more from cognitive behavioural counseling than those wedded to Freudian concepts such as the unconscious and infantile fixations. High intelligence is not a prerequisite. Motivation for counseling is important but not initially crucial. Some hopeless, unmotivated, or depressed clients become highly motivated once they experience improvement.

Counselor: As in any counseling approach, counselor characteristics are important. The ideal counselor are psychologically minded, versatile, attentive, empathic, and uncritical. They do not bring their own "personal baggage" (such as the need to control or show off) into the counseling session. Skill in conducting cognitive counseling is obviously important for successful treatment. Several studies have shown a surprisingly high correlation between counselor' competency and successful outcome. Counselor who are skilled at educating clients about the cognitive nature of their problems and how to resolve them seem to get the best results.

2.7 CRITICAL APPRAISAL

Strengths

In many ways, cognitive behaviour counseling has changed the fields of psychotherapy and clinical psychology (Wilson, 1997). The several major ways that it has had an impact include:

Effectiveness

There is ample evidence that cognitive-behavioural counseling is effective (Chambless et al., 1998; Emmelkamp, 1994; Hollon & Beck, 1994; Smith et al.,

1980). In fact, it appears to be the treatment of choice for many disorders (Wilson, 1997). On average, a client who received any of the forms of cognitive behaviour counseling was functioning better than at least 75% of those who did not receive any treatment.

Breadth of Application

A contribution of major proportions has been the extension of the range of applicability of counseling. Traditional counseling had been reserved for the middle and upper classes who had the time and money to devote to their psychological problems. Cognitive Behavioural counseling has changed all that. Now, even financially strapped individuals with a wide range of psychological problems and disorders and even chronic mental illness can be helped by counseling. Clients at lower socio-economic levels with limited sophistication were offered hope by these broad band of counseling techniques.

Limitations

Notwithstanding frequent successes with different individuals, for no obvious reason, some clients do not respond to cognitive behavioural counseling. Some with longstanding chronic conditions who have been treated by many professionals without lasting results may not do well in time-limited counseling. Sometimes an appropriate pharmacological agent added to counseling may produce better results. The counsellor should also consider a change of strategy; for example, spending more time on empathic listening and less on exploration or becoming more active and directive.

Several limitations to this treatment are suggested by clinical experience. Clients with severely impaired reality testing (e.g., fixed delusions) or impaired reasoning abilities or memory function (e.g., organic brain syndromes) do not appear to respond well to cognitive behavioural counseling. However, cognitive methods may have a place even in those conditions if integrated into a total therapeutic regimen.

Cognitive behavioural counseling has come under fire from therapists who claim that the data does not fully support the extent of attention and funding it receives.

Self Assessment Questions

1) Explain the types of cognitive phenomena having relevance in Cognitive Behavioural Counseling.

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2) Throw light on the therapeutic relationship and its importance in Cognitive Behavioural Counseling.

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3) Explain the various behavioural and cognitive techniques used in Cognitive Behavioural Counseling

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4) List the advantages and disadvantages of computerised Cognitive Behavioural Counseling

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5) Critically analyse the approach of Cognitive Behavioural Counseling.

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2.8 LET US SUM UP

In this unit you have read that Cognitive behaviour counseling is an action oriented form of counseling that assumes that maladaptive or faulty thinking patterns cause maladaptive behaviour and "negative" emotions. You have also understood the following points:

1) The treatment focuses on changing the individual's cognitive patterns in order to change their behaviour and emotional state.

2) Thoughts, actions and feelings are all inter-related in any given situation. Thus changing one's thoughts can change how one feels and acts in a situation.

3) The process of counseling involves the counselor and the client working towards eliciting the maladaptive cognitions, which are later challenged and substituted for more adaptive cognitions.

4) The common techniques used in Cognitive behaviour counseling include Cognitive Rehearsal, Validity Testing, Daily Record of Dysfunctional Thoughts (DRDT) Modeling, Homework, Aversive Conditioning, Systematic Positive Reinforcement, Evidence Record, Positive Data Log, Activity Scheduling, Pleasant activity scheduling, Graded task Assignments.

5) Computer assisted Cognitive behaviour counseling is among the recent and upcoming trends in the field.

6) Despite being proved efficacious in treatment of various disorders and supported by many researches, Cognitive behaviour counseling still has many critics.

2.9 GLOSSARY

Maladaptive Behaviour : Maladaptive behaviour is behaviour that is counter productive or interferes with everyday living.

Automatic thoughts : Automatic thoughts emerge spontaneously and automatically, and often serve to maintain abnormal mood states.

Psycho-education : Psychoeducation refers to the education offered to people who live with a psychological disturbance

Therapeutic Relationship : Refers to the relationship between a healthcare professional and a client. It is one of the means by which the professional hopes to engage with, and effect the process of change in a client.

Schema : An enduring and stable belief system that assists in explaining experiences, mediating perception, and guiding response.

2.10 SUGGESTED READINGS

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UNIT 3 COUPLE COUNSELING

Structure

3.0 INTRODUCTION

In this unit we deal with couple counseling. We begin with evolution of couple counseling followed by reasons couple seek counseling. This is followed by approaches to couple counseling in which we discuss the psychoanalytic to cognitive approaches to couple counseling. We also take up emotionally focused couples counseling. Then we elucidate the various factors that contribute to marital problems and distress. We put forward the 12 ways which are destructive ways that spoil a marital relationship. Then we deal with process of family counseling and the many factors that are involved in this kind of counseling. Then we take up goals and objectives of couple counseling and then deal with couple counseling process. After couple counseling takes place, we try to make assessment as to how successful has been the couple counseling process. This aspect is deal with in the next section of this unit. Then we delineate the various intervention processes in couple counselling.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Define the concept of couple counseling;
- Explain approaches to couple counseling;

- Factors that contribute to marital distress; and
- Explain the process of family counseling.

3.2 COUPLE COUNSELING

The institution of marriage is inherent in our civilised social system that ensures commitment and constant support to cope up with the ever changing circumstances and demands posed in the course of life of an individual and, thus, fulfilling the need for companionship and ensuring psychological, social and emotional well being of the two persons forming a couple.

However, in the present world many forces are at work to lessen the importance of marriage (Scharf, 2003). Particularly the factors, such as, each partner trying to self actualise and grow as a discreet individual in life thereby undermining the needs of the couple as a unit; open expression among partners with regard to differences in opinions that breeds mutual disliking; weak commitment patterns; impulsive decisions regarding keeping or calling off a relationship etc. result in quick break ups and divorces. More women are opting to become single parents. On the other hand, children of divorced parents do less well at school, in employment, and often, suffer from depression, low self esteem and neurotic symptoms more commonly than those with parents staying together (Dominian, 1968). In fact, the impact on divorcing partners is also multifold and cannot be undermined in the light of an end to an unsuccessful and distressing relationship.

Given the above stated scenario, marriage itself is becoming less popular, and instead people choose to stay alone or involve themselves in live-in hook ups that might or might not continue for long. Whether a marriage has solemnised between two individuals or they are in a live-in arrangement, the two people are trying to address the need for companionship and invariably form a couple. Any couple relationship is vulnerable and might go through its difficult and challenging phases wherein the need for professional help can be felt to save it.

Helping couples to stay together, however, is not the sole purpose of counseling. It can also be effective in dealing with many of the diverse problems that affect partners in a relationship. Intervention of this kind is usually sought because conflict in a relationship appears to be the cause of emotional disorder in at least one of the partners such as depression or because the relationship is unsatisfactory and is likely to break up, and both the partners wish to save it

Couple counseling focuses on the problems existing in the relationship between two people. These relationship problems might involve individual symptoms or psychological problems in one or both the partners, as well as the relationship conflicts.

