UNIT 1 INTRODUCTION TO COUNSELING AND CHARACTERISTICS OF A COUNSELOR

Structure

1.0 INTRODUCTION

This unit deals with counsllor, counseling and guidance issues. We start with the definition of Counseling and guidance and differentiate guidance from counseling. Then we take up characteristics of counseling and guidance and differentiate counseling from psychotherapy. Then we deal with the counsellor and the important aspects of a cousnellor. Then we take up the characteristics of a counsellor. We elucidate the typical training and educational qualifications to make a person a counsellor and provide information regarding licensing of counselors to practice both in India and other countries. Then we elucidate the other qualifications of counselors, the certification and advancement in the field. Then we deal with the values of the counselors and how they use the same in the profession.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Describe the concept of counseling;
- Define counseling psychology;
- Explain the difference between counseling and guidance;
- Explain the role and characteristics of a counselor;

- Describe the personal and academic qualification and training required of a counselor; and
- Analyse the role of values in counseling.

1.2 DEFINITION OF COUNSELING

Counseling is distinguished from other mental health disciplines by both its history and its emphasis. It focuses on development and the prevention of serious mental health problems through education and short term treatments. It emphasises on growth as well as remediation. It focuses on providing therapeutic treatments to clients who experience a wide variety of symptoms. It is also one of the largest specialty areas within psychology.

Counseling as a profession is relatively new. It grew out of the guidance movement, in opposition to traditional psychotherapy. In order to understand what counseling is, you must first understand these concepts.

Counseling is often performed face to face in confidential sessions between the counselor and client(s). However, counselling can also be undertaken by telephone, in writing and, in these days of the Internet, by email or video conferencing. Counselling can and may take many different formats to bring a person to a better understanding of himself and others. It can therefore be seen that counselling can be of benefit to a person experiencing problems in finding, forming, and maintaining relationships.

It is the ability to listen and respond in a way that will help others solve their own problems and attain their potential. It is the art of helping others arrive at the right answer by their own analysis of the situation and the facts. It has to be done skillfully without an attempt to influence the values and beliefs of the client.

Counseling involves talking with a person in a way that helps the person solve a problem or helps to create conditions that will cause the person to understand and/or improve his behaviour, character, values or life circumstances. It is a process that enables a person to sort out issues and reach decisions affecting their life. Often counselling is sought out at times of change or crisis, however it need not be so as counselling can also help us at any time of our life.

It emphasises on exploration and understanding the problem and stresses the idea of professional relationship and the importance of self determined goals (of course by the client). It should be differentiated from advice giving or directing. It should be noted that counselling is a principled profession.

Biswalo (1996) defines counselling as a process of helping an individual to accept and to use information and advice so that he/she can either solve his/her present problem or cope with it successfully. Counselling depends heavily on information.

According to British Association for Counseling and Psychotherapy (2002), counseling takes place when a counselor sees a client in a private and confidential setting to explore a difficulty a client is having, distress that the client may be experiencing or perhaps the client's dissatisfaction with life or loss of a sense or direction and purpose.

Both the American Counseling Association (ACA) and Division 17 of the American Psychology Association have defined counseling on numerous occasions. These definitions contain a number of common points, some of which are as follows:

- Counseling is a profession.
- Counseling deals with personal, social, vocational empowerment, and educational concerns.
- Counseling is conducted with persons who are considered to function within the normal range.
- Counseling is theory based and takes place in a structured setting.
- Counseling is a process in which clients learn how to make decision and formulate new ways of behaving, feeling and thinking.
- Counseling encompasses various subspecialties.

Now let us see how counseling is different from guidance.

1.2.1 Counseling and Guidance

Let us now see the difference between counseling and guidance. “Guidance is a term used to denote the process of helping an individual to gain self understanding and self direction (self decision making) so that he can adjust maximally to home, schools or community environment.” (Biswalo, 1996).

Guidance is giving leadership, supervision, direction, or professional guidance for future actions. Guidance has more to do with something that you are not sure of or something that you don‘t know about and you have some one who is familiar with explaining it to you while counselling has something do do with something that you have trouble with.

Someone who provides guidance offers you suggestions how to explore various alternatives. Counseling may also offer suggestions, but it also tries to teach you methods for reaching your goals and can help you determine what your goals are. In practice there may be no difference between the two, because it depends how people practice each technique and how they interpret their skills

Guidance is pre problem, that is there is no specific problem that is identified in an individual.

Counseling is post problem, meaning a problem has already been identified and therefore the counselor helps to address the problem but not to solve it.

Counseling is not giving opinion, instruction or advice, it is using facilitative listening and questioning to allow the client to choose the best solution for a problem. Counseling is based on a wellness model rather than a medical model. Authors such as Hershenson and Strein (1991); and Palmo, Shosh and Weikel (2001) emphasised that counselors are concerned about the client’s environment with a more global view than other professionals as well as a concern that goes beyond treating dysfunction or pathology and dealing with the clients’ self-awareness, personal growth, and wellness.

Guidance refers to the act or process of guiding. Guidance is a type of counseling, such as that provided for students seeking advice about vocational and educational matters.

1.2.2 Characteristics of Guidance

Guidance is a continuous process such that it a regular service, which is required at every stage for every person, not only for the problematic situations and abnormal people. It is a positive program geared to meet the needs of all people. It is needed right from early childhood, adolescence through adulthood and old age.

It is both generalised and a specialised service. It is a generalised service because teachers, lecturers, advisors, deans, parents and elders, all play a part in guidance.

It is a generic term as it includes information giving and research activities. It is a specialised service because specially qualified personnel as counselors, psychiatrists, psychologists join hands to help Individuals to adjust to the environment.

Thus we see that guidance is more information oriented and addresses the developmental issues. On the other hand, counseling is more remedial in nature, aimed at helping the person deal with the problems and conflicts in his life.

1.2.3 Counseling and Psychotherapy

Psychotherapy, or personal counselling with a psychotherapist, is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living. Traditionally it focuses on serious problems associated with intrapsychic, internal, and personal issues and conflicts. Characteristically, it emphasises the following issues:

- The past more than the present
- Insight more than change
- The detachment of the therapist
- The therapist's role as an expert

Psychotherapy usually involves a long term relationship that focuses on reconstructive change. It is provided in both outpatient and inpatient settings whereas counseling deals with minor problems of daily living and is usually provided in outpatient settings.

Self Assessment Questions

1) Define counseling.

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2) Discuss the difference between guidance and counseling.

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3) What is the difference between psychotherapy and counseling?

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4) Discuss the characteristics of guidance.

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1.3 HALLMARKS OF A COUNSELLOR

Effective counseling is a two way street. It takes a cooperative effort by both the person receiving counseling and the counselor and it takes a commitment to make sometimes difficult changes in behaviour or thinking patterns.

The term counselor has numerous meanings. Most often it is used to describe someone who is a therapist, which could mean a licensed clinical social worker, a marriage and family counselor, a psychologist or even a psychiatrist who conducts regular therapy sessions. Counselor is also a term used to describe lawyers, who advocate for others in court or give legal advice, a person working as a representative of a state, a person working at a children's camp, at a school to give academic advice, or for a church.

An effective counselor can identify negative thinking patterns such as feelings of sadness, depression or anxiety. By encouraging you to build upon personal strengths and suggesting skills that can overcome self inflicted feelings of hopelessness, a counselor can help you develop a more positive attitude.

A good counselor can assist you in making positive changes in your relationships with others, helping you recognise behaviours that may be contributing to a troublesome relationship. Your counselor can teach you effective ways of communicating, clearing the way for honest exchanges with people in your life who may be causing you emotional pain.

Counselor skills would certainly include knowledge of the psychological theories underpinning our understanding of the human experience. Without that understanding, using the techniques proponents of a particular theory offer becomes robotic, and can diminish a client's experience of counseling. Counselor must have an awareness of theories of personality and abnormal personality. Counselor should be aware of multi-cultural issues.

1.4 CHARACTERISTICS OF A COUNSELOR

A counselor's personality is a crucial ingredient in determining the effectiveness of counseling. The skills needed for effective counseling are non-negotiable and not open to compromise: all are necessary and when understood and internalised, form the value base for our profession.

Effective counselling requires an understanding of self and a detailed awareness of the impact of oneself on others.

A counselor needs to be equipped with advanced listening skills. They must be able to recognise the various levels of empathy of their responses, (i.e. reflecting an accurate understanding of the feeling being expressed by the client). It is necessary to develop the ability to listen with an open mind, to refrain from judgmental responses and to actively check with the client that the understanding of the feelings being expressed is correct.

Counselling demands a process of negotiation and problem solving. A clear goal needs to be set so that the client is able to take appropriate action in their own life space and also to take responsibility for the consequences of their action.

Self disclosure is a powerful tool that can be used by an effective communicator but when it is used within the constraints of the therapeutic encounter it needs to be done with considerable care.

An understanding of the complexity of communication is a basic foundation within the development of an effective counselling framework. An ability to read, interpret and respond non-verbally is critical. The use of conscious use of paralinguistic signals, postures and gestures to pace a distressed client for a sense of greater emotional self-control are just some examples of skills required.

Counselling will generally use a conversational style. As Eric Berne pointed out there is plenty left if you remove the solemn face and the big words. Counselors need not be afraid of ordinariness.

The effective counsellor requires the skills of assertiveness and the ability to confront a client when it is therapeutically appropriate.

Counsellors must be competent in their communication to be credible and must be able to self- monitor – they must have the ability to concentrate their messages so that they are immediate i.e. they relate to the here and now) and refer to concrete interpersonal issues.

He or she has an internal source of motivation and drive and seeks growth instead of external approval.

Counselors must recognise the impact of their own personal values, attitudes and self- esteem. The effective counsellor must develop and use the ability to model his or her behaviour for the client; this is one of the most potent media for personal growth and change. This brings us to the all important question of values.

Confidentiality is the key of successful counseling. The ability to uphold a therapist-patient relationship in which you do not talk about your clients outside of your office or in a professional setting with your colleagues is required as a practicing counselor. The American Counseling Association reminds that "clients must be able to trust the counselor and have faith in the therapeutic relationship if growth is to occur . . . the counselor must take care neither to threaten the therapeutic relationship nor to leave obligations unfulfilled."

The little time you spend with your client each week should allow him to feel he can express his concerns and feelings without reservation. Whether you are in school training towards your degree or you are running a private practice, you should always respect your client's privacy as if it were your own.

Empathy allows you to see the situation from the other person's view. It provides a grounding effect on the plan of action, ensuring that it is feasible and achievable from the perspectives of the employer and employee.

Counselors achieve credibility by being honest and consistent in their statements and actions.

Counselors take risks everyday and face rejection by their clients or face clients or situations they may not be prepared to face.

He or she is not racist and does not discriminate against others who are different from himself or herself.

He or she is not ego-centered but chooses to help others out of concern for others and not for glorification of the self.

1.4.1 Educational Qualifications of a Counselor

Education and training requirements for counselors are often very detailed in the Western countries and vary by State and specialty, but a master's degree usually is required to become a licensed counselor. Prospective counselors should check with State and local governments, prospective employers, and national voluntary certification organisations to determine which requirements apply.

1.4.2 Education and Training

Education requirements vary with the occupational specialty and State licensure and certification requirements. A master's degree usually is required to be licensed or certified as a counselor. Counselor education programs in colleges and universities often are found in departments of education, psychology, or human services. Fields of study may include college student affairs, elementary or secondary school counseling, education, gerontological counseling, marriage and family therapy, substance abuse or addictions counseling, rehabilitation counseling, agency or community counseling, clinical mental health counseling, career counseling, and related fields. Courses frequently are grouped into core areas, including human growth and development, social and cultural diversity,

relationships, group work, career development, counseling techniques, assessment, research and program evaluation, and professional ethics and identity. In an accredited master's degree program, 48 to 60 semester hours of graduate study, including a period of supervised clinical experience in counseling, typically are required.

Some employers provide training for newly hired counselors. Others may offer time off or tuition assistance to complete a graduate degree. Often, counselors must participate in graduate studies, workshops, and personal studies to maintain their certificates and licenses.

The processes involved in the training of counselors are given below:

1) Ability to explain the micro skills.

2) Demonstrate the skills involved in commencing the counselling process.

3) Evaluation of non verbal responses and minimal responses.

4) Demonstrate reflection of content, feeling.

5) Demostrate the appropriateness of both content and feeling in the counselling process.

6) Develop different questioning techniques.

7) Understand risks involved with some types of questioning.

8) Show how to use various micro skills including summarising, confrontation, and reframing.

9) Demonstrate self destructive beliefs and show methods of challenging them, including normalising.

10) Explain how counselling a client can improve their psychological well-being through making choices, overcoming psychological blocks and facilitating actions.

11) Demonstrate effective ways of terminating a counselling session and to explain ways of addressing dependency.

As for the student trainees

1) They have to report on an observed counselling session, simulated or real.

2) Identify the learning methods available to the trainee counsellor.

3) Demonstrate difficulties that might arise when first learning and applying micro skills.

4) Identify why trainee counsellors might be unwilling to disclose personal problems during training.

5) Identify risks that can arise for trainee counsellors not willing to disclose personal problems.

6) Discuss different approaches to modelling, as a form of counselling .

7) Evaluate verbal and non verbal communication in an observed interview.

8) Identify the counsellor's primary role (in a generic sense).

9) Show how to use minimal responses as an important means of listening with intent.

10) Explain the importance of different types of non verbal response in the counselling procedure.

11) Report on the discussion of a minor problem with an anonymous person which that problem relates to.

12) Identify an example of paraphrasing as a minimal response to reflect feelings.

13) Discuss the use of paraphrasing in counselling.

14) Differentiate catharsis from confused thoughts and feelings.

15) Identify an example of reflecting back both content (thought) and feeling in the same phrase.

16) Demonstrate/observe varying responses to a variety of closed questions in a simulated counselling situation.

17) Demonstrate/observe varying responses to a variety of open questions in a simulated counselling situation.

18) Compare student's use of open and closed questions in a counselling situation.

19) Student should identify the main risks involved in asking too many questions.

20) Learn to explain the importance of avoiding questions beginning with 'why' in counselling.

21) Identify in observed communication (written or oral), the application of different micro skills which would be useful in counselling.

22) The student should demonstrate examples of when it would be appropriate for the counsellor to use confrontation.

23) List the chief elements of good confrontation and discuss appropriate use of confrontation, in case studies.

24) The student should show how reframing can be used to change a client's perspective on things.

25) The student must develop a method for identifying the existence of self destructive beliefs (SDB's) and identify self destructive beliefs (SDB's) amongst individuals within a group. They should be able to explain the existence of self destructive beliefs in an individual. They should be able to list methods that can be used to challenge SDB's.

26) Explain what is meant by normalising, in a case study. Be able to demonstrate precautions that should be observed when using normalising.

27) The student should be able to determine optional responses to different dilemmas and evaluate those optional responses to different dilemmas.

28) The student should develop the ability to explain how the 'circle of awareness' can be applied to assist a client, in a case study.

29) Explain why psychological blockages may arise, and demonstrate how a counsellor might help a client to overcome psychological blockages.

30) Describe the steps a counsellor would take a client through to reach a desired goal, in a case study.

31) The student should be able to identify inter dependency in observed relationships and explain why good time management is an important part of counseling.

32) The student should know the difference between terminating a session and terminating the counseling process and be able to compare the same.

33) Demonstrate dangers posed by client counsellor inter-dependency and explain how dependency can be addressed and potentially overcome. Also the student should explain any negative aspects of dependency in a case study.