It is important to realise that couples counseling, marriage counseling and marital therapy are all the same. These different names have been used to describe the same process, with the difference often based on which intervention theory is favoured by the psychologist or counselor who is using the term, or taking up a case for intervention. Although we use the term *couple counseling,* this approach is not limited to married couple, but can be provided to unmarried couple, same sex couples, and others.

Couple counseling is often seen as different from individual counseling and psychotherapy because a relationship is the focus of attention, instead of one individual diagnosed with a specific psychological problem. All psychological problems, and all psychological changes, involve both individual symptoms (behaviour, emotions, conflicts, thought processes) and changes in interpersonal relationships. For example, if one is constantly arguing with ones spouse, one will probably be chronically anxious, angry or depressed (or all three). Or, if one has difficulty controlling ones temper, one will have more arguments with ones partner.

In *couple counseling*, the psychologist helps a couple to identify the conflict issues within his/her relationship, and helps create changes that are needed in the behaviour of each partner and in the relationship so that both the partners feel satisfied with the relationship. These changes may be different ways of interacting within the relationship, or they may be individual changes related to personal psychological problems. Couple counseling involves learning how to communicate more effectively, and how to listen more closely. Couple must learn how to avoid competing with each other, and need to identify common life goals and how to share responsibilities within their relationship. Sometimes, the process is very similar to individual counseling and psychotherapy, sometimes it is more like mediation, and sometimes it is educational. The combination of these three components is what makes it effective.

3.2.1 Evolution of Couple Counseling

Although the couple counseling movement, like the family counseling movement, owes much to interpersonal theorists such as Sullivan, Horney, and Fromm, the development of couples counseling can be attributed to pragmatic concerns (Fruzzetti & Jacobson, 1991). In fact, a wide variety of professionals from doctors to lawyers became increasingly involved in the couple counseling to resolve marital conflicts. Fruzzetti and Jacobson (1991) note the remarkable growth of couples counseling since the 1960s. A wide range of theoretical models of couple counseling has been expounded by psychoanalytic, behavioural, rational-emotive, cognitive and systems oriented practitioners. Today, the most popular forms of couple counseling are behavioural marital approach, cognitive couple counseling approach, emotionally focused couple counseling and insight-oriented (psychodynamic) couple counseling.

3.2.2 Reasons for Seeking Couple Counseling

Couples or individuals seek counseling to address a variety of problems associated with the dyadic relationship with each other. Couples may seek counseling due to the:

1) Increased frequency of arguments between partners due to poor communication pattern;
2) Emerging differences in opinions or value system;
3) Strained relationship between couple due to certain emerging familial issues;
4) Dissatisfaction in sexual relationship;
5) Feeling of being trapped in stale relationship due to lack of common interests and shared activities;

6) Constant dispute between the couple leading to excessive distress or psychopathology such as depression or alcohol abuse in one or both the partners;

7) Extramarital affair;

8) Few or frequent instances of intimate partner violence.

3.3 APPROACHES TO COUPLE COUNSELING

3.3.1 Psychodynamic (or Insight-oriented) Couple Counseling

The central concept in the psychoanalytic position, as reviewed by Daniell (1985) and Meissner (1978), is the inner, often unconscious world of the two partners determining the nature of their interaction and their responses to changing circumstances. It is as though each partner has an unconscious impression about the nature of relationship and their partner's personality which in disturbed marriages bears very little resemblance to what more objective observers perceive. Counseling aims to help the partners to become aware of these inner worlds and their origins enabling them to reduce misunderstandings through insight, and to get in touch with their own feelings and those of their partner. Transference towards the counselor is usually interpreted. An important focus is on understanding the infantile feelings underlying the marital relationship and the 'repetition-compulsion', which leads to the person treating his/her partner similarly to the way he/she felt about the opposite sexed parent. The principal outcome is liberation of the relationship from past adverse influences and a corresponding diminution of problems.

3.3.2 Systems Couple Counseling

The systems approach to couple counseling derives partly from concepts developed by therapists such as Minuchin (1974) and Haley (1980) in their work with families, and partly from a more detailed understanding of the couple's interaction such as that of Sluzki (1978). The approach is particularly suitable for couples because it addresses the relationship as such, in addition to the two partners who comprise it. The focus of treatment is on the hidden rules that govern the behaviour of the couple towards one another, on disagreements about who makes these rules, and on inconsistencies between these two levels of interaction. A central concept here is *enmeshment,* an excessive involvement of one person with the other person. It is most common in relationships between parents and their growing children; this type of enmeshment is also seen in couple relationships where one partner wants to be more intimate in couple relationships where one partner wants to be more intimate than the other. The concept of intimacy may relate to many aspects of life including sexual, physical, emotional, and 'operational' (Crowe and Ridley, 1990). The term 'operational' here refers to sharing of plans and information about each other. A conflict may arise between partners on how close or distant they wish to be in respect to one or more of these spheres. Systemic counseling attempts to clarify the degree of optimal distance.

Another key concept is *homeostasis* (discussed in the unit on 'Family Counseling')— the tendency for relationships to remain in the same configuration no matter what external factors or changes may impinge on them. Underlying all systems thinking is the concept of *circular causality*— the idea of a *cycle of*

cause and effect such that neither person is to be wholly blamed. That is to say, in a relationship things do not occur necessarily because one partner 'causes' them but rather as the result of a complex cycle of interaction in which both partners actively participate. These ideas are discussed around conflicts arising in the everyday life of the couple, for example, who decides where to go on holiday, and how the couple arrives at these trivial to significant decisions. Some counselors use 'paradoxical injunctions', that is, provocative statement designed to elicit a (beneficial) counter response that the couple have previously resisted. Thus, when approaching couple problems, systems counselor do not focus on one of the protagonists, but pursue, instead, change in which both partners contribute actively to facing and solving the problem. Failing that, the status quo is *reframed* as being of mutual benefit to the couple and the suggestion is made that they should not attempt to change.

3.3.3 Behavioural Couple Counseling

The beginnings of behavioural approach or as it is commonly called behaviour marital therapy (BMT) are often traced to the work of Richard Stuart (1969). Again, despite the term *marital* being used often, BMT does not require the couples to be essentially married. This form of couple counseling is brief and highly structured, and relies largely on currently observable and reported behaviour. This approach functions on the premise that the troubled couples have reached either a very low level of mutual positive reinforcement or are using overly coercive methods to control each other's behaviour. Stuart's intervention of marital dysfunction involved the application of reinforcement principles to couple's interactions. It emphasised the need for sensible negotiation of rights and duties, and work on everyday tasks in this pursuit. A major component of his intervention approach was a technique called *contingency* contr*a*cting, that is, the spouses were trained to modify their own behaviour in order to effect a specified desired change in their mate's behaviour.

As per this approach, two main types of therapeutic activities take place—'reciprocity negotiation' and 'communication training'. In *reciprocity negotiation,* each partner is asked to say what alternative behaviours they desire in their partner. These behaviours must be described in specific terms, for example 'talk to me for half an hour when you come in from work' rather than 'take more notice of me'. Each partner agrees a way of rewarding the other when the desired behaviour is carried out. The reward would be the expression of approval and affection, or doing something that the partner desires. In addition, under *communication training*, the couple is encouraged to communicate more directly and unambiguously to each other about feelings, plans, or perceptions; to listen to one another patiently, to provide feedback about what is heard and understood; and to express individual wishes more clearly.

Over the years, BMT has broadened to include a number of additional techniques. *Support-understanding* technique aims to increase positive behaviours emitted by partners. In this technique, each partner generates a list of behaviours that, if produced by his or her mate, will bring pleasure. Each partner agrees to perform three of the behaviours from his or her partner's list before the next session. *Problem solving* techniques involve training couples in the skills required for indulging in 'negotiating talks' and 'positive communication' both of which are essential so that effective decision-making and problem solving may follow. For

this, the couples are given a list of rules for maintaining negotiating talks and positive communication with the partner that the couple is suppose to practice during the session. The clinician intervenes if he or she feels it would be helpful or essential. Thus, as per behavioural approach, origins or deeper meanings of behaviours are down played, and the emphasis is laid more on here and now changes in the interaction.

Although, the behavioural and psychoanalytic models appear incompatible, they can be partly reconciled by regarding them as concentrating on different levels of the mind. Segraves (1982) has devised a combined psychodynamic-behavioural approach in which the underlying cause of the couple's problems is assumed to be their conflicting internal fantasies (or blueprints) of themselves and each other. Intervention, however, is directed at both helping them to understand these and to increase reality-based communication in order to improve their ability to negotiate.

3.3.4 Cognitive Behavioural Couple Counseling

Aaron Beck (1988) has applied his cognitive-behavioural scheme to the problems of couples, identifying in their communication misunderstandings, generalisations, and focus on negative aspects of a problem, typical of the thinking of depressed clients. His approach involves the same therapeutic processes which have been successful in treating depression: challenging assumptions; reducing expectations; relaxing absolute rules; and focusing on the positive rather than the negative.

In a similar way, the rational-emotive approach of Albert Ellis has been adapted to relationship problems (Dryden, 1985). A distinction is made between marital 'dissatisfaction' and 'disturbance'. Dissatisfactions are dealt with by negotiation as in the behavioural model, whereas disturbances need a more elaborate approach, reducing the exaggeration of problems by, for example, outlawing words like 'intolerable' and replacing them with less extreme terms like 'difficult to put up with' . There is an analysis of repetitive cycles of cognitive behavioural disturbance, in which each partner attributes negative or holistic intentions to the other. These distortions, dealt with in both individual and conjoint sessions, are examined to promote understanding and, in turn, to modify miscommunication.

3.3.5 Emotionally Focused (EF) Couple Counseling

Emotionally focused couples counseling is a brief intervention that seeks to change partners' problematic interaction styles and emotional responses so that a stronger and more secure emotional bond can be established (Johnson et al., 1999). This treatment approach assumes that negative affect and associated destructive interactional styles create marital distress. Further, it is believed that a more secure attachment to one's partner is necessary to stabilise a dyadic relationship.

Johnson and his colleagues (1999) have outlined the nine intervention steps in EF couple counseling. The first four steps involve assessment of the couple and attempts to interrupt the cycle of negative interactions. The next three steps involve helping create new, more adaptive interactional styles that meet partner's needs. Finally, the last two steps of emotionally focused counseling involve the consolidation of changes made.

Through these steps, partners are better able to recognise their own emotional and bonding needs, and to modify the way they interact with each other. In this way, they can ensure that these needs are more likely to be met and that destructive interactional patterns are minimised.

THE NINE (09) STEPS OF EMOTIONALLY FOCUSED COUPLE COUNSELING (EFCC)

Cycle De-escalation

Step 1: Assessment— Creating an alliance and explicating the core issues in the couple's conflict using an attachment perspective.

Step 2: Identifying the problem interactional cycle that maintains attachment insecurity and relationship distress.

Step 3: Accessing the unacknowledged emotions underlying interactional positions.

Step 4: Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

Changing Interactional Positions

Step 5: Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions.

Step 6: Promoting acceptance of the partner's new construction of experience in the relationship interactions.

Step 7: Facilitating the expression of specific needs and wants and creating emotional engagements**.**

Consolidation/ Integration

Step 8: Facilitating the emergence of new solutions to old problematic relationship issues.

Step 9: Consolidating new positions and new cycles of attachment behaviours.

3.4 FACTORS THAT CONTRIBUTE TO MARITAL DISTRESS

Couples who intend to seek professional help are usually quite distressed by the problems in their relationship. There are certain specific dysfunctional patterns that are evident in such distressed couples who eventually seek counseling. These may be integrated into *destructive patterns* of neglect, criticism, arguments, and negative expectations and beliefs concerning the spouse and the relationship and are discussed below:

1) **Faulty patterns of communication:** Distressed couples have few pleasant and rewarding interactions with each other but many angry, blaming or punishing ones. A typical pattern that can be identified in this regard is ***reciprocated negative behaviour*** which implies if one spouse behaves negatively, the partner is likely to respond in kind, and thus starts a chain of escalating negative interaction (Gottman, 1979). For example, such a chain of negative behaviours in a couple having marital problems start with one

spouse *expecting* to be criticised for not completing some household task that he or she normally performs. When the other spouse begins to ask about the task, however neutrally, then the first spouse, in anticipation of further criticism, starts responding to the query in a defensive manner and responds with a criticism of something the other did or did not do. The questioning spouse senses the critical tone and feels attacked so attacks back, and so forth. Thus, the components of this argument are a negative expectation of one spouse from the other, and reciprocated negative behaviours (*escalating criticism*).

2) **Faulty patterns of emotional reaction:** Distressed couples can be seen to have more impulsive, strong and negative reactions. High reactivity in distressed couples may increase the likelihood of misunderstanding and poor communication. Since spouses are so used to of feeling attacked, they may cease to listen carefully to one another and instead be prepared for a counter attack to the initial criticism.

3) **Poor coping skills and inability to resolve conflicts:** Distressed relationships are further characterised by an inability to resolve conflicts. Lack of conflict resolution skills leave couples with a backlog of unresolved fights and conflicts that have built up over the history of their relationship. A history of such unresolved conflicts may also contribute to negative expectations about future conflicts and make engagement in constructive problem-solving even likely to occur in their relationship.

4) **Reinforcement erosion:** This occurs when partners lose the satisfaction that was once present in the relationship. This might be attributed to habituation: behaviours that were pleasing at one time are not as important any where. They may fail to appreciate each other's efforts, take each other for granted, or have new and different needs that their partners have not yet learned to meet. One or both spouses may have stopped doing some of the nice things that formerly helped to provide many warm feelings between them.

Unlike distressed couples, non-distressed couples have more adaptive ways of communicating, reacting, coping and reinforcing the relationship and are less affected by moment-to-moment variations.

3.5 TWELVE (12) DESTRUCTIVE WAYS OF SPOILING A MARITAL/ SPOUSAL RELATIONSHIP

1) Frequent *critical comments*, especially in the presence of relatives and friends.

2) Frequent *neglect* of the partner in terms of being self-occupied even when the partner is around, not sparing exclusive time for the partner to have interaction or dialogue on regular basis.

3) Being insensitive or intentionally neglecting the partner's needs and necessities.

4) Despising the partner by showing frequent aggression.

5) Not considering the partner's opinion as worthy while taking decisions involving personal career, or other family, friends or finance related issues.

6) Taking the partner for granted, that is, not using words of appreciation, gratitude or acknowledgement of efforts towards the partner from time to time.

7) Devaluing the partner in public by being indifferent or neutral when others pass critical comments about your spouse/ partner.

8) Sticking on to the '*bygones'* (emotional baggage from the past arguments and fights) thereby repeatedly dragging in old and much discussed issues.

9) Devaluing the significance of important days and dates in a year that might hold some emotional significance for one partner.

10) Criticising each other's native family and friends.

11) Frequently involving family and friends to resolve marital conflict and issues.

12) Getting abusive and physically violent with the partner.

3.6 PROCESS OF COUPLE COUNSELING

3.6.1 Goals and Objectives of Couple Counseling Process

The goal of couples counseling is to understand the relationship dynamic of the couple, and to identify areas of strain and frustration which add stress to the partnership. In a series of counseling sessions which often include private as well as group sessions, the couple can explore their perception of the relationship, their expectations of each other, and the situations which may be causing them to feel alienated from each other. The counselor acts as a mediator and facilitator to keep discussions on track and to guide the conversation to specific points.