The students will gain a range of skills and knowledge necessary to apply counselling concepts to a range of situations as given below:

- Family support services
- NGOs
- Government agencies
- Community Health centers
- Outreach services
- Women health centers
- Counselling young people and children.
- Issues in family therapy
- Substance abuse: alcohol and drugs counselling
- The elderly. Death and bereavement counselling
- Counselling at work

Some of skills that the students will learn in the process include Cognitive Behaviour Therapy and Counselling clients with AIDS.

1.4.3 Licensure

Licensure requirements differ greatly by State, occupational specialty, and work setting. Some States require school counselors to hold a State school counseling certification and to have completed at least some graduate coursework; most require the completion of a master's degree. Some States require school counselors to be licensed, which generally entails completing continuing education credits. Some States require public school counselors to have both counseling and teaching certificates and to have had some teaching experience.

Counselors working in certain settings or in a particular specialty may face different licensure requirements. For example, a career counselor working in private practice may need a license, but a counselor working for a college career center may not. In addition, substance abuse and behaviour disorder counselors generally are governed by a different State agency or board than are other

counselors. The criteria for their licensure can vary greatly, and in some cases these counselors may need only a high school diploma and certification. Those interested in entering the field must research State and specialty requirements to determine what qualifications are necessary.

In India, the Rehabilitation Council of India provides these services for licensing persons with the appropriate qualifications to serve as counselors. The Rehabilitation Council of India (RCI) was set up as a registered society in 1986. On September, 1992 the RCI Act was encacted by Parliament and it became a Statutory on 22 June 1993. The Act was amended by Parliament in 2000 to make it more broadbased. The mandate given to RCI is to regulate and monitor services given to persons with disability, to standardise syllabi and to maintain a Central Rehabilitation Register of all qualified professionals and personnel working in the field of Rehabilitation and Special Education. The Act also prescribes punitive action against unqualified persons delivering services to persons with disability.

RCI trains master trainers, rehabilitation professionals and personnel for creating better service delivery facilities for the persons with disability. However, it does not offer any direct benefit, financial or material help to the persons with disability.

One of the main functions of the Council is to standardise the training courses for various categories of Professionals/Personnel for ensuring quality services to the people with disabilities. The Council keeps on modifying/revising the existing syllabus and adopt new training programmes incorporating new developments.

The Council has so for standardised 80 Long Term/ Short Term Training Courses, which include 11 Courses developed during the current year, with the help of respective Expert Committees constituted by the Council.

These RCI sponsored Training Courses are being adopted from time to time by various Universities/Institutions.

The persons registered with RCI shall be entitled to practice as a rehabilitation professionals/ personnel in any part of India and to recover in due course of law in respect of such practice any expenses, charges in respect of medicaments or other appliances or any fees to which he may be entitled. There are certain conditions also attached to these personnel who are working as rehabilitation professionals and these are given below:

No person, other than the rehabilitation professionals/ personnel who possess a recognised rehabilitation qualification and is enrolled on the Central Rehabilitation Register:

1) Shall hold office as rehabilitation professional or any such office (by whatever designation called) in Government or in any institution maintained by a local or other authority;
2) Shall practice as rehabilitation professional anywhere in India;
3) Shall be entitled to sign or authenticate any certificate required by any law to be signed or authenticated by a rehabilitation professional.
4) Shall be entitled to give any evidence in any court as an expert under Section 45 of the Indian Evidence Act, 1872 on any matter relating to the handicapped:

RCI is responsible for development and standardisation of training courses in the field of Disability Rehabilitation and Special Education and to update and upgrade the knowledge and skills of professionals working in different areas of disability.

The information regarding Continuing Rehabilitation Education (CRE) topics and programmes being conducted at selected RCI approved training institutions nationwide is given underneath for the Rehabilitation professionals and personnel working in disability areas, so that they can join the nearby centre to upgrade their skills.

The Council supports relevant CRE programmes with the following objectives :

To upgrade the knowledge and skills of in service and practicing Rehabilitation Professionals and Personnel already registered with the RCI u/s 19 of the RCI Act of 1992.

To update Professional knowledge of masters trainers working in the field of Rehabilitation and Special Education

1.4.4 Other Qualifications

In other countries aside from India, people interested in counseling should have a strong desire to help others and should be able to inspire respect, trust, and confidence. They should be able to work independently or as part of a team. Counselors must follow the code of ethics associated with their respective certifications and licenses. Counselors must possess high physical and emotional energy to handle the array of problems that they address. Dealing daily with these problems can cause stress.

1.4.5 Certification and Advancement

In advanced countries, some counselors elect to be certified by the National Board for Certified Counselors, which grants a general practice credential of National Certified Counselor. This national certification is voluntary and is distinct from State licensing. However, in some States, those who pass the national exam are exempt from taking a State certification exam. The board also offers specialty certifications in school, clinical mental health, and addiction counseling.

The Commission on Rehabilitation Counselor Certification offers voluntary national certification for rehabilitation counselors. Many State and local governments and other employers require rehabilitation counselors to have this certification. To become certified, rehabilitation counselors usually must graduate from an accredited educational program, complete an internship, and pass a written examination.

Certification requirements vary, however, according to an applicant's educational history. Employment experience, for example, is required for those with a counseling degree in a specialty other than rehabilitation. To maintain their certification, counselors must successfully retake the certification exam or complete 100 credit hours of acceptable continuing education every 5 years.

Other counseling organisations also offer certification in particular counseling specialties. Usually, becoming certified is voluntary, but having certification may

enhance one's job prospects. Prospects for advancement vary by counseling field. School counselors can become directors or supervisors of counseling, guidance, or pupil personnel services; or, usually with further graduate education, they may become counselor educators, counseling psychologists, or school administrators.

Some counselors choose to work for a State's department of education. Some marriage and family therapists, especially those with doctorates in family therapy, become supervisors, teachers, researchers, or advanced clinicians in the discipline. Counselors also may become supervisors or administrators in their agencies. Some counselors move into research, consulting, or college teaching or go into private or group practice. Some may choose to pursue a doctoral degree to improve their chances for advancement.

1.4.6 Counsellor and Values

Each of us comes to the counselling encounter with a complex and hard won set of values. Both client and counsellor will hold certain principles to do with interpersonal conduct. Not only that, but counsellor and client actually have different value systems. It is important to note that anyone's value system is likely to contain inherent contradictions, that is the contradictions which if exposed can result in high levels of anxiety and the need to grow. Inevitably the counselling encounter will be dealing with the client's inability to decide between possible causes of action and this will mean that they will need to explore, and if necessary, modify their own value system.

This in turn means that if the counsellor is to be at all helpful she must be able to enter the world of the client's value system so that she is able to understand potential sources of conflict. It is imperative that the Counselor is able to do this non judgmentally, that is, she needs to be able to entertain her own "disbeliefs" and, to the extent that she is able, to either model or suggest alternatives which will be effective as well as minimally disruptive.

If the counsellor has a sense of missionary zeal, or a desire to impose a set of beliefs other than those inherent in the skills listed above, she is likely to, at best, be ineffective and at worst highly destructive to the well being of her client. In relation to the notion that counselling is simply effective communication it should be noted that highly skilled communicators are often in the business of persuasion, such as for example Adolf Hitler was and so are sales people, politicians, and media representatives.

Effective counselling implies that the inherent values of tolerance, acceptance and respect for the individual often do not ensure effective communication. What we can say is that effective communicators are able to use many of the basic skills of counselling in order to "get their message across", but this has nothing to do with the value or otherwise of the message itself.

Both communication and counselling call upon knowledge, including an understanding of action based techniques, to promote constructive interpersonal dynamics. But this knowledge can be also used quite destructively. For clients, who are usually at their most vulnerable when attending counselling, it is imperative that counselors use their skills in a way that protects the fragile client from further "abuse" through misuse of authority and status. Effective counselors hold ethical values that effective communicators often do not have.

Self Assessment Questions

1) What educational qualification you need to become a counselor?

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2) Why license is mandatory for a counselor?

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3) Explain why does a counselor need to be aware of his value system?

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1.5 LET US SUM UP

In this unit you learned about the concept of counseling and characteristics of an effective counsellor. An effective counsellor does require more than effective communication skills. Counselling is definitely a discipline of its own. It is our belief that one can not be an effective counsellor without being an effective communicator. However, effective counselor goes beyond effective communication. Effective counselors have a strong knowledge base, an awareness of their own human vulnerability, a desire to continue searching and awareness that they are often dealing with vulnerable and easily influenced people. They are trained and many training and refresher programmes are organised for them so that they are in touch with the latest trends and their skills and knowledge are updated. Counsellors can be responsible for their clients' emotional life and death, which is indeed a very heavy burden to shoulder and one which is taken up consciously and willingly. If this is not the case then it is possible the counsellor may be just an effective communicator.

1.6 UNIT END QUESTIONS

1) Differentiate counseling and guidance.

2) Explain the concept of counselor in counseling profession.

3) Discuss the various characteristics of an effective counselor and compare the same with that of guidance personnel.

4) How does the values of a counselor influence the counseling client relationship?

5) What are the certification and license requirement for a counselor?

6) Give a note on Rehbailitation Council of India and its role in licensing counselors.

1.7 SUGGESTED READINGS

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UNIT 2 PROCESS OF COUNSELLING

Structure

2.0 INTRODUCTION

This unit deals with the counseling process. It starts the definition of the counseling process, what it is and the typical features of the counseling process. This is followed by steps in counseling process and the typical processes followed by counselors in this process. Then we discuss the procedures involved in the counseling process and how developing a relationship is important in this process. Then we describe the working of the counselor and the client within the relationship and then we present the termination of this relationship when the counseling process reaches its goal. The next section deals with the factors influencing counseling process which includes in it the structure, initiative to be taken by the client, the setting in which the counsellign process takes place, the client's and the counsellor's qualities.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define the process of counseling;
- Elucidate the steps/stages involved in the process of counseling;
- Describe the key components involved in the different stages of counseling;
- Discuss the steps involved in the termination process of counseling; and
- Explain important factors influencing the counseling process.

2.2 THE PROCESS OF COUNSELLING

In process of counseling, the goal is established by the client. He is encouraged and assisted by the counselor to be as specific about the goal as possible. The more specific the goal, the easier the process. Since humans are generally considered to be goal oriented, the more specific the goal, the more likely the client and the counsellor will keep themselves on the path to that goal. The client narrates their experiences and problems and thus create a focus on their fear and their goal in order to assist their mind to assist them. It is also of value to the counselor to guide them in identifying their fears and apprehensions. In the process of identifying the fear the counselor offers some alternatives while attempting to avoid interfering in the clients decision.

Some of the fears are:

- a fear of abandonment,
- a fear of rejection,
- a fear of not being enough

2.2.1 Counseling Process

Counseling can help client learn to make better decisions. It can help improve personal skills, develop greater confidence in the person's academic or work performance, define career directions and acquire a keener awareness and appreciation of the client's needs and those of other people. With counseling, clients can improve their communication with a special person, establish more meaningful relationships, or cope more effectively with feelings of depression or anxiety. Any personal, academic, or career concern may be explored in counseling.

During counseling, the client will be helped to clarify feelings and needs. The client and the counselor will work together to define realistic goals and explore available options. As the client discovers ways to make changes, he will be better able to direct his choices. Counseling is an active process, both during sessions and outside of counseling, as the client implements new skills and insights. Depending upon the intensity of concern(s), and level of involvement in making needed changes, clients are generally able to resolve difficulties in four to eight counseling sessions.

The client's personal commitment to helping him or herself is crucial to an effective counseling process. Counselors can help the clients only if they are willing to receive help, attend scheduled sessions, and engage in new ways of thinking and acting outside of the counseling setting.

Counselling is a process with a beginning, a middle and an end, where the counsellor facilitates an individual to consider the aspects of their life they wish to change.

The whole idea is to enable the client to explore a difficulty or distress which they may be experiencing, assisted by the counsellor whose main role is to facilitate the client to make his or her own decisions on how to proceed. It is not an environment where the counsellor will say what has to be done or even give advice. However, through this process the counsellor will endeavour to guide

the client from feeling a victim of circumstances to feeling that they have more control over their life.

There are different models of counselling, differing routes or tools to enable the client to change. Transactional Analysis (TA) is a model for understanding personality, relationships and communication. In TA counselling, people talk about their Parent, Adult and Child. These are distinctive parts of us all, available and necessary for living as a whole, integrated person. TA holds that everyone has intrinsic dignity and worth; they are 'OK'. Everyone has the capacity to think. There is a commitment to change, to making decisions and taking personal responsibility for personal outcome.

Clarifying the problem and the desired change encourages the person to decide how they wish to be. Often unpacking one problem may reveal its connection to another. When people start the process of counselling they begin to experience the recurring patterns in their lives, to identify their negative feelings and how they play games and thereby limit themselves. A decision to make positive change is a further step. Someone may know what their goal is, but they have to decide to take positive action to achieve that goal.

The Counsellor offers support and facilitation on the basis that the client has decided what he or she feels.

2.2.2 Steps in Counseling Process

The basic steps of counselling involve people in:

- gaining recognition for their skills and experience
- being confronted, from a caring position, by the ways they used to discount themselves and others
- re-experiencing, in the present, any relevant events from the past. This can help them to obtain emotional release from feelings or beliefs to which they may be clinging, that are stopping them from meeting their immediate needs.

Emphasis is given to feelings and thoughts, as stimuli for action and change. Support, challenge and practice are essential to enable all these steps to be achieved.

Counselling may comprise a few sessions, or it may take longer, but it does not go on for ever. In the end, the clients are helped to find the tools to enable them to think, feel and behave in the way they desire.

2.2.3 Stages of Counselling Process

Effective leaders use the counseling process. It consists of four stages:

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

Counselling is a process that focuses on enhancing the psychological well being of the client, such that the client is then able to reach their full potential. This is

achieved by the counsellor facilitating the client's personal growth, development, and self understanding, which in turn empowers the client to adopt more constructive life practices.

Counselling may be helpful in a number of ways. It can enable the client to develop a clearer understanding of his or her concerns and help the client acquire new skills to better manage personal and educational issues. The counsellor can offer a different perspective and help the client to think of creative solutions to problems. For the client, sharing his thoughts and feelings with someone not personally involved in his life can be most helpful.

The counsellor treats all the information that the clients share as confidential material. The counsellors are involved in case consultations and supervision for the purposes of best practice. These meetings involve discussion of clients concerns with the aim of formulating the best possible assessment and intervention plan. Where possible, the identifying personal information is removed from the discussion.

2.2.4 Counselling Process Followed by Counsellors

The counselling process will depend on the individual counsellor, the individual client and the specific issue. However, there is a general counselling process that the counsellors will follow:

1) Background information collection
2) Identification of core issues
3) Case formulation
4) Goal setting for the therapeutic process
5) Implementation of intervention
6) Evaluation of intervention
7) Closure

Prior to the initial interview, reception staff will ask the client to complete a personal data sheet. During the initial interview, the counsellor will discuss the client's concerns with him and explore with him the alternative services if indicated. By the end of the initial interview the client and the counsellor may decide on one of the following options:

- *no further counselling* is required at this time, if during the initial interview the client has been able to clarify his concerns and plan and appropriate course of action.
- *further appointments* are needed to continue to explore the issues before reaching a decision. A second appointment will be made with the client either by the counsellor or by reception.
- *alternative services* are appropriate and the counsellor will assist the client to identify specific resources to consider and pursue.