3.6.2 Assessment in Couple Counseling

Couple counseling, like any other counseling process, involves assessment of target problems. So the process usually begins with two or three sessions of assessment, unless there is an acute crisis. The purpose of the process of assessment is to develop a comprehensive understanding about the nature of problem and the couple's suitability and commitment for counseling. The focus is on gathering information: couples are told that no changes are to be expected during the assessment phase because the treatment will proceed only after the counselor learns enough about the couple and their problems to make an informed decision about the course of counseling, and indeed whether marital counseling is indicated at all.

Approaching the first few sessions in this manner has important benefits besides those already stated. First, it helps to reduce unrealistic expectations about the power of the counseling process in bringing about the immediate and large-scale changes. On the other hand, if some improvements are made early in the process of counseling, the couple may work harder for positive results and quick gains.

Stages of Assessment Process

a) **Taking an initial interview and identifying problem areas in a conjoint session:** The initial assessment begins with familiarising with both the spouses, understanding their relationship and the nature of problem so as to establish rapport with the couple. The essential aspects that the counselor should try to practice during the initial interviews are:

- develop rapport with both the partners, without favoring either;
- remain in control
- maintain momentum
- maximise opportunities for the couple to experience a change in their interaction

Also important is information about how long the couple has perceived the problem(s), what steps they have taken to help alleviate their difficulties, what has worked, and what has not been successful. If the couple has had previous counseling that was not helpful, the counselor must be sure not to attempt the same interventions a second time. Not only are they likely to be ineffective, but the counselor's credibility would be harmed in the process. Each partner's complaints need to be behaviourally specified. Couples are likely to do this naturally or spontaneously, so the counselor must help them clarify their formulation.

b) **Taking a detailed relationship history in a conjoint session*:*** After setting the parameters for discussion, the counselor should help the partners trace the history of their relationship; if married, the nature of their marriage i.e. by self choice or familialy settled match, including how they met, the courtship phase, what attracted each spouse to the other, fun things they have done together, and how the marriage was materialised.

By the time, most couples enter in for counseling, they are largely focused on negative aspects of each other and their marriage. There is often relief, hopefulness, and even a cheery response as the counselor redirects the couple's attention to more positive phases in the history of their relationship. During this initial session, the counselor should also encourage the couple to put up their queries with regard to the process of counseling and should outline any other expectations the counselor has for them.

c) **Holding individual interview sessions with each partner so as to get individual impressions about the nature of problem:** Brief individual sessions must follow the initial conjoint session. The primary purpose of these interviews is to understand the spouses better as individuals and hence develop a fuller picture of the relationship while building rapport.

d) **Assessing the strengths of the relationship and the couple's suitability for marital counseling in a conjoint as well as individual session:** It is always essential in couple's counseling to evaluate the strengths of the relationship in a conjoint session as well as that from which it is perceived by each of the partner individually, so as to be able to understand the basis on which to restructure and rebuild the foundation of the relationship during the process of counseling. Also, it gives an understanding to the counselor about the prospects of improving the relationship with the process of counseling. In certain cases, it is evident that either or both the partners are likely to show poor commitment towards the counseling process and hence, the probable chances of success in couple counseling are less.

(*Both individual and conjoint sessions may be complemented with the administration of specific appropriate tests and scales.)

Few of the pertinent scales specifically used for assessing marital satisfaction are mentioned below:

1) Dyadic Adjustment Scale (Spanier, 1976) provides a global measure of marital satisfaction, id widely used, and norms are available;

2) Areas of Change Questionnaire (Weiss, Hops, & Patterson, 1973) is a measure of the degree of dissatisfaction with a number of common presenting problems;

3) Marital Satisfaction Inventory (Snyder, 1981) yields a comprehensive MMPI-like profile of distress in nine content areas for each spouse, plus Global distress and validity scores;

4) Marital Status Inventory (Weiss & Cerreto, 1980) provides what can be referred to as 'how many toes out the door', i.e. how many specific steps the spouse has taken towards divorce and separation.

3.6.3 Intervention Process and Techniques in Couple Counseling

The intervention process begins by trying to renew some warm feelings by having spouses do nice things for each other in an attempt to provide some immediate relief from current difficulties and to provide a basis for later interventions. A focus on improving communication typically follows, because this is a basic requisite for learning to solve problems in a systematic manner that is not overly emotionally charged. A problem-solving approach may then be employed through the remaining sessions to resolve a variety of presenting problems. This may be followed with attention to the sexual or affectional aspects of the relationship. Specific sessions towards the end of the counseling process may be reserved for work on relapse prevention and generalising improvements across a wide array of areas in a couple's lives. Woven throughout the process of counseling are cognitive interventions and conflict management strategies, depending upon events that occur over the course of counseling. Integrating and weaving specific techniques into a coherent whole, unique to the couple counseling, is the challenge which faces the marital counselor.

Techniques Used in Couple Counseling

a) **Behaviour exchange:** Behaviour exchange engages both spouses in activities designed to increase each other's marital satisfaction, that is, an exchange of behaviours which are pleasing to each partner. Typically theses activities are thoughtful, fairly simple, low effort behaviours that can be readily incorporated into spouses' daily repertoires. Behaviour exchange is designed to induce short-term positive changes in the pattern of interaction early in counseling, and to have immediate effects in the couple's life outside of counseling, and thereby lay the groundwork needed for work on other major issues.

Each spouse is asked, 'What could you do to improve your spouse's satisfaction with your relationship?' Each spouse is helped to pin-point specific behaviours that could have a positive effect on the other spouse's marital happiness. Initially, each spouse should do this without input from the partner. The counselor should encourage each of them to focus on small steps and easy, low effort things which could increase the other's satisfaction.

If an individual or couple has particular difficulty in creating a list of positive behaviours, the counselor might provide a questionnaire or supplement to help with ideas (e.g.: the Spouse Observation Checklist, Patterson, 1976). Behaviour exchange is commonly used in the early stages of counseling because the warm feelings it may foster often encourage a new sense of collaboration between spouses.

b) **Cognitive Interventions:** In distressed relationships, spouses' emotional responses to their partners' behaviour and the meaning they ascribe to it, rather than just the behaviour itself. Relabelling or reinterpreting partner behaviour is a powerful intervention that may be constantly on the lookout for distorted and/or dysfunctional thinking, and should intervene regardless of the content or phase in the counseling, cognitive interventions are an integral part of cognitive behavioural couple counseling.

As with other procedures, it is helpful to give the clients a rationale for focusing on their thoughts. The rationale varies depending on the circumstances and the particular problematic thinking pattern. One rationale is simply that even if the negative assumptions about a spouse's behaviours are partially true, there are likely to be other more positive things contributing to the partner's behaviours as well, and that the angry or hurt spouse might feel better if he or she thought about the partner's behaviour differently.

c) **Communication Training:** Not only are communication skill deficits a common presenting problem of couples, but difficulties with expressive and receptive communication skills are linked to a host of other typical complaints: lack of understanding, insufficient attention to each other, poor listening, conflict escalation, and difficulty in problem solving.

Expressive skills include the speaker identifying his or her own thoughts, feelings, wishes etc., then expressing them in the first person, in a specific and clear manner (e.g., 'When you don't help get the children ready for school, I feel frustrated', or 'It really makes me happy when you come home and ask me how my day went'). Receptive skills include non-verbal listening and attending (making eye-contact, head-nodding etc.), empathizing, paraphrasing, and other expressions of good listening and understanding. These communication skills are the building blocks for the problem-solving techniques in the following section.

d) **Problem Solving:** Problem solving is an important component of most cognitive behaviour therapies, especially when working with couples. Along with communication skills described above, problem solving skills provide the couple with a framework to be their own 'counselors' with many subsequent problems.

Problem solving training has two discrete phases: problem definition and problem solution. This two-phase process helps couples to avoid proposing changes before the problem has been defined, and helps them to continue to redefine the problem when a solution to the originally defined problem has not been found.

In the spirit of collaboration, the first spouse states how she or he contributes to the problem and what his or her own role is in the problem. Inducing the complainant to make this statement is crucial because:

- It reduces the accusing nature of the problem definition, helps the other spouse to feel less attacked, and encourages that spouse to listen and engage in the problem-solving endeavour; and

- It is consistent with the collaborative approach, which never allows one partner to be responsible for 100 percent of any problem or 100 percent of any solution.

Explaining the rationale to the couple usually facilitates their compliance with this format. The partner is encouraged to summarise the other person's statements and to show willingness to work with the spouse to solve the problem which has been identified.

e) **Reducing conflict: Trouble shooting:** Sometimes couples will come to sessions angry and frustrated, seemingly unable to focus on new tasks and proceed with the session. This generally occurs when they have had an unsolved argument during the week. Trouble shooting is a technique designed to teach couples *conflict de-escalation (keeping conflict from getting increasingly more hostile and damaging), which facilitates conflict resolution. The two steps involved in trouble shooting are:*

- *Reconstruction* of the argument involves an exploration of the intent and impact of each step in the argument, and clarification of the feelings, thoughts, and assumptions of each spouse at each step.
- *Exploration* of the cognitive and behavioural options of each spouse at each step that might have reduced the negative feelings or de-escalated the conflict. This may be accomplished by simply asking each spouse 'What was a different way of thinking about your partner's actions at that time' or 'what else it could have meant?'

Thus, the technique of trouble shooting serves two purposes: to help the couples understand their thoughts and feelings during the argument, and to make them aware of behavioural options to stop escalation of the argument so they can turn their attention to a resolution of the conflict.

f) **Affection and sexual enrichment:** It is not uncommon for couples who present for couple counseling to also have some specific sexual dysfunction. For these couples, counseling time is devoted to ameliorate the dysfunction. The intervention for sexual dysfunctions is considered then.

With couples who have no specific sexual dysfunction, it is often important at an appropriate point in the process of counseling to emphasise affection and the enhancement of sexual relationship. Timing will depend upon how important these areas are relative to other presenting issues.

3.7 LET US SUM UP

Helping to generalise treatment gains: The success of intervention process depends on how well the skills learned during the process of counseling are carried out in the home environment. Diligent completion of assignments between sessions is crucial to the success of couple counseling because these exercises are the bridge between successful therapy and the couple's ability to maintain or even advance their gains after counseling is over.

Preventing Relapse: Regardless of the extent of progress or skill level a couple may achieve, some lapses into old negative patterns or the rekindling of old problems inevitably occur. One way to reduce relapses (Marlatt & Gordon, 1985) includes two basic components:

- anticipate and intervene to prevent the situations or behaviours that would increase the likelihood of a relapse; and
- establish strategies to help the clients recover from small setbacks to avert a complete relapse.

Contraindications for couple counseling: Couple counseling is usually contraindicated when a spouse refuses to give up an extramarital affair, or when one spouse has decided to seek divorce. In such a case, it is essential to have the counseling process focus on the withdrawing partner to develop a realistic and insightful cognisance about his or her decision to part from his/her spouse and a deeper and more practical understanding of the associated consequences in terms of both gains and losses involved. The other partner, on the other hand, has to be prepared for legal separation that might follow, and provide supportive counseling so as to help him/her grapple with the sense of rejection, loss and failure in life.

Another contraindication for couple counseling is a history of unstable relationships in the past that is attributable to severe character disturbance in personality or a personality disorder; it may be best to work with the personality difficulties in individual counseling before conjoint session. Physical abuse may be a contraindication for couple counseling, especially if the abuser has problems with alcohol or substance abuse or dependence.

Individuals with severe emotional or behavioural problems or couples with differing expectations from the process of counseling have been found to show poor outcome to couple counseling.

Couple counseling can involve discussion of volatile topics and a spouse who has difficulty with anger control may be at higher risk for abusing his or her spouse during counseling. Anger management training may be a prerequisite for conjoint work with such couples. Similarly, control over, or abstinence from, alcohol and substance abuse need to be gained before couple counseling. Ambiguous issues may need to be addressed openly in a conjoint session before agreeing to proceed with the intervention.

3.8 UNIT END QUESTIONS

1) Define couple counseling.
2) Explain the situation where couples are needed counseling session.
3) Explain behaviour counseling and emotionally focused couple counseling.
4) As a counselor what assessment process you will apply in counseling session?
5) Explain technique used n couple counseling.

3.9 SUGGESTED READINGS

Stuart, R.B. (1980). *Helping Couples Change: A Social Learning Approach to Marital Therapy.* Guildford press, New York.

Jacobson, N.S. & Gurman, A.S. (ed.) (1986). *Clinical Handbook of Marital Therapy.* Guilford press, New York.

UNIT 4 COUNSELLING IN EDUCATIONAL SETTINGS

Structure

4.0 INTRODUCTION

In this unit we are dealing with counseling in educational settings. We start with Guidance, its definition and description. What guidance is and how it is done in regard to students. This is followed by objectives of student counseling which includes giving information to students on matters important to success, help students in solving their problems, to help student to work out a plan etc. Then we take up the scope of student counselling in which we include individual and group counseling in addition to the various other scopes listed Then we take up educational counseling in which we discuss educational guidance and igts various components. This is followed by a discussion on career cousnelling followed by Group counseling, its advantages etc. The next section deals with individual counseling in which we include students who are abusing drugs, who have witnessed domestic violence, whose parents are separated etc. Then we take up typical disorders and the counseling in regard to the same such as counseling for ADHD etc. In this unit we also discuss gifted children who also need counseling of a different nature.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe guidance;
- Explain student counseling, its objectives and scope;
- Describe educational counseling;
- Explain career counseling;
- Explain group counseling, its objectives and advantages; and
- Describe individual counseling and special student groups who require it.

4.2 GUIDANCE

Guidance may be defined as the process of helping the individual in selecting, preparing, entering and progressing in the behavioural patterns which comprise human activities in the educational, vocational, recreational field as well as in connection with community service group. Husband, in his book entitled *Applied Psychology,* has defined the term as, "Guidance may be defined as assisting the individual to prepare for his future life, to fit him for his place in society." In this way, guidance prepares the individual for his life. It informs the individual of the kind of education that he requires, the subjects that he would be advised to choose in his study, the vocation of which he should apply himself when old enough, as well as the means he should employ when faced with problems that he must solve. The counselor's guidance helps an individual to fit into his or her role and status in society.

In the words of Jones (1951), "Guidance involves personal help given by someone; it is designed to assist a person in deciding where he wants to go, what he wants to do, or how he can best accomplish his purposes; it assists him in solving problems that arise in his life. It does not solve problems for the individual, but helps him to solve them. The focus of guidance is the individual, not the problem; its purpose is to promote the growth of the individual in self-direction."

The following may be summed up as the characteristics of guidance:

1) It is promotion of the growth of the individual in self-direction.
2) It is the process of helping the individual in effecting changes in him.
3) It helps the individual himself through his own efforts.
4) It assists an individual to find his place.
5) It is helping the individual to establish harmonious relationships.
6) It is assisting the individual to adjust himself.
7) It is helping the individual in making appropriate educational, vocational and personal choices.
8) Its programme and content is organised.
9) It consists of specialised services – counseling, educational and vocational information placement and follow up.
10) Its programme is an integral part of the school system.
11) It is helping an individual to identify and develop his potentialities and talent.