Counsellors work from differing theoretical approaches. Different counsellors will place varying levels of emphasis on behaviour, on thinking and/or on emotional aspects. All counsellors have the central goal to assist the client in increasing his or her sense of well being.

Change does not happen quickly for most of us. The length of treatment depends on a number of variables. Variables include:

- the severity of the problem,
- the motivation of the client,
- the type of problem and
- the age of the client.
- The more focused and limited the problem being addressed, the shorter treatment can be.
- The more the treatment addresses healing emotional injuries, the longer it is likely to take.

If the client feels dissatisfied with any aspect of the Counselling Services, they are encouraged to discuss their concerns with the Senior Counsellor.

2.2.5 Procedure in the Counseling Process

1) Establish a safe, trusting environment
2) Help the person put their concern into words.
3) Active listening: find out the client's agenda
    a) paraphrase, summarize, reflect, interpret
    b) focus on feelings, not events
4) Transform problem statements into goal statements.
5) Explore possible approaches to goal
6) Help person choose one way towards goal
7) Make a contract to fulfill the plan (or to take the next step)
8) Summarize what has occurred, clarify, get verification
9) Get feedback and confirmation

In general, a counsellor will listen to the client without butting in or imposing their own values and beliefs on him or her. They will give the client the needed space to explore their thoughts, feelings, or behaviour, whatever they are. People can find it helpful just to have their concerns taken seriously.

The counsellor may also employ a variety of techniques to help the clients understand their feelings. For instance, the counsellor may ask questions designed to reflect back to the clients their thought processes and to help them make sense of their feelings. The client thus might explore and implement changes in the way he or she does things, and then can go on to enhance his life or his relationship.

Counselling is a process guided by theory. Process can refer to what the counselor does with the client as well as how change occurs within the client. The process of counseling develops in definable stages with recognisable transitions. There is a natural progression that takes place within the context of the helping relationship. This process enables the counselor 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.

The process of counseling is dynamic in nature. The effectiveness of counseling ultimately depends upon how the process of counseling happens. It can be said to start with rapport establishment, then progress through problem identification, goal setting, intervention and then finally follow up.

Broadly, three major stages in the process can be described as follows:

1) Developing a relationship
2) Working in a relationship and
3) Terminating a relationship

Each stage has its own universal qualities and problems associated with it. Counselors must be aware of the problems involved in the process of counseling. Now let us discuss each stage in the process of counselling.

2.2.6 Developing a Relationship

Building a relationship, the first stage in the process of counselling, is a continuous process. It begins by having the counsellor win the battle for structure and client win the battle for initiative. In such situations both parties are winners. The client wins by becoming more informed about the nature of counselling and learning what to expect. The counsellor wins by creating an atmosphere where the client is comfortable about sharing thoughts and feelings.

In order to develop positive helping relationships with the client, the counsellor has to connect with them. This can only happen when they are made to feel like the counsellor genuinely care about the clients well being and that the counsellor understands why the clients are coming and the causes thereof. It is about behaving and demonstrating the core conditions of genuineness, respect and empathy. To develop solid relationships, the counsellor needs to create a safe environment where they will feel comfortable enough to open up and talk to the counselor about anything that is on their minds. The counsellor also needs to help them see that despite their circumstances they have strengths.

Early stages of the counselling relationship afford the chance to build counsellor understanding of client and issues faced. The counsellor is advised to use listening skills and attend to non verbal communication. The counsellor should not be judgmental in his decisions and jump to conclusions immediately. Certain tasks to be taken care of by the counsellors are:

- Laying foundations for trust
- Establishing the structure and form the relationship will take
- Informed consent process
- Articulating roles of counselor and client and developing a collaborative working alliance
- The “getting to know you” phase is the most critical stage of the relationship. The counselor should work on the following things during this stage:
    1) Developing Rapport and Building Trust
    2) Create core conditions necessary for counselling

1) **Developing Rapport and Building Trust**

i) ***Predictability and consistency***

During the first stage of the relationship, it is critical to be both predictable and consistent. If the counsellor schedules an appointment to meet the client at a certain time, it's important to keep it. It is understandable that at times things come up and appointments cannot be kept. Consistency is the key to speed up the trust building process.

ii) ***Testing***

Young people generally do not trust adults. As a result, they use testing as a coping or defense mechanism to determine whether they can trust the counsellor. They will test to see if the counsellor really cares about them. A client might test the counsellor by not reaching for a scheduled meeting to see how the counsellor will react.

iii) ***Establish confidentiality***

During the first stage of the relationship, it is important to establish confidentiality with one's client. This helps in developing trust. The counsellor should let the client know that whatever he or she wants to share with the counsellor will remain confidential, as long as (and it's important to stress this point) what the client tells the counsellor is not going to harm the client or someone else. It's helpful to stress this up front, within the first few meetings with the client. Later on if the counsellor needs to break the confidence because the information the client shared was going to harm him or her or someone else, the client will not feel betrayed.

iv) ***Goal setting (transitions into Stage 2)***

It is helpful during Stage 1 to take the time to set at least one achievable goal together for the relationship. What do the client and counsellor want to get out of this relationship? It is also good to help the client set personal goals. Sometimes the client does not know how to set goals, and this will provide them with the opportunity to set goals and work toward achieving them.

2) **Core Conditions Necessary for Successful Counselling**

Rogers (1957) originally proposed core conditions needed in building a relationship:

i) **Empathetic understanding:** Empathy promotes rapport and relationship.

ii) **Unconditional positive regard:** Considering Client as person of worth, and is separate from actions.

iii) **Congruence:** Showing Genuine self in client interaction

Carkuff (1969) adds to these…

i) **Respect:** It strengthens the focus.

ii) **Confrontation:** It promotes realistic and accurate view.

iii) **Immediacy:** Consideration of problem with Here and Now attitude.

iv) **Concreteness:** Paying attention on what is practical in the process.

v) **Self disclosure:** Promoting positive perception and appropriate focus in counseling relationship.

2.2.7 Working in a Relationship

The successful outcome of any counselling process depends on a working alliance between counsellor and the client. This occurs after clients and counsellors have established a relationship and explored possible goals towards which to work. Once trust has been established, the relationship moves into Stage 2. These phases are facilitated by mutual interaction between the individuals involved. The counsellor can help the client by appropriate leads, challenges to perception, multi focused responding, accurate empathy, self disclosure, immediacy, confrontation, contacts and rehearsal.

i) ***Changing Perceptions***

Clients often come to counsellor as a last resort when they think that situation is not only serious but hopeless. Counsellors can help clients change their distorted or unrealistic perceptions by offering them an opportunity to explore thoughts within a safe, accepting and in a non judgmental atmosphere. Perceptions commonly change through the process of reframing which offers the client another probable and positive viewpoint of what a situation is or why an event might have happened.

ii) ***Leading***

Changing client's perceptions requires a high degree of persuasive skill and some direction from the counselor. Such input is known as leading.

iii) ***Accurate Empathy***

Use of empathy is one of the most vital elements in the counseling. Empathy is the counsellor's ability to experience the client's world as if it were your own without ever using the quality.

Two Components of Empathy are:

a) **Empathic rapport.** This refers to accurately sensing and being able to see the client's world the way they do.

b) **Communicative attunement**. This refers to verbally sharing one's understanding with the client.

There are two types of Empathy:

1) **Primary Empathy.** The ability to respond in such a way that is apparent to both client and counsellor that the counsellor has understood the client's major themes.

2) **Advanced empathy.** It is a process of helping a client explore themes, issues and emotions new to his or her awareness.

iv) ***Self Disclosure***

Self disclosure is an important way to let clients know the counsellor as a person. Self disclosure at a moderate level is seen more positively by clients than

disclosure at a high or low level (Edwards & Murdock, 1994). In moderation, it is helpful for the counsellor to disclose facts about himself, if it serves the needs of the session / client.

Self disclosure takes the following forms:

- The counsellor's own problems
- Facts about the counsellor's role
- The counsellor's reactions to the client (feedback)
- The counsellor's reactions to the counselor-client relationship

v) ***Positive Regard***

Client revelations must be protected from counsellor's "personal reactions," especially rejection or disdain. The counsellors should express appreciation of the client as a unique and worthwhile person and embrace the client's ethnic self as well as other experiences that have shaped the client's worldview.

vi) ***Responding Styles***

Counselling is often perceived as just focusing on feelings but it is not true. While counselling helps people work through feelings, how one responds and communicates with others will affect how the counsellor responds to the client. There are different Responding Styles of the clients;

1) Affective Responding. This focuses on feelings;
2) Behavioural Responding. This focuses on actions and behaviours;
3) Cognitive Response. This focusses on thoughts and cognitions. The counsellor will balance these throughout the session with a client.

vii) ***Immediacy***

This involves a counselor's understanding and communicating of what is going on between the counsellor and client within the helping relationship.

There are 2 types of immediacy

1) Relationship immediacy. (Between client & counsellor); 2)
2) "Here & Now" immediacy focuses on some particular event in the session.

viii) ***Humor***

Humor can have a positive effect on the counselling process when used properly. It must be used with sensitivity and timing. It does not demean and is supportive. A session is not a time to try out a new joke heard at lunch.

ix) ***Confrontation***

This is not skill at putting the client down for doing something wrong. This is an invitation to the client to look more closely at behaviour that is not working or interfering with growth, change, or healthy functioning.

x) ***Transference and Counter-transference***

A concept as old as Freud, transference and counter-transference are issues that affect all forms of counselling, guidance, and psychotherapy.

Transference: This is the client's projection of past or present feelings, attitudes, or desires onto the counsellor. It can be direct or indirect and will cause the client to react to the counselor as they would in the past or present relationship.

Counter-transference: This is the counsellor's projected emotional reaction to or behaviour towards the client. It can take on many forms, from a desire to please the client, to wanting to develop a social or sexual relationship with the client. When this happens, supervision or counseling for the counsellor is called for.

2.2.8 Terminating a Relationship

Termination is an important, though often misunderstood phase of counselling. This is often ignored or taken for granted. Yet successful termination is vital for the well being of client as well as counsellor. Termination is the end of the professional relationship with the client when the session goals have been met. It is a phase of counselling that can determine the success of all previous phases and must be handled skillfully. A formal termination serves three functions:

- Counselling is finished and it is time for the client to face their life challenges.
- Changes which have taken place have generalised into the normal behaviour of the client.
- The client has matured and thinks and acts more effectively and independently.

Timing of Termination

There is no one answer when termination is to take place. Questions the counselor may wish to ask concerning termination include:

- Have clients achieved behavioural, cognitive, or affective goals?
- Can clients concretely show where they have made progress in what they wanted to accomplish?
- Is the counselling relationship helpful?
- Has the context of the initial counselling arrangements changed?

Resistance to Termination

Clients and Counsellors may not want counseling to end. In many cases this may be the result of feelings about the loss and grief or insecurities of losing the relationship. For clients, this is something to process. For counsellors, this is an issue for supervision.

Premature Termination

Client

Many clients may end counselling before all goals are completed. This can be seen by not making appointments, resisting new appointments etc. It is a good idea to try and schedule a termination/review session with the client so closure may take place. At this time a referral may be in order.

Counsellors

At times, counsellors have to end counselling prematurely. Whatever the reason for the termination, a summary session is in order and referrals are made, if appropriate, to another counsellor.

Referrals

At times, a counsellor needs to make a referral. When this is done, specific issues need to be addressed with the client.

Reasons for the referrals

Note specific behaviours or actions which brought the need for a referral.

Have the names of several other counsellors ready for referral.

It is important to remember that the counselor cannot follow up with the new counsellor to see if the client followed through (Confidentiality issue).

Follow Up

At times, a follow-up may be scheduled for various reasons including evaluation, research, or checking with client. It needs to be scheduled so as to not take the responsibility of change away from the client.

Self Assessment Questions

1) List out the things to be taken care of during the first stage of developing a relationship.

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2) Describe the different core conditions necessary for successful counselling.

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3) Describe the different responding styles of the client.

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4) Discuss the different issues related to terminating a relationship.

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5) When does premature termination occur? What are the things to be kept in mind during premature termination.

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2.3 FACTORS INFLUENCING COUNSELLING PROCESS

The counselling process is influenced by several factors. The counselor need to know these so that he can help it becto make the counseling time a productive one both for the client and counsellor. The major factors which influence the counselling process are as follows.

2.3.1 Structure

Structure in counselling is defined as the "joint understanding between the counsellor and client regarding the characteristics, conditions, procedures, and parameters of counselling" (Day & Sparacio, 1980, p.246). It helps in clarify the counsellor client relationship and give it direction. It protects the rights, roles and obligations of both counsellors and clients and ensure the success of counselling.

Structure gives form to what the formal process will look like. Practical guidelines are part of building structure. They include time limit of the session, action limits for the prevention of destructive behaviour, role limits and procedural limits. Counselling moves forward when client and counsellor know the boundaries of the relationship and what is expected.

Structure is provided throughout all stages of counselling but is especially important at the beginning. Its importance is most obvious when the client arrives for counselling with unrealistic expectations or with no idea what to expect. Counsellors need to stay flexible and continually negotiate the nature of structure with their clients.

2.3.2 Initiative

Initiative can be thought of as the motivation to change. Majority of the clients who visit the counsellors are reluctant to some degree. Such clients lack initiative. Some counsellors become impatient, irritated and insensitive and may ultimately give up trying to work with such clients. Many counsellors end up blaming either themselves or their clients. A role reversal exercise can help the counsellor to understand the mental state of the involuntary, reluctant and resistant client.

A reluctant client is one who has been referred by the third party and is frequently unmotivated to seek help. They do not wish to be in counselling. Many reluctant clients terminate counselling pre maturely and report dissatisfaction with the process.

A resistant client is one who is unwilling or opposed to change. Such an individual may actively seek counselling but does not wish to go through the pain that change demands.

There are several ways in which counsellors can help clients to win the battle for initiative and achieve success in counselling. One way is to anticipate the anger, frustration and defensiveness that some clients display. A second way is to show acceptance, patience, and understanding as well as non judgmental attitude. A third way is to use persuasion and the fourth way is through confrontation.

2.3.3 Setting

Counselling can happen anywhere, but some physical settings promote the process better than others. Among the most important factors that help or hurt the process is the place where the counselling occurs. The room should be comfortable and attractive with soft lighting, quiet colors, an absence of clutter, and harmonious and comfortable furniture. The professional generally works in a place that provides Privacy, Confidentiality, Quiet and Comfort. When working with a client, youthe counselor must want to send a message that he is listening. This can be done by being attentive both verbally and nonverbally. A distance of 30 to 39 inches is the average range of comfort between counsellor and clients of both genders.

In addition to the above arrangements the counsellors should not be interrupted during sessions. The counsellor should keep in mind the SOLER technique. SOLER is an acronym which serves to remind the counselors how to listen:

S: Face the client squarely*;* that is, adopt a posture that indicates involvement.

O: Adopt an open posture. Sit with both feet on the ground to begin with and with your hands folded, one over the other.

L: As you face your client, lean toward him or her. Be aware of their space needs.

E: Maintain eye contact. Looking away or down suggests that you are bored or ashamed of what the client is saying. Looking at the person suggests that you are interested and concerned.

R: As the counselor incorporates these skills into the attending listening skills, relax.

2.3.4 Client Qualities

Counselling relationship starts with first impressions. The way the counsellor and the client perceive one another is vital to the establishment of a productive relationship. Counsellors generally like to work with clients who are most like them. They are influenced by the physical characteristics of one's best work to all clients.