Change is the essence of counseling in schools and elsewhere. Students enter counseling because someone, usually a teacher or parent, desires a change in their school performance or behaviour. Occasionally, the student may himself/ herself approach for help.

4.3 OBJECTIVES OF STUDENT COUNSELING

Dunsmoor and Miller believe that the core of student counseling is to help the student to help himself. From this point of view they describe the following objectives of student counseling:

- To give the student information on matters important to success
- To get information about student which will be of help in solving his problems
- To establish a feeling of mutual understanding between student and teacher
- To help the student work out a plan for solving his difficulties
- To help the student know himself better – his interests, abilities, aptitudes and opportunities
- To encourage and develop special abilities and right attitudes
- To inspire successful endeavor toward attainment
- To assist the student in planning for educational and vocational choices.

4.4 SCOPE OF STUDENTS COUNSELING

Counseling in educational settings has a vast scope.

Williamson summarises it: "The techniques of counseling individual students may be observed in greatly modified form, in the individualised service; granting loans and scholarships; handling discipline cases; assignment of rooms and selection of room-mates in dormitories; advising on student activities and programmes; helping students choose vocational objectives; selecting optional courses of study; learning to read at college rate and comprehension."

Professional school counselors ideally implement a school counseling program that promotes and enhances student achievement. Professional school counselors meet the needs of student in three basic domains: academic development, career development, and personal/social development (Dahir & Campbell, 1997) with an increased emphasis on college access.

School counselor interventions include individual and group counseling for some students. For example, if a student's behaviour is interfering with his or her achievement, the school counselor may observe that student in a class, provide consultation to teachers and other stakeholders to develop (with the student) a plan to address the behavioural issue(s), and then collaborate to implement and evaluate the plan. They also provide consultation services to family members such as college access, career development, parenting skills, study skills, child and adolescent development, and help with school-home transitions.

School counselors develop, implement, and evaluate school counseling programs that deliver academic, career, college access, and personal/social competencies to all students in their schools.

4.5 EDUCATIONAL COUNSELING

According to Brewer, "Educational guidance is a conscious effort to assist in the intellectual growth of individual- anything that has to do with instruction or learning may come under the term of guidance."

Jones clarified, "Educational guidance is the assistance given to the pupils in their choices and adjustments with relation to schools, curriculums, courses and school life."

Hence, career counseling may be seen as an extension of educational guidance and both are inter-dependent and inter-linked with each other.

The following are the functions of educational counseling:

a) **Making a good beginning**

This aims at preventing drop-outs, highlighting the incentives of good education, thus paving way for a good educational beginning for the child.

b) **Planning intelligently**

The counselor provides the opportunity to children to explore his abilities, aptitudes and interests, and relate them to the courses available in secondary school.

c) **Secondary stage**

It acquaints students with the nature and purpose of senior secondary school curriculum through class talks, and exploratory or try-out courses when possible.

d) **Improvement in the method of study**

Wherever required, the counselor may suggest important improvements in the study method of the individual. These may include mode of taking notes, mode of reading, mode of memorising.

4.6 CAREER COUNSELING

Super posited five stages of vocational development:

- Growth (up to 14 years)
- Exploration (15 to 24 years)
- Establishment (25 to 44 years)
- Maintenance (45 to 64 years)
- Decline (post 64 years)

The focus in career counseling is generally on issues such as career exploration, career change, personal career development and other career related issues, often occurring in the Growth and Exploration stages of vocational development. Typically when people come for career counseling they know exactly what they want to get out of the process, but are unsure about how it will work.

Career counselors work with people from various walks of life seeking to explore career options, or experienced professionals contemplating a career change. Career counselors typically have a background in vocational psychology or industrial/ organisational psychology.

The approach of career counseling varies, but will generally include the completion of one or more assessments. These assessments typically include cognitive ability tests, and personality assessments. Based on the interest of the client, his aptitude and the personality factors of the client, a career most suited for him is suggested.

4.7 GROUP COUNSELING

A group counseling intervention is a planned, developmental program of guidance activities designed to foster students' academic, career, and personal/social development. In group counseling, a school counselor works with two or more students together. Group size generally ranges from five to eight members. In a group setting, group members have the opportunity to learn from each other. They can share ideas, give and receive feedback, increase their awareness, gain knowledge, practice skills, and think about their goals and actions. Group discussions may be problem-centered, where attention is given to particular concerns or problems. Generally, information received from clients is private and confidential.

According to Crow and Crow, "Guidance in a group usually is thought of as referring to those guidance services that are made available by school personnel to large or small group of pupils."

Group counseling is an important and effective intervention technique that has been recognised by the profession for many years. School counselors have all been trained in group counseling techniques and may find it to be more effective and efficient than individual counseling for selected students.

4.7.1 Objectives of Group Counseling

Kitch and McCreasy have listed the following objectives of group counseling:

- To assist in the identification of common problems;
- To provide information useful in the solution of adjustment problem;
- To provide opportunities for experiences that promote self-understanding; and
- To lay the foundation of individual counseling.

The school counselor establishes and maintains group rules such as being sensitive to the feelings of other group members, being a good listener, and not being critical or sarcastic about the contributions of other group members. He or she also establishes specific goals for each session and facilitates purposeful goal-oriented discussion.

4.7.2 Advantages of Group Counseling

Efficiency: Enables the counselor to convey relevant information to a group of students thus saving time and effort

Opportunity to understand students in group situations: The counselor gets an opportunity to acquaint himself with the social attitudes and behaviour of student/s.

Discussion of common problems of students: Students get a chance to come up with their common problems and also find out solutions for the same with the help of the counselor and also of fellow-students.

Balanced Judgments: In group counseling, students usually accept suggestions that have grown out of face exchange of opinions and realistic analysis of attitudes.

Enlightenment of students: Through group discussion, the normal student learns to manage his own affairs in a better way.

Collective judgment on common problems: Group counseling provides outlets for discussion to the problems which the students might be uncomfortable with or unwilling to discuss in private interviews.

Individual counseling: Group counseling prepares the way for individual counseling

The common problems taken up for group counseling programmes include those relating to educational plans, home and school adjustment, use of leisure time, hobbies, age-related issues, and job hunting.

Self Assessment Questions

1) What is Guidance?

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2) Explain the importance of student counseling.

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3) What are the objectives and advantages of group counseling?

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4.8 INDIVIDUAL COUNSELING

Despite counseling in groups, there are many specific students who require the undivided attention and focus of the counselor. These students may include the following groups:

4.8.1 Students Engaging in Substance Abuse

Substance abuse is a critical problem across all segments of the population and impacts in some way all members of our society. It is the one of the most prevalent disorder affecting the youth in this day and age.

While similarities of behaviour exist across all types of substance abuse, individuals cannot be categorised, defined, and treated in relation only to their substance abuse problem. An individual with a substance abuse problem is unique in his/her history, pattern of use and abuse, and counseling and related treatment needs.

Counselors must be able to establish the same open, collaborative, therapeutic relationship in counseling individuals with substance abuse problems as they do with other client populations. This ability is viewed as a prerequisite to successful outcome in any counseling setting. Within this relationship, the counselor must provide focus for the process by addressing the client's presenting problems directly and identifying client need for change. Counselors of clients with substance abuse problems often find this process difficult because of the chronic nature of interrelated destructive attitudes and coexisting disorders these clients often bring to counseling. Once problem identification and client need for change are identified, the counselor must be able to articulate and implement counseling intervention strategies perceived by both the counselor and the client as appropriate to the client's need to change.

The counselor emphasis is on the person not the substance abuse problem. Additional knowledge and skill on the part of the counselor relates to being able to assess the extent and impact of a client's substance abuse problem and the client's need to change.