The client: Clients come in all shapes and sizes, personality characteristics, and degree of attractiveness. The most successful candidates are said to be YAVIS: Young, Attractive, Verbal, Intelligent, and Successful (Schofield, 1964). Less successful clients are seen as HOUND: Homely, Old, Unintelligent, Nonverbal, and Disadvantaged; or DUD: Dumb, Unintelligent and Disadvantaged (Allen, 1977).

A counsellor must consider a client's body gestures, eye contact, facial expressions and vocal quality to be as important as verbal communication. Cultural background of the client should keep in mind while evaluating the non verbal communication.

2.3.5 Counsellors Qualities

The personal and professional qualities are very important in building up relationship with the client. Okun (1992) lists five important characteristics that counsellors must possess:

- Self awareness,
- Honesty,
- Congruence,
- Ability to communicate, and
- Knowledge.

Clients depending on their culture initially like to work with counsellors who are perceived as Experts, Attractive and Trustworthy. Expertness is the degree to which a counsellor is perceived as knowledgeable and informed about his or her specialty. Attractiveness is a function of perceived similarity between a client and a counsellor. Counsellors can make themselves attractive by speaking in clear, simple sentences and offering appropriate self disclosure. Trustworthiness is related to the sincerity and consistency of the counsellor. The counsellor is genuinely concerned about the client and shows it over time by establishing a close relationship with the client.

Self Assessment Questions

1) Describe the importance of providing structure to the counselling process.

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2) Describe the different aspects related to the setting of counselling.

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2.4 LET US SUM UP

The process of counselling develops in definable stages with recognisable transitions. There is a natural progression that takes place within the context of the helping relationship. There are certain important factors that influence the counselling process. The major are: Structure, Initiative, Setting, Client Qualities, and Counselor Qualities. The process of counselling occurs in stages like, developing a relationship, working in a relationship, terminating a relationship. The counsellor has to keep certain tasks in mind such as laying foundations for trust, establishing the structure and form the relationship will take, in its first stage of building relationship. Empathetic understanding, Unconditional positive regard and Congruence are certain core conditions which are mandatory for successful counselling. The last phase includes termination which is the end of the professional relationship with the client when the session goals have been met. It is a phase of counselling that can determine the success of all previous phases and must be handled skillfully. Counselling can not be considered complete and successful without the follow-up procedure.

2.5 UNIT END QUESTIONS

1) Differentiate between a reluctant and a resistant client.

2) What is SOLER technique?

3) List qualities of a client needed for successful counselling relationship.

4) What is transference and counter transference?

5) Explain Empathy and its components.

6) Discuss the significance of termination in counselling relationship.

2.6 SUGGESTED READINGS

Corey, G. (2008): *Theory and Practice of Counseling and Psychotherapy*. USA: The Thompson Brooks.

Welfel & Peterson (2004): *The Counseling Process: a Multi-theoretical Integrative Approach.* Thomson/Brooks/Cole.

Narayana Rao (2008): *Counseling and Guidance*. New Delhi: Tata Mc-Graw Hill.

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UNIT 3 THEORETICAL APPROACHES TO COUNSELING

Structure

3.0 INTRODUCTION

In this unit we will be dealing with theoretical approaches to counseling. We start with psychoanalytic and Adlerian Approach, and put forward the view of human nature within which the concepts of psychoanalytical theory such as the id, ego and super ego are presented. Then we take up the role of counselor in psychoanalytical approach the goals and techniques in which we present the free association, dream analysis, analysis of transference and interpretation. Then we take up the phenomenological approach that is of Adler and discuss the theory ion terms of counseling. We consider the view of human nature in this theory, the role of counselor, goals of the phenomenological approach and the techniques thereof. This is followed by person centered, Existential and Gestalt Approaches and here woo we consider the view of human nature and indicate how it is differently viewed as compared to the psychoanalytical theory. We then consider the role of counsellor in person centered approach the goals and techniques in the same. The next section deals with rational emotive therapy and transactional analysis and how these are used in counseling. Finally we take up the behavioural approach, its principles, goals and techniques. Then we take up the reality therapy and discuss how counselors use the same.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the need of theoretical approaches to counseling;

- Define psychoanalytic approach to counseling;
- Differentiate between cognitive and behavioural approach to counseling;
- Explain the views of human nature proposed by different approaches;
- Distinguish the role of a counselor in different counseling techniques; and
- Explain the techniques used in different theoretical approaches.

3.2 PSYCHOANALYTIC AND ADLERIAN APPROACH

There are many theoretical models of psychology and counselling. Some are best utilised for particular situations and needs. Often, an eclectic approach, or the utilisation of several approaches is best for the resolution of problems. Effective counselors scrutinise all theories and match them to personal beliefs about the nature of people and change. Since the 1950s, psychologists have adopted a number of diverse approaches to understanding human nature and behaviour. Most counselling approaches fall within four broad theoretical categories: psychoanalytic, affective, cognitive and behavioural. In addition to these, there are Cognitive Behavioural approaches also which are gaining importance in recent years.

Different approaches exist because there are different ways of explaining the phenomena, for example, emotions can be explained in terms of the thoughts associated with them or the physiological changes they produce. Psychologists try to explain psychological phenomena from a range of different perspectives, and so use different approaches.

3.2.1 Psychoanalytic Approach

This approach developed by Sigmund Freud in the early 1900s, involves analysing the root causes of behaviour and feelings by exploring the unconscious mind and the conscious mind's relation to it. Psychoanalysis can take on a variety of forms, varying from practitioner to practitioner. 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.

Psychoanalysis focuses on an individual's unconscious, deep rooted thoughts that often stem from childhood. Through free association, dreams or fantasies, clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

i) ***View of Human Nature***

The Freudian view of human nature is dynamic. According to him, human nature could be explained in terms of a conscious mind, a sub conscious and an unconscious mind. The conscious mind is attuned to the events in the present, to an awareness of the outside world. The subconscious mind is an area between the conscious and unconscious mind which contains aspects of both. Within the subconscious are hidden memories or forgotten experiences that can be remembered if a person is given the proper cues. Finally beneath the subconscious mind is the unconscious mind, the most powerful and least understood part of

the personality. The instinctual, repressed and powerful forces of the personality exist in the unconscious.

ii) ***Id, Ego and Super Ego***

Id is a concept equivalent to a demanding child and it is ruled by the pleasure principle. It refers to the raw, unorganised, inherited part of the personality. Its main goal is to reduce tension created by our primitive drives such as hunger, sex, aggression and irrational impulses.

Ego is a concept analogous to a traffic policeman and it is ruled by the reality principle. Ego's job is to meet the needs of the id, while taking into consideration the reality of the situation. The ego is sometimes called "the executive" of an individual's personality. It is responsible for the higher cognitive functions such as intelligence, thoughtfulness and learning.

Superego is the third concept which can be equaled to that of a judge and it is ruled by the moral principle. Superego represents the rights and wrongs of the society. It has two subparts: the conscience and the ego-ideal. The conscience prevents us from doing morally wrong or bad things. The ego ideal is that part of the superego that includes the rules and standards for good behaviours. These behaviours include those that are approved of by parental and other authority figures. Obeying these rules leads to feelings of pride, value, and accomplishment. The ego ideal motivates the person to do what is morally proper. The superego helps to control the id impulses, making them less selfish and more morally correct.

iii) ***Ego-Defense Mechanisms***

Ego-defense mechanisms are normal behaviours which operate on an unconscious level and tend to deny or distort reality. They help the individual to cope up with anxiety and prevent the ego from being overwhelmed. They have adaptive value if they do not become a style of life to avoid facing reality. Some of the major defense mechanisms described by psychoanalysts are the following:

1) **Repression:** It is the withdrawal of an unwanted idea, affect, or desire from consciousness by pushing it down, or repressing it, into the unconscious part of the mind.

2) **Reaction formation:** It is the fixation of an idea, affect, or desire in consciousness that is opposite to a feared unconscious impulse.

3) **Projection:** It is a form of defense in which unwanted feelings are displaced onto another person.

4) **Regression:** When confronted by stressful events, people sometimes abandon coping strategies and revert to patterns of behaviour used earlier in development.

5) **Sublimation:** It is the diversion or deflection of instinctual drives, usually sexual ones, into non-instinctual channels. It allows us to act out unacceptable impulses by converting these behaviours into a more acceptable form.

6) **Denial:** It is used to describe situations in which people seem unable to face reality or admit an obvious truth.

7) **Rationalisation:** It is the substitution of a safe and reasonable explanation for the true, but threatening cause of behaviour.

8) **Displacement:** Displacement involves taking out our frustrations, feelings and impulses on people or objects that are less threatening.

9) **Intellectualisation:** It allows us to avoid thinking about the stressful, emotional aspect of the situation and instead focuses only on the intellectual component.

iv) ***Role of a Counselor***

Counselors who practice psychoanalysis play the role of experts. They encourage their clients to talk about whatever comes in their mind, especially childhood experiences. After a few face to face interactions such an environment is created, often have the client lie down while the analyst remains out of view, in which the client feels free to express difficult thoughts. The role of the analyst is to let the clients gain insight by reliving and working through the unresolved past experiences that come into focus during sessions. The development of transference is encouraged to help clients deal realistically with unconscious material. Psychoanalytic counselors also use diagnostic labels to classify clients and help develop appropriate plans for them.

v) ***Goals***

The goal of psychoanalysis varies according to the client, but they focus mainly on personal adjustment, usually inducing a reorganisation of internal forces within the person. In most cases, a primary goal is to help the client become more aware of the unconscious aspects of his or her personality, which include repressed memories and painful wishes. A second major goal is to help a client work through a developmental stage, not resolved in primary goal. If accomplished, clients become unstuck and are able to live more productively. A final goal is helping clients cope with the demands of the society in which they live. Psychoanalysis stresses environmental adjustment, especially in the areas of work and intimacy.

vi) ***Techniques***

Free Association: Client reports immediately without censoring any feelings or thoughts. The client is encouraged to relax and freely recall childhood memories or emotional experiences. In this way, unconscious material enters the conscious mind, and the counselor interprets it. At times clients resist free association by blocking their thoughts or denying their importance. Psychoanalysts make the most of these moments by attempting to help clients work through their resistance.

Dream Analysis: Dream analysis is considered the first scientific approach to the study of dreams. In this clients report dreams to counselor on regular basis. Freud believed that dreams were a main avenue to understanding the unconscious. Counselor uses the “royal road to the unconscious” to bring unconscious material to light. Clients are encouraged to remember dreams. The counselor analyse two aspects; The Manifest Content (obvious meaning), and the Latent Content (hidden but true meaning).

Analysis of Transference: Transference is the client’s response to a counselor as if the counselor were some significant figure in the client’s past, usually a parent figure. This allows the client to experience feelings that would otherwise be inaccessible. The counselor encourages this transference and interprets positive or negative feelings expressed. Analysis of transference allows the client to achieve insight into the influence of the past. Counter-transference: It is the reaction of the counselor towards the client that may interfere with objectivity.

Interpretation: Interpretation should consider part of all above mentioned techniques. When interpreting, the counselor helps the client understanding the meaning of the past and present personal events. It consists of explanations and analysis of a client's thoughts, feelings and actions. Counselor points out, explains, and teaches the meanings of whatever is revealed. Counselors must carefully time the use of interpretation.

3.2.2 The Phenomenological (Adlerian) Approach

Alfred Adler attempts to view the world from the client's subjective frame of reference e.g. how life is in reality is less important than how the individual believes life to be. 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.

i) ***View of Human Nature***

He emphasised that it is not the childhood experiences that are crucial but it is our present interpretation of these events. He thought that people are primarily motivated by social interest. It is Adler's most significant and distinctive concept which refers to an individual's attitude toward and awareness of being a part of the human community. He measured mental health by the degree to which we successfully share with others and are concerned with their welfare. He explained how happiness and success are largely related to social connectedness.

Another major component of his theory is that people strive to become successful. Each person strives for growth and has a need for wholeness. If this need is fulfilled, the person develops a superiority complex otherwise the person can develop inferiority complex. His theory places considerable emphasis on birth order and sibling relationships. Adler's explained five psychological positions:

Oldest child receives more attention, spoiled, center of attention.

Second of only two behaves as if in a race, often opposite to first child.

Middle often feels squeezed out.

Youngest is being considered as the baby.

Only - does not learn to share or cooperate with other children, learns to deal with adults.

ii) ***Role of Counselor***

Adlerian counselors function primarily as diagnosticians, teachers and models in equalitarian relationships they establish with their clients. They try to assess why clients are oriented to a certain way of thinking and behaving. The counselor makes an assessment by gathering information on the family constellation and client's earliest memories. The counselor then shares interpretations, impressions, opinions and feelings with clients. The client is encouraged to examine and change a faulty life style by developing social interest.

iii) ***Goals***

The goals of Adlerian counseling revolve around helping people develop healthy life styles. One of the major goals is to develop social interest. The four major goals of the therapeutic process:

- Establishment and maintenance of an egalitarian counseling relationship.
- Analysis of a client's life style.
- Interpretation of client's life style in such a way that [promotes insight].
- Re-orientation and re-education of the client with accompanying behaviour change.

iv) ***Techniques***

To establish above mentioned goals and to accomplish behaviour change, counselors use following techniques:

1) Confrontation: The counselor challenges clients to consider their own private logic. When clients examine this logic, they often realise they can change it and their behaviour.

2) Asking the question: The counselor asks, "what would be different if you were well?' The question is often asked during the initial interview, but it is appropriate any time.

3) Encouragement: Counselors encourage their clients by stating their beliefs that behaviour change is possible. It is the key to make productive life style changes.

4) Acting "as if": Clients are instructed to act as if they are the persons they want to be.

5) Task Setting: Clients initially set short term range, attainable goals and eventually work up to long term and realistic objectives.

6) Catching oneself: Clients learn to become aware of self destructive behaviours or thoughts. At first counselor may help in this process, but eventually this responsibility is taken over by clients.

7) Push Button: Clients are encouraged to realise that they have choices about what stimuli in their lives they pay attention to. The technique is like pushing the button because clients can choose to remember negative or positive experiences.

Self Assessment Questions

1) Differentiate between id, ego and superego.

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2) Describe the different defense mechanisms.

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3) Explain the different types of goals in psychoanalysis.

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4) How does Adlerian approach view human nature?

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5) Describe the importance of birth order and sibling relationship in Adlerian theory.

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3.3 PERSON-CENTERED, EXISTENTIAL AND GESTALT APPROACHES

3.3.1 Person Centered Approach

Person-Centered approach, founded by Carl Rogers in the 1940's, is based on the belief that people have the capacity and the right to move toward self-actualisation. This approach views people as rational, forward-moving, and realistic beings. He contended that negative, antisocial emotions are the result of frustrated basic impulses.This approach views the client as their own best authority on their own experience, and the client is fully capable of fulfilling their own potential for growth.

i) ***View of Human Nature***

Rogers believed that people are essentially good. Humans are characteristically positive, forward- moving, constructive, realistic and trustworthy. 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 approach is often considered the most optimistic approach to human potential.

Rogers views the individual from a phenomenological perspective, that is according to him the important aspect is the person's perception of reality rather than an event itself. His ideas are often referred to as "Self Theory". The self is an out growth of what a person experiences, and an awareness of self helps a person differentiate him or herself from others.

ii) ***Role of a Counselor***

The counselor's role is a holistic one. He or she sets up and promotes a climate in which the client is free and is encouraged to explore all aspects of self. The counselor strives to develop a greater degree of independence and integration for individuals in their surroundings and the people in their lives. Clients are prepared to be open to the experience of counseling, to have trust in themselves, to evaluate themselves internally, and pursue a willingness towards continued growth. Clients will experience this technique differently depending on perceptions of both the past and the possibilities of future events. Exploring a wider range of beliefs and feelings help clients in this process. It helps clients to better appreciate who they are and what they are capable of accomplishing.

iii) ***Goals***

The goals of person centered counseling considers the client as a person, not his or her problem. Rogers emphasises that people need to be assisted in learning how to cope with situations. The client moves towards the goals of realisation, fulfillment, autonomy, self determination, and perfection by becoming more realistic in their perceptions. The aim is to make them more confident, more self directed, more positively valued by themselves and less likely to be upset by stress. They should be healthier, integrated, and well functioning persons in their personality structure.

iv) ***Techniques***

The counselor as a person is vital to person centered counseling. Counsellors display openness, empathic understanding, independence, spontaneity, acceptance, mutual respect and intimacy. They encourage clients to work toward achieving these same conditions as ultimate counselling goals. The primary techniques are the counsellor's attitudes toward people in the following:

1) **Unconditional positive regard:** It means that the counsellor accepts the client unconditionally and non judgmentally. The client is free to explore all thoughts and feelings, positive or negative, without danger of rejection or condemnation. Crucially, the client is free to explore and to express without having to do anything in particular or meet any particular standards of behaviour to 'earn' positive regard from the counsellor.

2) **Empathic understanding:** It means that the counsellor accurately understands the client's thoughts, feelings, and meanings from the client's own perspective. When the counsellor perceives what the world is like from the client's point of view, it demonstrates not only that that view has value, but also that the client is being accepted.

3) **Congruence:** It means that the counsellor is authentic and genuine and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counsellor is 'really like'.

Rogers mentioned the following six core conditions for personality change:

- Two persons are in psychological contact.
- The client is in a state of incongruence.
- The counsellor is congruent and involved in the relationship.
- The counsellor experiences unconditional positive regard for the client.
- The counsellor experiences understanding of the client's frame of reference.
- The communication of empathic and positive regard is achieved.

Methods that help promote the counselor client relationship include:

- Active and passive listening
- Reflection of thoughts and feelings
- Clarification
- Summarizing
- Confrontation of contradictions
- General or open leads that help client self exploration.

3.3.2 Existential Approach

Existential approach can be described as a philosophical approach that is not designed to cure people but instead helps the client reflect and search for value and meaning in life. Existentialism understands the human to be challenged by the reality of temporary existence, and the view that life has no inherent meaning and that the meaning had to be constructed. Authentic human beings are those who could face existential futility and yet still go on to construct a meaningful life.

The existential perspective was introduced into the US by Rollo May. He believed that individuals can only be understood in terms of their subjective sense of self. May was concerned with people's loss of faith in values. If we lose our commitment to a set of values we will feel lonely and empty. Life will be meaningless. Viktor Frankl, a famous existentialist, believed that the prime motive of human behaviour is the "will to meaning". In order to find a meaning in our troubled existence we need to discover meaning through values and we discover our values through work, through love for others and through confrontation with our own suffering.

i) ***View of Human Nature***

According to the existentialists, human beings form their lives by the choices they make. They focus on the freedom of choice and the action that goes with it.

We have no existence apart from the world. Being in the world is man's existence. The basic issue in life is that life inevitably ends in death. Thus we experience angst or anguish because of our awareness of death's inevitability. According to Frankl (1962), the meaning of life always changes but it never ceases to be. We can discover life's meaning in three ways:

- By doing a deed. That is, by achieving or accomplishing something.
- By experiencing a value. As for instance experience the value of work of nature, culture or love.
- By Suffering. That is, finding a proper attitude towards unalterable fate.

ii) ***Role of a Counsellor***

Existential counsellors are focused on helping the client achieve and expand their self awareness. It is assumed that once self awareness is achieved the client can examine new ways of dealing with problems and accept the responsibility of choosing. The role of the counsellor is to facilitate the client's own encounter with himself or herself, to work alongside him in exploring and understanding better his values, assumptions and ideals. The counsellor is concerned about what matters most to the client and to avoid imposing her own judgments, and to help the client to elaborate on his own perspective.

The counsellor's responsibility is to be aware of his or her own biases and prejudices. The counsellors' goal is to understand the client's meaning rather than their own and recognising the client's assumptions and underlying life themes. The counsellor must be sensitive to and help the client explore his weaknesses, limitations and responsibilities as well as his strengths, opportunities and freedoms.

iii) ***Goals***

The goal of this technique is not to cure people of disorders, not to simply get rid of symptoms. Rather it is to help them become aware of what they are doing and encourage them to act, make life changing decisions etc. It is aimed at helping people get out of their rigid roles and see more clearly the ways in which they have been leading a narrow and restricted existence. The specific goals of existential counselling are:

- To enable people to become more truthful with themselves.
- To help the clients to reflect upon and understand their existence.
- To increase self awareness and authentic living.
- To take responsibility for decisions.
- To encourage clients to find their own meanings and truths.
- To help people examine roots of some of their anxieties and learn how to better cope with them.
- To get the person to believe to experience life and to live more fully in each moment

iv) ***Techniques***

Existential therapy is not considered as a system of highly developed techniques. Subjective understanding of clients is primary and techniques are secondary. It

is not technique oriented. The interventions are based on philosophical views about the nature of human existence. It is free to draw techniques from other orientations. The use of counsellor's self is the core of therapy. It is commonly integrated within other frameworks.

The most effective and powerful technique counsellors have is the relationship with the client. They also make use of confrontation. Existential counsellors borrow some techniques such as imagery exercises, awareness exercises goal setting activities etc., from other models.

3.3.3 Gestalt Approach

Gestalt approach is an integrative orientation in that it focuses on whatever is in the client's awareness. This term was first used as the title of a book, written by Fritz Perls, et.al (1951), " Gestalt," a German word meaning "whole" . It operates as a therapy by keeping the person in what is known as the here and now. In this approach, feelings, thoughts, body sensations and actions are all used as a guide to understanding what is central for the client in each moment. The centrality of whatever is in the client's awareness is an ideal way to understand the world of the client. Unresolved conflicts are worked out in the counseling session as if they are happening in that moment. An emphasis is placed on personal responsibility for one's own well being.

i) ***View of Human Nature***

Human nature is rooted in existential philosophy, phenomenology, and field theory. Individuals have the capacity to self regulate in their environment. Gestalt counsellors believe that human beings work for wholeness and completeness in life. Self actualising tendency emerges through interaction in environment. Each person tries to integrate self into healthy, unified whole. Overdependence on intellectual experience and inability to resolve unfinished business causes problems, such as the client may lose contact with environment, or become over involved, may encounter unfinished business, or become fragmented.

ii) ***Role of a Counselor***

Gestalt counsellor can help their client to both work through and move beyond their painful emotional blocks. By following their client's ongoing process, with special attention to both the therapeutic relationship and the client's style of interrupting that process, the counsellor uses appropriate techniques. The counsellor must pay attention to clients' awareness, to clients' body language, nonverbal language, and inconsistence between verbal and nonverbal message (e.g., anger and smile). The counselors must create atmosphere that promotes growth. The counselor is exciting, energetic, fully human and personally involved.

iii) ***Goals***

The main goal is to increase the client's awareness of "what is." Awareness includes knowing the environment, knowing oneself, accepting oneself, and being able to make contact. Stay with their awareness, unfinished business will emerge. Change occurs through a heightened awareness of what the client is experiencing moment to moment. The approach stresses present awareness and the quality of contact between the individual and the environment.

Four Major Principles of Gestalt Therapy are:

Holism interested in the whole person emphasis on integration thoughts, feelings, behaviours, body, & dreams.

Field Theory organism must be seen in its environment or its context as part of a constantly changing filed-relational, in flux, interrelated and in process

Figure Formation Process how individual moment to moment organises environment:

1) Background=undifferentiated field or ground
2) Figure=Emerging focus of attention
3) Organismic self-regulation =-restore equilibrium or contribute to growth and change

iv) ***Techniques***

Some of the most innovative techniques ever developed are found in Gestalt therapy. These techniques take two forms:

i) Exercise and

ii) Experiments.

Exercises are readymade techniques such as enactment of fantasies, role playing, psychodrama, dream work, empty chair, confrontation such as what and how, making the rounds, exaggeration.

Experiments on the other hand are activities and grow out of the interaction between counsellor and clients. They are not planned. The experiments are to assist clients self awareness of what they are doing and how they are doing it.

Gestalt experiments include the following:

- Internal dialogue exercise,
- Making the rounds,
- Reversal technique,
- Rehearsal exercise,
- Exaggeration exercise,
- Staying with the feelings.

Self Assessment Questions

1) Discuss the role of counselor in the person-centred approach.

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2) Describe the goals of counseling in existential approach.

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3) Explain the major principles of Gestalt therapy.

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3.4 RATIONAL EMOTIVE THERAPY AND TRANSACTIONAL ANALYSIS

3.4.1 Rational Emotive Therapy

Albert Ellis started Cognitive Behaviour Therapy in 1955. This technique assumes that cognitions, emotions, and behaviours interact and have a reciprocal cause and effect relationship. It is very directive and concerned as much with thinking as with feeling. It also teaches that our emotions stem mainly from our beliefs, evaluations, interpretations, and reactions to life situations. It is an educational process in which clients learn to identify and dispute irrational beliefs that are maintained by self indoctrination and replace ineffective ways of thinking with effective and rational cognitions.

i) ***View of Human Nature***

RET assumes that we all are born with a potential for both rational and irrational thinking. There is a biological and cultural tendency to think crookedly and to needlessly disturb ourselves. Humans are self talking, self evaluating and self sustaining. We develop emotional and behavioural problems when we mistake simple preferences (love, approval, success) for dire needs. There is a tendency to invent disturbing beliefs and keep ourselves disturbed through our self talk. Humans have the capacity to change their cognitive, emotive, and behavioural processes.

ii) ***Role of a Counsellor***

Counsellors are active and direct in this approach. They act as instructors who teach and correct client's cognitions. Therefore they must listen carefully for illogical and faulty statements from the clients and challenge their beliefs. The counsellor focusses on the thoughts and beliefs of the client trying to identify those, which create problems. Ellis identifies several characteristics desirable for counsellors.

They need to be:

- bright,
- knowledgeable,
- empathetic,
- persistent, and
- scientific.

iii) ***Goals***

The primary goal of RET is to focus on helping people realise that they can live more rational and productive lives and to change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schema restructuring. Another goal of RET is to help people change self defeating habits of thought or behaviour. One way of teaching them through ABC of RET

A = existence of fact, event, behaviour, attitude of individual.

B = person's belief

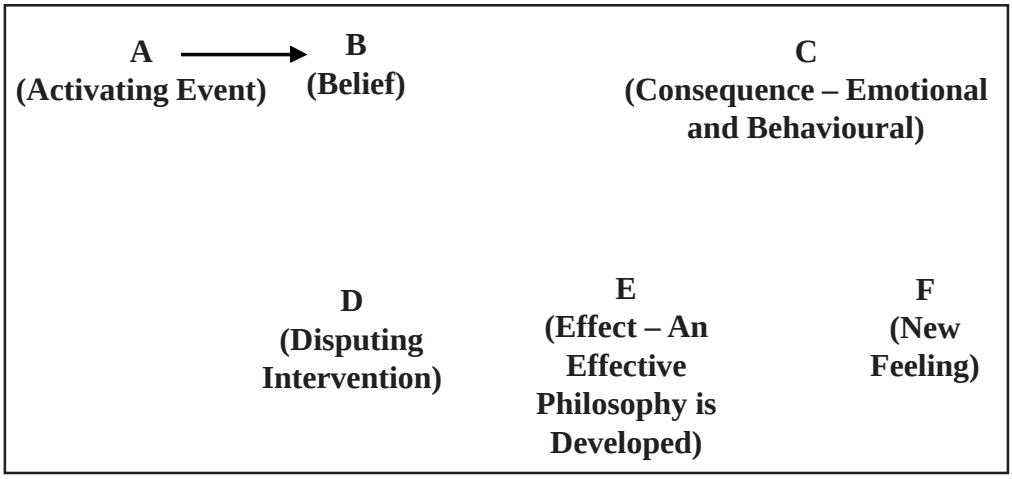
C = emotional & behavioural consequence or reaction of individual

D = disputing intervention-challenge beliefs

E = effective philosophy after disputing

F = new set of feelings

Human beings are largely responsible for creating their own emotional reactions and disturbances. Goal is to show people how to change irrational beliefs that directly "cause" disturbed emotional consequences.



iv) ***Techniques***

RET encompasses a number of diverse techniques. Two primary ones are teaching and disputing. In the first few sessions, counsellors teach their clients the anatomy of an emotion, that feelings are a result of thoughts, not events and that self talk influences emotion. Disputing thoughts take one of three forms: cognitive, imaginal and behavioural.

Cognitive disputation involves the use of direct questions, logical reasoning, and persuasion. It also uses syllogisms, that is a deductive form of reasoning.

Imaginal disputation depends on the client's ability to imagine and explore a technique known as rational emotive imagery (REI).

Behavioural disputation involves behaving in a way that is opposite of the client's usual way. Two other powerful techniques are confrontation and encouragement.

3.4.2 Transactional Analysis

Transactional analysis is another cognitive theory formulated by Eric Berne in the early 1960s. He believed that the majority of our life experiences are recorded in our subconscious minds in an unaltered fashion and become a part of the way we behave. The behaviour is subconsciously designed to get reactions and determine how others feel about us. It is a method of dealing with behavioural disorders and can be used to manage classroom behaviour if we understand that children's acceptable and unacceptable behaviour is designed to ascertain how others feel about them. He believed that there were three states of mind in all humans, no matter how old they were, called the ego states.

Berne believed that a lot of people get stuck in one ego state more than the other two and that this may be due to early childhood experiences. His theory was that in childhood we have a life position assigned to us, because of the experiences we have from birth onwards. He thinks there are four possible life positions:

I'm not OK, You're OK;
I'm not OK, You're not OK;
I'm OK, You're not OK;
I'm OK, You're OK.

i) ***Views of Human Nature***

Transactional analysis is an optimistic theory based on the assumption that people can change despite an unfortunate events of the past. It focuses on four methods of understanding and predicting human behaviour:

- Structural analysis: understanding what is happening within the person.
- Transactional analysis: describing what happens between two or more people
- Game analysis – understanding transactions that lead to bad feelings
- Script analysis – understand a person's life plan

ii) ***Role of a Counsellor***

The counsellor initially plays the role of a teacher. The counsellor helps the client obtain the tools necessary for change in the present. Counsellors work contractually on solving "here and now" problems and focuses on creating productive problem solving behaviours. Using transactional analysis, counsellors establish an egalitarian, safe and mutually respectful working relationship with their clients. This working relationship provides tools which the clients can utilise in their day to day functions to improve the quality of their lives.

iii) ***Goals***

The primary goal of TA focuses on helping clients transform themselves from "frogs" into "princes and princesses".

Others goals are:

- to learn the language and concepts underlying Transactional analysis,
- to learn analyse relationships with one another in terms of TA, and
- to develop our ability to engage in straight, effective communication with one another on a daily basis.

iv) ***Techniques***

TA has initiated a number of techniques for helping clients to reach their goals. The most common are structural analysis, transactional analysis, game analysis and script analysis. Other techniques include: Treatment Contract, Interrogation, Specification, Confrontation, Explanation, Illustration, Confirmation, Interpretation and Crystallisation.