Familiarity with and ability to utilise standardised assessment instruments specific to substance abuse will help the counselor in this assessment process. Familial and social environment assessment also is required to identify the extent of and to utilise the client's support systems. The counselor's ability to identify the needs of the client and the quality of counseling and related treatment intervention strategies obviously linked to his/her assessment and diagnostic skills.

Counselors should be thoroughly familiar with the facilities and services in his/her community to ensure proper referral for clients with substance abuse problems, when required.

They counsel and empower individuals with substance abuse problems versus treat the substance abuse problem.

4.8.2 Students Witnessing Domestic Violence

In the past decade, a growing body of empirical research has demonstrated that exposure to domestic violence deleteriously affects children's social, emotional,

and cognitive development. Furthermore, data suggest that such exposure has long-term consequences for children's well-being, ultimately affecting their adult functioning. Given the negative repercussions of children's exposure to domestic violence, there exists a need for programs that can intervene in these children's lives to improve their potential for healthy psychological adjustment.

Children's responses to their experiences with domestic violence vary. Children may reveal any of a range of adjustment problems and psychopathology, or may emerge from their experiences relatively unscathed. Factors that appear to affect these responses include the child's proximity to the violence (that is, what the child actually saw or heard), the child's temperament, the age of the child at the time(s) of exposure, the severity and chronicity of the violence, and the availability of adults who can emotionally protect or sustain the child.

Research reveals that some of the symptoms these children may display include aggressive behaviour, reduced social competencies, depression, fears, anxiety, sleep disturbances, and learning problems.[1] Underlying many of those problems are the children's emotional responses to the violence, such as intense terror, fear of death, and fear of loss of a parent. In addition, children may harbor rage, feelings of guilt, and a sense of responsibility for the violence.

The first challenge to providing services to children who witness domestic violence is identifying this population. Complicating the identification process is the veil of secrecy that surrounds violence in families. Children may experience feelings of shame, guilt, and divided loyalties to parents, as well as fear of repercussions, making it unlikely that they will disclose the violence to others. To respond properly to these children, personnel in schools, health and mental health care settings must develop and implement guidelines for screening and responses if a child discloses domestic violence.

Once children who have witnessed domestic violence are identified, professionals must assess the child, the family, the living situation, and the nature of the events the child witnessed. Different recommendations may be appropriate depending upon the child's age and stage of development, the nature and duration of the child's symptoms and the impact on the child's functioning, the child's perceptions of and experiences with the violence, the child's ability to speak about the violence, the safety of the child's current environment, the presence of adults in the child's life who can be emotional resources, and the influence of the child's ethnicity and culture on defining the domestic violence and seeking help. The most commonly used assessment technique with children who have witnessed domestic violence is a focused clinical interview that explores the children's experiences with the violence, supplemented by data collection from various other sources, such as parents and teachers. In many cases, a group counseling approach is recommended for it helps the child identify with other students having similar problems, bringing down guilt and motivating him to open up regarding his experiences.

In individual counseling, some counselors have adapted models developed to treat related phenomena, such as posttraumatic stress disorder (PTSD) in children. The counselor seeks to stabilise the child's life situation, to help the child integrate the experiences of the violent event(s) in an adaptive manner, and to work with the child to manage the symptoms that resulted from the trauma.

4.8.3 Students Coping with Divorce/Separation of Parents

Schools can represent one stable force in the children's lives during the family transition which happens during divorce, and school personnel can help them cope with the effects of divorce.

Research examining children's mechanisms for coping with divorce has shown that children's reactions depend on their age and developmental stage at the time the divorce occurs (Cantrell, 1986; Freeman & Couchman, 1985; Kieffer, 1982; Wallerstein & Kelly, 1980).

Early Latency (ages 5-8). Children between the ages of five and eight at the time of their parents' divorce tend to react with great sadness. Some may feel fearful, insecure, helpless, and abandoned by the missing parent. Younger children often express guilt and blame themselves for their parents' divorce.

Late Latency (ages 9-12). Children in late latency at the time of their parents' divorce are distinguished from younger children by their feelings of intense anger. Nine to 12-year-olds may still feel loneliness, loss, shock, surprise, and fear, but anger and possibly the rejection of one parent are the predominant reactions of this age group.

Adolescence (ages 13-18). Adolescents whose parents are divorcing also experience loss, sadness, anger, and pain. A typical adolescent reaction to parental divorce, however, often involves acting-out behaviours. Sexual promiscuity, delinquency, the use of alcohol and drugs, and aggressive behaviour have all been identified as adolescent reactions to parental divorce.

The school is in an excellent position to offer supportive services to children of divorce (Kieffer, 1982). Children spend much time in school, where the continuity and routine can offer a safe environment for interventions. Counselors, teachers, and other school personnel are available on a daily basis and can provide help that avoids both the stigma and the expense associated with seeking help form private practitioners. Finally, the number of children in the school provides the possibility for group interventions.

The school counselor can provide valuable assistance directly through counseling with the children and indirectly through services to school administrators, teachers, and parents. Scherman and Lepak (1986) suggest that counselors not view divorce as a single problem with negative consequences, but focus on changes caused by divorce (e.g., single-parent homes, changes in routines and life stlyes, visitation patterns with relatives) and their positive, negative, or neutral effects on the children.

Counselors can also help to sensitise teachers to the transition a child is experiencing and to the implications of that transition. Teachers may need to change their choice of words, or to adapt their curriculum and classroom resource materials to include various family types.

Counselors can make parents aware of the special needs of their child during the divorce transition. Counselors can also assist parents by referring them to divorce support groups in the community, by recommending reading materials that deal with families of divorce, and by suggesting ways that parents can help their children adjust to divorce.

4.8.4 Students with Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a significant problem impacting hundreds of children in our schools. These children are at higher risk for learning, behavioural, and emotional problems. Children who exhibit the behaviours characteristic of ADHD often have difficulty attending to tasks, remaining seated, and resisting distractions, and they often act impulsively. In addition, children with ADHD may be noncompliant or aggressive, or may exhibit other disruptive behaviours. Children with ADHD also are more likely than their peers to have academic problems.

At present, a multimodal approach to ADHD treatment is the most widely accepted approach (e.g., Barkley, 1998; DuPaul & Stoner, 1994). The model includes four major areas in which intervention may be addressed:

a) Educational accommodations,

b) Promoting appropriate behaviour,

c) Medical management, and

d) Ancillary support services for children and parents (e.g. counseling, parental support groups).

This role of the counselor is important in the two facets of ADHD treatment: educational accommodations and interventions for promoting appropriate behaviour.

Educational accommodations are directed at manipulating the classroom environment (or antecedents) in an attempt to prevent behaviour problems from occurring. The goal is to alter the classroom environment to better fit the child's needs. Most classroom accommodations for manipulating antecedents are of the common-sense variety—simple to implement, practical, and most important, requiring minimal time and effort on the instructor's part.

Most classroom accommodations can be grouped into three major areas:

a) Classroom environment (e.g. seating of the child with ADHD at a place where it is easy to monitor his behaviour, arrange seating to minimise distraction etc.)

b) Tasks/materials (e.g. easy to understand, and neatly arranged study material, breaking material into small and easy steps)

c) Curriculum/ instruction. (E.g. simple and step by step manner of giving instructions).

If teachers are to work successfully with children who have ADHD in any instructional environment (either special education or general education), good class management technique is essential. The goal here is to systematically instill appropriate behaviours and increase their frequency. The ability to behave appropriately within classroom constraints is a necessary prerequisite for the academic success of any child. Children with ADHD are hindered if the classroom is noisy, disorderly, or lacking clear consistent regimens and expectations.

For children with ADHD to succeed, there is a need to (a) create and maintain a stable, predictable, structured instructional regimen, and (b) effectively communicate expectations.

Creating a stable instructional regimen is simple and straightforward. It involves making a written schedule of daily activities in which the school day is divided into blocks of time; posting it prominently (typically on a designated spot on the chalkboard); and maintaining this daily routine. Best practice suggests that counselors schedule nonpreferred activities before preferred activities and make preferred activities contingent upon successful completion of nonpreferred activities. For example, math seatwork would be scheduled (and must be completed) before the student could participate in a 15-minute free-reading period.

Communicating expectations requires teachers to establish appropriate, effective class rules and procedures, and to actively monitor behaviour. Students with ADHD might need additional prompts or cues to remind them of what is expected. One useful technique is to tape to the student's desk a prompt card listing important behaviours (e.g., "Am I doing my work? Am I listening to the teacher?"). Prompts serve to remind the student what he or she should be doing and to redirect behaviour.

4.8.5 Gifted Students

While there are many methods of counseling, there are few specific modalities designed for counseling gifted children. Because of the exceptional nature attributed to giftedness, it would be naive to assume that conventional approaches to counseling would suffice when working with this population.

Beginning with assessment, it is extremely important that the counselor make a precise distinction as to the etiology of the child's problem. In other words, is the problem indicative of a psychiatric disturbance, an implication of something related to giftedness, or a complex combination of variables?

There are several psychiatric symptoms and diagnostic categories that resemble characteristics of giftedness including obsessive compulsive disorder, bipolar affective disorder, autism, personality traits or disorders etc.

In addition, the counselor's role is shaded by subtleties that pertain specifically to her giftedness and her knowledge issues related to giftedness. To be fully prepared to effectively work with gifted people, counselors should:

Know their own giftedness. A counselor needs a clear concept of his or her own identity as a gifted person, attributes and deficits alike.

Counselors need to have a strong theoretical base and knowledge of the characteristics of gifted children. It is important that they are aware of the resources available for gifted children: support groups, parent organisations, educational opportunities, bibliographies, etc. The approach to counseling requires creativity since conventional counseling methodologies may not be the best choice for relatively unconventional clientele.

Gifted children have exceptional abilities and hence it is easy to be fooled by their exceptional intellect and interpersonal abilities. The counselor needs to be on guard for the same.

Exceptional cases require exceptional help.

One of the main characteristics of gifted children is their strong sense of independence. The counselor should be able to model interdependence and seek the insight of more knowledgeable colleagues, if required. This may also require expanding the role of a counselor by educating others involved with the child and coordinating services for them.

Gifted children often demonstrate deviant behaviour. Counselors should be mindful of their value structures for deviant behaviour and be conscious of their real feelings.

Gifted children require authenticity in relationships. They see right through contrived methodologies. They seek and require relatedness in their interactions.

Some of the more relevant issues to be addressed in the counseling process are:

Identifying Giftedness and Forming a "Gifted" Identity. The child needs the opportunity to know precisely how he is gifted, what that giftedness means to him, and how that giftedness plays a role in his identity and life. Identity is perhaps the most significant issue to be addressed in counseling.

Denial of Giftedness: Many gifted children are distressed because they lack awareness and acceptance of their giftedness. Help them know and accept the construct of being gifted as it applies to them. The same issue applies to the parents of the gifted child.

Struggling with Deviance: The denial that giftedness may exist can happen in part because having deviant behaviour is not always an accepted trait. The child's deviance in behaviour can lead to a whole host of social and emotional problems. It is important to assist the client to be aware of his deviance and develop methods to foster their differences rather than be distressed by them.

Family Issues: It is crucial that the parents have a strong involvement in the counseling process, either through family therapy, parent education, or other support services.

Facing Deficits: This is one of the primary themes and most delicate to deal with in counseling the gifted. Once the counselor has first assisted the client in identifying specific areas of giftedness, the process can then move forward in helping the gifted child identify areas of deficit. Facing these deficits will be the most challenging aspect for the child and the counselor and will be the most rewarding for both.

Identifying the issues of counseling gifted children in the areas of assessment, counselor's role and the counseling process will assist counselors in providing an exceptional approach to these exceptional children.

4.8.6 Students with Physical Disabilities

Evidence suggests that the physically disabled may have fewer and less frequent social experiences, and consequently, less social competence. Hence, use of interviewing skills and observation becomes all the more important with such children.

As with non-disabled children, the counselor's work in the early years involves the parents centrally. Parents of disabled children face a variety of tasks not demanded of other parents. They are expected to:

a) Take care for the greater physical needs of the child, yet not overprotect,

b) To allow themselves to grieve about the disability without rejecting the child,

c) To treat the child as normal, yet not deny the disability,

d) To exert greater effort, often for lesser reward than with other children.

Not surprisingly, many parents struggle hard to meet these delicate adjustments. This is where the role of the counselor becomes important. Parents often need reassurance that their efforts and attitudes make a difference in the child's life. This psychological support is offered by the counselor.

Often, the counselor may also act as a mediator in decisions calling for parent-child negotiation. Although counseling is not qualitatively different for disabled and non-disabled children, the clinician must be sensitive to the special life situation of the disabled child, which may have resulted in a prolonged period of dependence on parents and to deficits in social skills, self-evaluative ability, and social awareness.

In adolescence, these children have to come to terms with a realistic appraisal about their future and ambitions. At this time physical attractiveness and peer acceptance may also play a crucial role in their lives. The counselor steps in to make the child more accepting of the reality, which may often be denied by the adolescent. The counseling approaches take into account these stressful changes in their lives. The adolescent's need for a fresh understanding of disability and its implications is dealt with. Supportive and informative discussions on the available options are offered. Further, the client may need help in learning to value his/her self and assets. The counselor may also work on improving the social skills of the client as well as his social awareness.

Self Assessment Questions

1) Explain the importance of therapeutic relationship in dealing with children engaging in substance abuse.

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2) What challenges does the counselor face in dealing with children who witness domestic violence?

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3) Describe the Late Latency reactions of children dealing with parental divorce.

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4) What considerations should be kept in mind in counseling children with physical disabilities?

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4.9 LET US SUM UP

In this unit you have read that Counseling in educational settings has a lot of scope and objectives. You also learnt the following points:

Educational counseling helps a student in make his future plans and choices intelligently Career counseling involves assessment of the student for his/her interest, aptitude and personality factors, aiding in planning for the apt career.

Group counseling is an effective counseling intervention comprising of more than 2 students who share ideas, gain knowledge and give and receive feedback.

Certain student groups may benefit more from individual counseling. These include students engaging in substance abuse, those witnessing domestic violence, or dealing with parental divorce, suffering from ADHD, gifted children, and, children with physical disabilities.

Special student groups may also require specific skills, techniques or knowledge on part of the counselor.

4.10 UNIT END QUESTIONS

1) Describe the meaning of guidance with the help of its characteristics.

2) How can counseling is helpful for students?

3) Describe the importance of career counseling.

4) Describe group counseling and discuss its objectives and advantages of counseling.

5) What types of counseling you will provide to:

   a) Students engaging in substance abuse

   b) Students witnessing domestic violence

   c) Students with ADHD

   d) Students with physical disabilities.

4.11 GLOSSARY

Substance Abuse : A maladaptive pattern of substance use leading to clinically significant impairment or distress.

Domestic Violence : Domestic violence includes behaviours used by one person in a relationship to control the other. These may include physical assault, sexual abuse, stalking etc.

Attention Deficit Hyperactivity Disorder (ADHD) : A developmental disorder that presents during childhood, in most cases before the age of seven, and is characterised by developmentally inappropriate levels of inattention and hyperactive-impulsive behaviour.

4.12 SUGGESTED READINGS

Ladany, N. & Inman, A. (2008) *Handbook of Counseling Psychology*, (4th ed.). John Wiley & Sons: New York.

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