Self Assessment Questions

1) Describe the assumptions of Rational Emotive Therapy about human nature.

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2) Explain the A B C D E F model of Rational Emotive Therapy.

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3) Describe the four life positions as mentioned in transactional analysis.

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3.5 BEHAVIOURAL APPROACH

This approach is based on the premise that primary learning comes from experience and applies learning principles to the elimination of unwanted behaviours. The initial concern is to help the client analyse behaviour, define problems, and select goals. Behavioural Therapy is effective for individuals who

require treatment for some sort of behaviour change, such as addictions, phobias and anxiety disorders. It concentrates on the 'here and now' without focusing on the past to find a reason for the behaviour. The behavioural approach says that people behave in the way that their environment has taught them to behave, e.g., through rewards and punishments, modeling, etc. So this approach attempts to change the way the environment reinforces particular behaviour and works at applying learning principles to help people to learn new behaviours by behavioural experiments, role playing, assertiveness training, and self management training.

Four Aspects of Behaviour Therapy

1) **Classical Conditioning**

In classical conditioning certain respondent behaviours, such as knee jerks and salivation, are elicited from a passive organism.

2) **Operant Conditioning**

It focuses on actions that operate on the environment to produce consequences. If the environmental change brought about by the behaviour is reinforcing, the chances are strengthened that the behaviour will occur again. If the environmental changes produce no reinforcement, the chances are lessened that the behaviour will recur.

3) **Social Learning Approach**

It gives prominence to the reciprocal interactions between an individual's behaviour and the environment.

4) **Cognitive Behaviour Therapy**

It emphasises cognitive processes and private events (such as client's self-talk) as mediators of behaviour change.

i) ***View of Human Nature***

As the behaviourist views human nature, humans are neither good nor bad but are living organisms capable of experiencing a variety of behaviours. Their personality is composed of traits. The behaviourist believes that people can conceptualise and control their behaviour and have the ability to learn new behaviours. In addition, people can influence the behaviour of others as well as be influenced by the behaviour of others. Behaviourists concentrate on behavioural processes as they are closely associated with overt behaviour and believe that all behaviour is learned, whether it is adaptive or maladaptive. They also believe that learning and development occur in one of the three ways:

- respondent learning,
- operant conditioning and
- social modeling.

ii) ***Role of a Counsellor***

A counsellor may take one of the several roles, depending on his or her behavioural orientation. The counsellor functions as a consultant, teacher, advisor and facilitator. The behaviour counsellor tries to help the individual to learn new and more adaptable behaviours and to unlearn old non adaptable behaviours. The behaviour counsellor focuses attention on the individual's ongoing behaviours

and their consequences in his own environment. He tries to restructure the environment so that more adaptable patterns of behaviour can be learned and non adaptable patterns of behaviour can be unlearned. An effective behavioural counsellor operates from a broader perspective and involves the client in every phase of counselling.

iii) ***Goals***

Basically behavioural counsellors want to help clients make good adjustments to life circumstances and achieve personal and professional objectives. A major step is to reach mutually agreed upon goals. Blackham and Silberman(1971) suggests four steps in this process:

1) **Defining the problem**

The clients are asked to specify when, where, how and with whom the problem arises.

2) **Take a developmental history**

Knowledge about how the client has handled past circumstances.

3) **Establish specific goals**

Counselors help clients break down goals into small, achievable goals.

4) **Determine the best method for change**

Helping the client to reach desired goal by choosing the appropriate method. Continuous assessment of the effectiveness of method is must.

iv) ***Techniques***

General behavioural techniques are applicable to all behaviour theories, although a given technique may applicable to a particular approach at a given time in a specific circumstance.

Systematic desensitisation: This is a technique used specifically with phobias. It helps the client to pair relaxation with previously feared stimuli.

Aversive therapy: It is almost the opposite of systematic desensitisation and has the client pair some aversive stimuli (e.g., nausea, pain, disturbing images, etc.) with some behaviour that he/she is having difficulty giving up. For example, a person trying to quit drinking might take a drug that makes her nauseous whenever she drinks alcohol. Both systematic desensitisation and aversive therapy make use of classical conditioning learning principles—learning that occurs when things get paired together. Systematic desensitisation "teaches" the client a new thing by pairing relaxation with something they fear whereas Aversive therapy "teaches" a new thing by pairing a bad experience with some behaviour they want to eliminate.

Behaviour Modification programs: These approaches try to increase positive behaviour and decrease negative behaviour by using reinforcements and punishments in the most effective ways based on learning principles. The counselor will try to help the parents identify in what ways the undesired behaviour is being reinforced and eliminate that reinforcement and help them develop ways to reinforce desired behaviour.

Use of Reinforcers: Reinforcers are those events which increase the probability of occurrence of a desired behaviour in the future by applying consequences that depend on the behaviour in question.

Positive Reinforcement: The administration of positive consequences to workers who perform desired behaviours- Pay, promotions, interesting work, praise, awards.

Negative Reinforcement: The removal of negative consequences when workers perform desired behaviours-Nagging, complaining.

Punishment: Administering negative consequences to undesirable behaviours in an effort to decrease the probability that the behaviour will occur again in the future.

Shaping: It is a process in which undifferentiated operant behaviours are gradually changed into a desired behaviour pattern by the reinforcement of success approximations, so that the behaviour gets closer and closer to the target behaviour.

Extinction: When pairing of conditioned and unconditional stimulus stops then association weakens and conditioned response becomes less frequent till it disappears.

Generalisation: Conditioned response occurs in response to stimuli which are similar to the conditioned stimulus.

Discrimination: Conditioned response does not occur to all possible similar stimuli-learned difference between stimuli

The cognitive behavioural approach examines the patient's beliefs and behaviours. Individuals hold beliefs about themselves and relationships that affect behaviour. Negative beliefs lead to maladaptive behaviours. By examining and challenging these beliefs with new information, subsequent new behaviours can change. This approach also examines behaviours directly so that new, more adaptive behaviours can be developed. This approach is especially beneficial for changing habits, learned behavioural patterns, phobias, and many forms of depression.

3.6 REALITY THERAPY

Counselling approach developed by psychiatrist William Glasser helps people gain control over their lives by self-evaluating their behaviour, then choosing behaviour that meets their needs effectively and responsibly. It is based on choice theory that how we deal with unsatisfying relationships. Clients choose their behaviours to cope with unsatisfying relationships (depressing, obsessing, and worrying). We often mistakenly choose misery in our best attempt to meet our needs. We act responsibly when we meet our needs without keeping others from meeting their needs. Two basic needs which are important are:

1) To love and to be loved, and

2) To feel worth.

i) ***View of Human Nature***

William Glasser's Reality technique focuses on consciousness that human beings operate on a conscious level and that they are not driven by unconscious forces

or instincts. A second belief about human nature is that there is a health or growth force within everyone. The force manifests at two levels, viz. (i) physical and (ii) psychological.

Physical needs or survival needs like food, water, shelter etc. are automatically controlled by the body. The four primary psychological needs are:

- Belonging – the need for friends, family and love;
- Power – the need for self esteem, recognition and competition;
- Freedom – the need to make choices and decisions; and
- Fun – the need to play, laughter, learning and recreation.

Behaviour is purposeful because it is destined to close the gap between what we want and what we perceive we are getting. All behaviour has four components:

Acting, Thinking, Feeling, and Physiology

ii) ***Role of a Counsellor***

The counselor basically serves as a teacher and model, accepting the client in a warm and involved way while focusing the client on the control if displayed thoughts and actions. The counsellor assists the client in dealing with present and establishes satisfying relationship. The counsellor is a role model of a human who knows what life is all about and is also one who is successful in dealing with life and not afraid to discuss any subject with their clients, teaches them to behave in more effective ways and helps client look for better choices.

iii) ***Goals***

1) The primary goal of reality technique is to make their clients psychologically strong and rational. They must learn to be responsible for their own behaviour that affects themselves and others.
2) The second goal is to help clients in knowing what they want in life. It is vital to know the goals of life if we want to act responsibly.
3) Other goals are to help clients to get connected or reconnected with people they have chosen to place in their quality world;
4) To teach clients choice theory and to teach client to behave in more effective ways.

iv) ***Technique***

Reality therapy is an action oriented technique. Some of its more effective and active techniques are:

- teaching,
- employing,
- humor,
- confrontation,
- role playing,
- involvement and
- contracts.

It uses the WDEP system (Given in the box).

W. Wants: What do you want to be and do?

D. Doing and Direction: What are you doing? Where do you want to go?

E. Evaluation: Does your present behaviour have a reasonable chance of getting you what you want?

P: Planning – "SAMIC"- Simple, Attainable, Measurable, Immediate and Controlled.

There are eight steps in reality therapy that strategically incorporates its goals and techniques and these are given below:

1) Develop a relationship with client. (Involvement).
2) Focus on behaviour. Ask "what are you doing"?
3) Client evaluates his/her behaviour. Ask "is your behaviour helping you or getting you what you want"?
4) If not, make a plan to change your behaviour.
5) Get a commitment to carry out plan. Perhaps sign contract.
6) Accept no excuses when plan is not carried out. Simply remind client of plan. Perhaps revise plan.
7) Do not punish. Clients who fail already have a failure identity. Punishment does no good.
8) Never give up.

Self Assessment Questions

1) Discuss the role of counselor in behaviour therapy.

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2) How does reality therapy view human nature?

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3) Explain the technique of reality therapy.

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3.7 LET US SUM UP

There are many theoretical models of psychology and counseling. Most counseling approaches fall within four broad theoretical categories: psychoanalytic, affective, cognitive and behavioural. The Freudian view of human nature is dynamic. According to him, human nature could be explained in terms of a conscious mind, a sub conscious and an unconscious mind whereas Adler focuses on our present interpretation of the events. He thought that people are primarily motivated by social interest. Existentialism understands the human to be challenged by the reality of temporary existence, and the view that life has no inherent meaning; meaning had to be constructed.

The person centered approach views the client as their own best authority on their own experience, and the client is fully capable of fulfilling their own potential for growth. In Gestalt approach, feelings, thoughts, body sensations and actions are all used as a guide to understand client behaviour in each moment. The centrality of whatever is in the client's awareness is an ideal way to understand the world of the client.

The behaviour approach is based on the premise that primary learning comes from experience and applies learning principles to the elimination of unwanted behaviours. Reality approach is based on choice theory that how we deal with unsatisfying relationships. Clients choose their behaviours to cope with unsatisfying relationships. Each theory has its own benefits and limitation. The counselor should use an integrative approach depending upon the problem of the client.

3.8 UNIT END QUESTIONS

1) Define psychoanalytic approach and its view on human nature.
2) Describe the different techniques of psychoanalysis.
2) Explain Adler's perspective.
3) Discuss the goals and techniques involved in behaviour approach to counselling.
4) What is Transactional Analysis? Explain the role of counsellor in this technique?
5) Describe the techniques involved in Person Centered Approach.
6) Describe the important features of Existential therapy.
7) How do counselors use Rational Emotive therapyapporach.

3.9 SUGGESTED READINGS

Corey, G. (2008): *Theory and Practice of Counseling and Psychotherapy*. USA: The Thompson Brooks

Narayana Rao (2008): *Counseling and Guidance*. New Delhi: Tata Mc-Graw Hill

Samuel T. Gladding (2004): *Counseling Theories: Essential Concepts and Applications*. Publisher: Prentice Hall

Baruth & Robinson (1987): *An Introduction to the Counseling Profession.* Prentice-Hall

UNIT 4 ETHICS IN COUNSELING

Structure

4.0 INTRODUCTION

In this unit we will be dealing with ethical issues in counseling. First we define what are Ethics and why there is a need for ethical code. This is followed by ethical Principles of Counseling and in this we elucidate the principles of ethics in counseling. Then we take up professional codes of ethics and then almost reproduce the American counseling Association's ethical principles and codes, widely used and as defined in their 8 different sections. The ethics are felated to the relationship between the counselor and the client, in regard to confidentiality, professional responsibility, relationship with other professionals and ethics as related to evaluation etc. The next section deals with ethical issues related to supervision, training and teaching, research and publication.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Discuss the concept of ethics;
- Explain the need for ethical issues;
- Describe Kitchener's main principles;
- Explain purpose of ACA Code of Ethics; and
- Discuss main sections of American Counseling Association.

4.2 WHAT ARE THE ETHICS?

Counseling is not a value free or neutral activity rather it is a profession based on values which are orienting beliefs about what is good and how that good should be achieved. On the basis of the values, counselors and clients take directions in the counseling process and make decisions. Counselors are guided in their thoughts and actions by moral values, professional and personal ethics, and legal precedents and procedures. Counselors who are not aware of their values, ethics and legal responsibilities as well as those of clients they can cause harm to their clients despite their good intentions. It is, therefore, vital for counselors to have knowledge of professional counseling guidelines. Ethical counselors display care and wisdom in their practice.

The term is often used synonymously with morality, in some case the two terms overlap. Both deal with what is good and bad or study of human conduct and values. Yet each has a different meaning.

Kitchener (1986): Ethics involves "making decisions of a moral nature about people and their interaction in the society".

Van Hoose (1985): Ethics is generally defined as a philosophical discipline that is concerned with human conduct and moral decision making.

Ethics are normative in nature and focus on principles and standards that govern relationship between counselors and clients.

Morality, on the other hand, involves judgment and evaluation of action. It is associated with such words as good, bad, right, wrong, ought and should (Brandt, 1959).

4.2.1 Reasons for Ethical Codes

Ethical standards exist for many reasons. They are designed to provide some guidelines for the professional behaviour of members. One of the primary reasons is that "without a code of established ethics, a group of people with similar interests can not be considered a professional organisation" (Allen, 1986). Van Hoose and Kottler(1985) offer three reasons for the existence if ethical codes:

Ethical standards protect the profession from the government. They allow the profession to regulate itself and function autonomously.

Ethical standards help control internal disagreement and bickering, thus promoting stability within the profession.

Ethical standards protect practitioners from the public. Especially in malpractice cases. If professionals behave according to ethics, the behaviour is judged to be in compliance with the standards.

In addition, these provide clients with some protection from incompetent counselors.

Certain other reasons are:

1) Ensuring competent professional behaviour

2) Responsibility to public trust
3) Professionals monitor their own and other members' professional behaviour
4) Controversies over the development of ethical codes
5) Ethical dilemmas
6) Character and virtue
7) ACA Ethics code
8) Aspirations and Guidelines
9) Standards

4.3 ETHICAL PRINCIPLES OF COUNSELING

Kitchener (1984) has identified five moral principles which often help to clarify the issues involved in a given situation. The five principles are: autonomy, justice, beneficence, non-maleficence.

1) **Being trustworthy (fidelity):** It involves the notions of loyalty, faithfulness, and honoring commitments. Being trustworthy is regarded as fundamental to understanding and resolving ethical issues. Practitioners who adopt this principle: act in accordance with the trust placed in them; strive to ensure that clients' expectations are ones that have reasonable prospects of being met; honor their agreements and promises; regard confidentiality as an obligation arising from the client's trust; restrict any disclosure of confidential information about clients to furthering the purposes for which it was originally disclosed.

2) **Autonomy:** The essence of this principle is allowing an individual the freedom of choice and action. This principle emphasises the importance of developing a client's ability to be self-directing within therapy and all aspects of life. It addresses the responsibility of the counselor to encourage clients, when appropriate, to make their own decisions and to act on their own values. There are two important considerations in encouraging clients to be autonomous. First, helping the client to understand how their decisions and their values may or may not be received within the context of the society in which they live, and how they may impinge on the rights of others. The second consideration is related to the client's ability to make sound and rational decisions. The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends.

3) **Beneficence:** The principle of beneficence means acting in the best interests of the client based on professional assessment. Beneficence reflects the counselor's responsibility to contribute to the welfare of the client. Simply stated it means to do good, to be proactive and also to prevent harm when possible (Forester-Miller & Rubenstein, 1992). It directs attention to working strictly within one's limits of competence and providing services on the basis of adequate training or experience. There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development. An obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished

because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints.

4) **Non maleficence:** Nonmaleficence is the concept of not causing harm to others. Often explained as "above all do no harm", this principle is considered by some to be the most critical of all the principles, even though theoretically they are all of equal weight (Kitchener, 1984; Rosenbaum, 1982; Stadler, 1986). This principle reflects both the idea of not inflicting intentional harm, and not engaging in actions that risk harming others (Forester-Miller & Rubenstein, 1992). Non-maleficence involves avoiding sexual, financial, and emotional or any other form of client exploitation; avoiding incompetence or malpractice; not providing services when unfit to do so due to illness, personal circumstances or intoxication. The practitioner has an ethical responsibility to strive to mitigate any harm caused to a client even when the harm is unavoidable or unintended.

5) **Justice:** The principle of justice requires being just and fair to all clients and respecting their human rights and dignity. Justice does not mean treating all individuals the same. Kitchener (1984) points out that the formal meaning of justice is "treating equals equally and unequals unequally but in proportion to their relevant differences" (p.49). It directs attention to considering conscientiously any legal requirements and obligations, and remaining alert to potential conflicts between legal and ethical obligations. Practitioners have a duty to strive to ensure a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients. If an individual is to be treated differently, the counselor needs to be able to offer a rationale that explains the necessity and appropriateness of treating this individual differently.

Self Assessment Questions

1) Differentiate between ethics and morality.

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2) Explain the importance of having ethical code.

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3) What are the different ethical principles of counseling?

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4.4 PROFESSIONAL CODES OF ETHICS

A professional code of ethics is a set of standards of conduct based upon on agreed on set of values by which professionals in a given occupation such as counseling or psychology.

The American Counseling Association (ACA) is a nonprofit professional and educational organisation dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association representing professional counselors in various practice settings. ACA is instrumental in setting professional and ethical standards for the counseling profession. The Association has also made considerable strides in accreditation, licensure, and national certification.

In ACA, ethical standards are arranged under topical section headings. There are five main purposes and eight major sections of standards.

4.4.1 ACA Code of Ethics: Purpose

The ACA Code of Ethics serves five main purposes:

i) The Code enables the association to clarify to current and future members, and to those served by members, the nature of the ethical responsibilities held in common by its members.

ii) The Code helps support the mission of the association.

iii) The Code establishes principles that define ethical behaviour and best practices of association members.

iv) The Code serves as an ethical guide designed to assist members in constructing a professional course of action that best serves those utilising counseling services and best promotes the values of the counseling profession.

v) The Code serves as the basis for processing of ethical complaints and inquiries initiated against members of the association.

Rehabilitation Council of India Code of Ethics for Counsellors

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.

4.5 THE ACA EIGHT MAIN SECTIONS

Section A: The Counseling Relationship

Section B: Confidentiality, Privileged Communication, and Privacy

Section C: Professional Responsibility

Section D: Relationships with Other Professionals

Section E: Evaluation, Assessment, and Interpretation

Section F: Supervision, Training, and Teaching

Section G: Research and Publication

Section H: Resolving Ethical Issues

Each section of the ACA Code of Ethics begins with an Introduction. The introductions to each section discuss what counselors should aspire to with regard to ethical behaviour and responsibility. The Introduction helps set the tone for that particular section and provides a starting point that invites reflection on the ethical mandates contained in each part of the ACA Code of Ethics. When counselors are faced with ethical dilemmas that are difficult to resolve, they are expected to engage in a carefully considered ethical decision-making process.

Reasonable differences of opinion can and do exist among counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, counselors are expected to be familiar with a credible model of decision making that can bear public scrutiny and its application. Through a chosen ethical decision-making process and evaluation of the context of the situation, counselors are empowered to make decisions that help expand the capacity of people to grow and develop.

ACA (1995) reproduced below:

4.5.1 Section A: The Counseling Relationship

Counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process. Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return.

A.1) Welfare of Those Served by Counselors

- A.1.a) Primary Responsibility
- A.1.b) Records
- A.1.c) Counseling Plans
- A.1.d) Support Network Involvement
- A.1.e) Employment Needs

A.2) Informed Consent in the Counseling Relationship

- A.2.a) Informed Consent
- A.2.b) Types of Information
- A.2.c) Developmental and Cultural
- A.2.d) Inability to Give Consent

A.3 Clients Served by Others

A.4 Avoiding Harm and Imposing Values

- A.4.a) Avoiding Harm
- A.4.b) Personal Values

A.5) Roles and Relationships with Clients

- A.5.a) Current Clients
- A.5.b) Former Clients
- A.5.c) Nonprofessional Interactions or Relationships
- A.5.d) Potentially Beneficial
- A.5.e) Role Changes in the Professional Relationship

A.6) Roles and Relationships at Individual, Group, Institutional, and Societal Levels

- A.6.a) Advocacy
- A.6.b) Confidentiality and Advocacy

A.7) Multiple Clients

A.8) Group Work

- A.8.a) Screening
- A.8.b) Protecting Clients

A.9) End-of-Life Care for Terminally Ill Clients

A.9.a) Quality of Care

A.9.b) Counselor Competence, Choice, and Referral

A.9.c) Confidentiality

A.10) Fees and Bartering

A.10.a) Accepting Fees from Agency Clients

A.10.b) Establishing Fees

A.10.c) Nonpayment of Fees

A.10.d) Bartering

A.10.e) Receiving Gifts

A.11) Termination and Referral

A.11.a) Abandonment Prohibited

A.11.b) Inability to Assist Clients

A.11.c) Appropriate Termination

A.11.d) Appropriate Transfer of Services

A.12) Technology Applications

A.12.a) Benefits and Limitations

A.12.b) Technology-Assisted Services

A.12.c) Inappropriate Services

A.12.d) Access

A.12.e) Laws and Statutes

A.12.f) Assistance

A.12.g) Technology and Informed Consent

A.12.h) Sites on the World Wide Web

ACA made several additions to this section in 2005. In the 1995 ethical code, there was an emphasis on the need to avoid any type of non professional relationship with clients , but in 2005 code speaks of potentially beneficial interaction between counselors and clients. This goes beyond the traditional professional counseling relationship. Another change is in regard to the boundary issues related to having sexual or romantic relationships with ex clients for 2-5 years. Now this ex clients includes one's family members, romantic partners etc. A siginificant addition is in regard to guidance to counselors serving terminally ill clients. It directs the counselors to take measures that enable clients to obtain high quality end of life care; to exercise the highest degree of self determination possible, to be given every opportunity to engage in informed decision making regarding their end of life care; to receive complete and adequate assessment regarding their ability to make competent rational decision on their own behalf from a professionakl experienced in end of life care practice.

4.5.2 Section B: Confidentiality, Privileged Communication, and Privacy

Introduction

Counselors recognise that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

B.1) Respecting Client Rights

- B.1.a) Multicultural/Diversity Considerations
- B.1.b) Respect for Privacy
- B.1.c) Respect for Confidentiality
- B.1.d) Explanation of Limitations

B.2) Exceptions

- B.2.a) Danger and Legal Requirements
- B.2.b) Contagious, Life-Threatening Diseases
- B.2.c) Court-Ordered Disclosure
- B.2.d) Minimal Disclosure

B.3) Information Shared With Others

- B.3.a) Subordinates
- B.3.b) Treatment Teams
- B.3.c) Confidential Settings
- B.3.d) Third-Party Payers
- B.3.e) Transmitting Confidential Information
- B.3.f) Deceased Clients

B.4) Groups and Families

- B.4.a) Group Work
- B.4.b) Couples and Family

B.5) Clients Lacking Capacity to Give Informed Consent

- B.5.a) Responsibility to Clients
- B.5.b) Responsibility to Parents and Legal Guardians
- B.5.c) Release of Confidential Information

B.6) Records

- B.6.a) Confidentiality of Records
- B.6.b) Permission to Record
- B.6.c) Permission to Observe
- B.6.d) Client Access
- B.6.e) Assistance with Records

B.6.f) Disclosure or Transfer

B.6.g) Storage and Disposal after Termination

B.6.h) Reasonable Precautions

B.7) Research and Training

B.7.a) Institutional Approval

B.7.b) Adherence to Guidelines

B.7.c) Confidentiality of Information Obtained in Research

B.7.d) Disclosure of Research Information

B.7.e) Agreement for Identification

B.8) Consultation

B.8.a) Agreements

B.8.b) Respect for Privacy

B.8.c) Disclosure of Confidential Information

One major change in section B is an increased discussion of privacy and confidentiality when working with clients who are minors or adults who cannot give informed consent. Standardss B.5.a,b and c outline the need for counselors to protect the confidentiality of such clients and to include clients in all decisions. Counsellors are expected to work to establish as appropriate collaborative relationships with parents / guardians to best serve clients. There is a significant change related to family counseling. Standard B.2.b (family counseling) of 1995 stated that information about one family member cannot be disclosed to another member without permission. In 2005 code, (couples and family counseling) Ethics requires the counselors to clearly define who is considered the "client" and discuss expectations and limitations of confidentiality. They have to seek agreement and then document in writing the agreement involving all members in the counseling and preserve the confidentiality of information known.

4.5.3 Section C: Professional Responsibility

Introduction

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. They practice in a non-discriminatory manner within the boundaries of professional and personal competence and have a responsibility to abide by the ACA Code of Ethics. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling.

Counselors advocate promoting change at the individual, group, institutional, and societal levels that improves the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered.

Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. In addition, counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1) Knowledge of Standards

C.2) Professional Competence

- C.2.a) Boundaries of Competence
- C.2.b) New Specialty Areas of Practice
- C.2.c) Qualified for Employment
- C.2.d) Monitor Effectiveness
- C.2.e) Consultation on Ethical Obligations
- C.2.f) Continuing Education
- C.2.g) Impairment
- C.2.h) Counselor Incapacitation or Termination of Practice

C.3) Advertising and Soliciting Clients

- C.3.a) Accurate Advertising
- C.3.b) Testimonials
- C.3.c) Statements by Others
- C.3.d) Recruiting Through Employment
- C.3.e) Products and Training Advertisements
- C.3.f) Promoting to Those Served

C.4) Professional Qualifications

- C.4.a) Accurate Representation
- C.4.b) Credentials
- C.4.c) Educational Degrees
- C.4.d) Implying Doctoral-Level Competence
- C.4.e) Program Accreditation Status
- C.4.f) Professional Membership

C.5) Nondiscrimination

C.6) Public Responsibility

- C.6.a) Sexual Harassment
- C.6.b) Reports to Third Parties
- C.6.c) Media Presentations
- C.6.d) Exploitation of Others
- C.6.e) Scientific Bases for Treatment Modalities

C.7) Responsibility to Other Professionals

- C.7.a) Personal Public Statements

2005 modification states that in addition to counselors being responsible to seek assistance for problems that reach the level of professional impairment, the counselors are now ethically obligated to assist colleagues or supervisors in recognising their own professional impairment and provide consultation and assistance when warranted. Another addition is to c.6.e. that is scientific bases

for treatment modalities. 1995 code directed the counsllors to monitor their effectiveness, but did not speak of their responsibility to base techniques and treatment plans on theory and empirical or scientific results. The 2005 modification requires that the counselors define the techniques and procedures and explain the potential risks and ethical considerations of using such techniques and procedures and take steps to protect clients from possible harm.

4.5.4 Section D: Relationships with Other Professionals

Introduction

Professional counselors recognise that the quality of their interactions with colleagues can influence the quality of services provided to clients.

They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

D.1) Relationships with Colleagues, Employers, and Employees

- D.1.a) Different Approaches
- D.1.b) Forming Relationships
- D.1.c) Interdisciplinary Teamwork
- D.1.d) Confidentiality
- D.1.e) Establishing Professional and Ethical Obligations
- D.1.f) Personnel Selection and Assignment
- D.1.g) Employer Policies
- D.1.h) Negative Conditions
- D.1.i) Protection from Punitive Action

D.2) Consultation

- D.2.a) Consultant Competency
- D.2.b) Understanding Consultees
- D.2.c) Consultant Goals
- D.2.d) Informed Consent in Consultation

2005 modifications: Counsellors actross work settings are part of interdisciplinary teams. There are several new standards that address responsibilities to develop and strengthen relationships with colleagures from other disciplines to best serve clients (standard D.1.b) The 2005 modification requires the counselors to keep the focus on the well being of clients by drawing on the perspectives, values and experiences of the counslling progession and those of colleagues from other disciplines and to clarify professional roles, parameters of confidentiality and ethical obligations of the team and its members.

4.5.5 Section E: Evaluation, Assessment and Interpretation

Introduction

Counselors use assessment instruments as one component of the counseling process, taking into account the client personal and cultural context. Counselors

promote the well-being of individual clients or groups of clients by developing and using appropriate educational, psychological, and career assessment instruments**.**

E.1) General

E.1.a) Assessment

E.1.b) Client Welfare

E.2) Competence to Use and Interpret Assessment Instruments

E.2.a) Limits of Competence

E.2.b) Appropriate Use

E.2.c) Decisions Based on Results

E.3) Informed Consent in Assessment

E.3.a) Explanation to Clients

E.3.b) Recipients of Results

E.4) Release of Data to Qualified Professionals

E.5) Diagnosis of Mental Disorders

E.5.a) Proper Diagnosis

E.5.b) Cultural Sensitivity

E.5.c) Historical and Social Prejudices in the Diagnosis of Pathology

E.5.d) Refraining From Diagnosis

E.6) Instrument Selection

E.6.a) Appropriateness of Instruments

E.6.b) Referral Information

E.6.c) Culturally Diverse Populations

E.7) Conditions of Assessment Administration

E.7.a) Administration Conditions

E.7.b) Technological Administration

E.7.c) Unsupervised Assessments

E.7.d) Disclosure of Favorable Conditions

E.8) Multicultural Issues/ Diversity in Assessment

E.9) Scoring and Interpretation of Assessments

E.9.a) Reporting

E.9.b) Research Instruments

E.9.c) Assessment Services

E.10) Assessment Security

E.11) Obsolete Assessments and Outdated Results

E.12) Assessment Construction

E.13) Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a) Primary Obligations

E.13.b) Consent for Evaluation

E.13.c) Client Evaluation Prohibited

E.13.d) Avoid Potentially Harmful Relationships

2005 modifications: One noteworthy change in this section is the terminology used. The word tests used in 1995 code has been replaced with the word assessment which has a broader and more holistic meaning. In E 13.a and in E.13.d. the counselors are required to understand their primary obligations when conducting forensic evaluations, how these obligations differ from those involved in counseling and their responsibility to explain to the clients. The new standards also prohibit counselors from conducting forensic evaluations with clients they are counseling or have counseled so as to avoid potentially harmful professional or personal relationships with family members, romantic partners and close friends of individuals they are evaluating or have evaluated in the past. (Standard E 13.d)

4.5.6 Section F: Supervision, Training and Teaching

Introduction

Counselors aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students. Counselors have theoretical and pedagogical foundations for their work and aim to be fair, accurate, and honest in their assessments of counselors-in-training.

F.1) Counselor Supervision and Client Welfare

F.1.a) Client Welfare

F.1.b) Counselor Credentials

F.1.c) Informed Consent and Client Rights

F.2) Counselor Supervision Competence

F.2.a) Supervisor Preparation

F.2.b) Multicultural Issues/Diversity in Supervision

F.3) Supervisory Relationships

F.3.a) Relationship Boundaries with Supervisees

F.3.b) Sexual Relationships

F.3.c) Sexual Harassment

F.3.d) Close Relatives and Friends

F.3.e) Potentially Beneficial Relationships

F.4) Supervisor Responsibilities

F.4.a) Informed Consent for Supervision

F.4.b) Emergencies and Absences

F.4.c) Standards for Supervisees

F.4.d) Termination of the Supervisory Relationship

F.5) Counseling Supervision Evaluation, Remediation, and Endorsement

F.5.a) Evaluation

F.5.b) Limitations

F.5.c) Counseling for Supervisees

F.5.d) Endorsement

F.6) Responsibilities of Counselor Educators

F.6.a) Counselor Educators

F.6.b) Infusing Multicultural Issues/ Diversity

F.6.c) Integration of Study and Practice

F.6.d) Teaching Ethics

F.6.e) Peer Relationships

F.6.f) Innovative Theories and Techniques

F.6.g) Field Placements

F.6.h) Professional Disclosure

F.7) Student Welfare

F.7.a) Orientation

F.7.b) Self-Growth Experiences

F.8) Student Responsibilities

F.8.a) Standards for Students

F.8.b) Impairment

F.9) Evaluation and Remediation of Students

F.9.a) Evaluation

F.9.b) Limitations

F.9.c) Counseling for Students

F. 10) Roles and Relationships between Counselor, Educators and Students

F.10.a) Sexual or Romantic Relationships

F.10.b) Sexual Harassment

F.10.c) Relationships with Former Students

F.10.d) Nonprofessional Relationships

F.10.e) Counseling Services

F.10.f) Potentially Beneficial Relationships

F.11) Multicultural/Diversity Competence in Counselor, Education and Training Programs

F.11.a) Faculty Diversity

F.11.b) Student Diversity

F.11.c) Multicultural/Diversity Competence

2005 modifications: This section has been reorganised since 1995 and greatly expanded in terms of noting ethical obligations of counselors who supervise counseling students, trainees and staff. This section F focussesn on counselor supervision and client welfare across settings, informed consent in the supervisory

relationship. It also deals with competence of counseling supervisors, supervisor responsibilities and potentially harmful or beneficial relationships between supervisors and supervisees. It also deals with the relationship between faculty members and students, students welfare and orientation, self growth experiences, impairment of counseling students and supervisees. It also presentsthe requirement of ethical evaluation of the performance of supervisees and students and endorsement of supervisees and students.

4.5.7 Section G: Research and Publication

Introduction

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research programs.

G.1) Research Responsibilities

- G.1.a) Use of Human Research Participants
- G.1.b) Deviation from Standard Practice
- G.1.c) Independent Researchers
- G.1.d) Precautions to Avoid Injury
- G.1.e) Principal Researcher Responsibility
- G.1.f) Minimal Interference
- G.1.g) Multicultural/Diversity

G.2) Rights of Research Participants

- G.2.a) Informed Consent in Research
- G.2.b) Deception
- G.2.c) Student/Supervisee Participation
- G.2.d) Client Participation
- G.2.e) Confidentiality of Information
- G.2.f) Persons Not Capable of Giving Informed Consent
- G.2.g) Commitments to Participants
- G.2.h) Explanations after Data Collection
- G.2.i) Informing Sponsors
- G.2.j) Disposal of Research

G.3) Relationships with Research Participants

- G.3.a) Non professional Relationships
- G.3.b) Relationships with Research Participants
- G.3.c) Sexual Harassment and Research Participants
- G.3.d) Potentially Beneficial Interactions

G.4) Reporting Results

G.4.a) Accurate Results

G.4.b) Obligation to Report Unfavorable Results

G.4.c) Reporting Errors

G.4.d) Identity of Participants

G.4.e) Replication Studies

G.5) Publication

G.5.a) Recognising Contributions

G.5.b) Plagiarism

G.5.c) Review/Republication of Data or Ideas

G.5.d) Contributors

G.5.e) Agreement of Contributors

G.5.f) Student Research

G.5.g) Duplicate Submission

G.5.h) Professional Review

2005 modifications: The term research subjects has been replaced by the terms research participants. According to new standards G.1.c. the independent researchers have an ethical obligation to consult with researchers who are familiar with Institutional Review Board requirements in order to provide appropriate safeguards for research participants. This section also deals with issues related to publication. The new standards specifically state that the counselors do not plagiarise the work of others. The professional review has also been expanded in the new code.

4.5.8 Section H: Resolving Ethical Issues

Introduction

Counselors behave in a legal, ethical, and moral manner in the conduct of their professional work. They are aware that client protection and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and re willing to take appropriate action to ensure that these standards are upheld.

Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work. They engage in ongoing professional development regarding current topics in ethical and legal issues in counseling.

H.1) Standards and the Law

H.1.a) Knowledge

H.1.b) Conflicts Between Ethics and Laws

H.2) Suspected Violations

H.2.a) Ethical Behaviour Expected

H.2.b) Informal Resolution

H.2.c) Reporting Ethical Violations

H.2.d) Consultation

H.2.e) Organisational Conflicts

H.2.f) Unwarranted Complaints

H.2.g) Unfair Discrimination against Complainants and Respondents

H.3) Cooperation with Ethics Committees

2005 modifications: The 2005 code provides greater clarity to counselors about ways to address potential conflicts between ethical guidelines and legal requirements. Standard H.1.b. notes that in such situations counselors make known their commitment to the code of ethics and take steps to resolve the conflict. If the conflict cannot be resolved by such means, counselors may adhere to the requirements of law, regulations or other governing legal authority. Another change in this section is the expanded list of potential agencies and organisations to which information regarding suspected or documented ethical violations may be reported to include "state or national certification bodies, state licensing boards or appropriate institutional authorities. (standard H.2.c.) Finally there is a new standard (H.2.g) that protects the rights of ACA members who have made or been the subject of an ethics complaint.

4.6 LET US SUM UP

The challenge of working ethically means that counselors will inevitably encounter situations where there are competing obligations. Counselors are having code of ethics to guide them in the practice of helping others. Counselors generally consult ethical standards of ACA when they face ethical dilemmas. In making ethical decisions, counselors rely on personal values as well as ethical standards. They also consult with professional colleagues. It is imperative that counselors become well informed regarding ethics for their as well as their client's welfare. Counselors should have academic and working knowledge of ethics.

These ethics are intended to be of assistance in such circumstances by directing attention to the variety of ethical factors that may need to be taken into consideration and to alternative ways of approaching ethics that may prove more useful. No statement of ethics can totally alleviate the difficulty of making professional judgments in circumstances that may be constantly changing and full of uncertainties. By accepting this statement of ethics, members of the American Counseling Association are committing themselves to engaging with the challenge of striving to be ethical, even when doing so involves making difficult decisions or acting courageously.

4.7 UNIT END QUESTIONS

1) Define Ethics.

2) Discuss the ethical principles of counseling.

3) What are the purposes of ACA code of ethics?

4) Explain Section C of ACA.

5) Explain the meaning of Beneficence and Nonmaleficence.

6) What are professional codes of ethics?

4.8 SUGGESTED READINGS

Corey, G. (2008): *Theory and Practice of Counseling and Psychotherapy*. USA: The Thompson Brooks.

Narayana Rao (2008): *Counseling and Guidance*. New Delhi: Tata Mc-Graw Hill.

Tim Bond (2000): *Standards and Ethics for Counselling in Action*. SAGE Publication

Samuel T. Gladding (2009): *Counseling: A Comprehensive Profession.* Publisher: Pearson/Merrill Prentice Hall.

UNIT 1 PSYCHOANALYSIS, PSYCHODYNAMIC AND PSYCHOTHERAPY

Structure

1.0 INTRODUCTION

In this unit we will be dealing with psychotherapy, psychoanalysis and other related therapies. It provides a detailed account of psychoanalysis and presents the component factors in the same. We then discuss the essentials of Psychotherapy and point out its importance. Then we take up psychoanalysis and as the first step we elucidate the evolution of psychoanalysis and then follow it up by presenting a history of psychoanalysis. Then we take up the functions of a psychoanalyst and detail the same. This is followed by the goals of psychoanalysis and the techniques of psychoanalysis. The next section deals with the psychodynamic therapies and their significance. Then we point out the differences between Psychodynamic Therapy and Psychoanalysis

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the concept of psychotherapy;
- Define psychoanalysis;
- Describe the goals of psychoanalysis;
- Identify the difference between psychodynamic therapy and psychoanalysis; and
- Explain the techniques like dream analysis and free association used by the psychotherapist.

1.2 PSYCHOTHERAPY

Psychotherapy consists of the whole range of psychologically based treatments by which trained practitioners help people who have psychological problems. Sometimes it is used in more restricted way. It refers to forms of treatment in which a psychotherapist and a client tackle client's problem through talking. Traditionally it focuses on serious problems associated with intra psychic, internal, and personal issues and conflicts. Characteristically, it emphasises the following issues:

- The past more than the present
- Insight more than change
- The detachment of the therapist
- The therapist's role as an expert

Psychotherapy is a systematic interaction between a therapist and a client that brings psychological principles to bear on influencing the client's thoughts, feelings, or behaviour to help that client overcome abnormal behaviour or adjust to problems in living. The interaction is between two or more individuals where one of them, called client or patient, is seeking help for a problem and the other participant, called therapist, provides necessary therapeutic help. The interaction is usually mediated by verbal means although facial expressions, bodily gestures and movement are also used. It usually involves a long term relationship that focuses on reconstructive change. Psychotherapies are procedures in which persons with mental disorders interact with a trained psychotherapist who helps them change certain behaviours, thoughts, or emotions so that they feel and function in a better way. It helps the patients to manage their symptoms better and function at their best in everyday life. It consists of a series of techniques for treating mental health, emotional and some psychiatric disorders and helps the individuals understand what helps them feel positive or anxious, as well as accepting their strong and weak points.

1.2.1 Essentials of Psychotherapy

i) **Systematic Interaction:** Psychotherapy is a systematic interaction between a client and a therapist. The therapist structures the therapy process based upon a theoretical viewpoint and an understanding of the client's cultural and social background.

ii) **Psychological Principles:** Psychotherapy is based on psychological theory and research in various areas such as personality, learning and abnormal behaviour.

iii) **Thoughts, feelings and behaviours:** Psychotherapy influences clients' thoughts, feelings and behaviour.

iv) **Psychological Disorders, adjustment problems and personal growth**: While psychotherapy is often used with people who have psychological disorders, it can also be used to help people with adjustment (loss of spouse, shyness) and personal growth.

Psychotherapy or talk therapy is currently used by psychologists and other professionals in different forms. It uses varied range of procedures and can be conducted with individuals as well as with groups. There are many different therapy styles and techniques including Psychodynamic Psychotherapy, Cognitive Behavioural Therapy (CBT), Group Therapy, and Couples Therapy. The unique elements of psychotherapy are that it varies according to different theoretical perspectives. The first organised system of psychotherapy which has a considerable influence in the field of Psychology was Psychoanalysis by Sigmund Freud.

1.3 PSYCHOANALYSIS

Psychoanalysis is a very significant perspective in the field of psychology. It is a method of analysing psychic phenomena and treating emotional disorders that involves treatment sessions during which the client or the patient is encouraged to talk freely about personal experiences and especially about early childhood and dreams. Psychoanalysis is both a theory of mental functioning and a specific type of psychological treatment philosophy. It is generally known as a theory of human behaviour.

It has three applications:

i) a method of investigation of the mind;

ii) a systematised set of theories about human behaviour;

iii) a method of treatment of psychological or emotional illness.

Psychoanalysis was first devised in Vienna in the 1890s by Sigmund Freud. It involves analysing the root causes of behaviour and feelings by exploring the unconscious mind and the conscious mind's relation to it. It focuses on an individual's unconscious, deep-rooted thoughts that often stem from childhood.

Freud believed that Id, Ego and Super-Ego are three major parts of personality which represent desire, reason and conscience.

He was of the opinion that the root cause of all mental disorders is repressed desired in the unconscious mind.

This repression occurs due to non acceptance of Id impulses to ego or superego. These urges persist in the unconscious and individuals devote a considerable time to have a check on them and to keep them out of conscious part of the personality. People often use defense mechanisms to protect the ego from feeling of anxiety generated by these inner conflicts.

1.3.1 Phases in the Evolution of Psychoanalysis

Freud (1914b, 1927) described three phases in the evolution of Psychoanalysis.

The first phase

During first phase of psychoanalysis, Freud found that the central aspect of human mind was unconscious thoughts that could be accessed through dreams, fantasies, jokes, slip of tongues, hypnosis, free association, and so on.

The second phase

In the second phase, Freud discarded hypnosis and emphasised on free association. He found that clients voluntarily permitted the emergence of unconscious materials in free association. As Freud always wanted a unique theory so he developed his own specific techniques like Dream Analysis, Free Association and so on.

Third phase

During the third phase**,** he elaborated his dream analysis technique and described primary and secondary processes. Primary processes are governed by Id, the pleasure principle and are illogical. They can be found in dreams, poetry, myth and magic. Psychosis is the ultimate form of this process.

Secondary processes are governed by logic and are associated with the ego and reality principle.

At the end of the third phase of Psychoanalysis, other analysts such as Jung(1875-1961), Adler(1870-1937), Horney(1885-1952), Sullivan(1892-1949) and Erikson (1902-1992) modified Freud's psychoanalysis.

1.3.2 Brief History of Psychoanalysis

Psychoanalysis has also its roots in hypnosis. The first contributor was Franz Mesmer, who is known for inducing a mental state called Mesmerism. He has presented the idea of animal magnetism. He used magnets for the treatment of paralysis, later he claimed that he could treat paralysis without magnets by directing his own magnetic fluid to the patient's body.

Liebault and Bernheim introduced Mesmerism in the Nancy school, France. Jean Martin Charcot was a French Neurologist who used hypnosis to treat hysterical patients. In 1885 Charcot introduced Freud to hypnosis. Freud began developing his own theory of psychoanalysis under Charcot's influence. Josef Breuer introduced Freud to Cathartic method of treatment of hysteria.

Freud emphasised on unconscious drives. He used the term Psychoanalysis in *three distinct ways***:** Firstly, it is a theory which describes the structure of the mind, the development of the personality, and psychopathology; secondly it is used as a technique to treat psychological difficulties; and thirdly it is a method of scientific investigation based on a clinical observation called case study.

Anna Freud (1895-1982) was especially instrumental in carrying on her father's tradition, particularly in her pioneering work on defense mechanisms.

Carl Jung, viewed by Freud as his heir apparent, separated away from Freud's inner circle**.** He had serious differences with Freud's theory of drives. He agreed with the importance of the unconscious but condemned Freud for his

overemphasising the sexual and aggressive drives. Jung emphasised on collective unconscious which was consistent with Freud's primitive universal fantasies. He laid emphasis on cultural symbols and believed that humans inherited a desire for higher religious fulfillment and self development.

Alfred Adler was the first disciple of Freud to disagree with the master. He developed individual psychology and emphasised on societal pressures which shape the personality and believed that behaviour is motivated by need to be superior.

Karen Horney disagreed with Freud's premise that women have penis envy rather felt that men on the other hand envied women. She believed that the basic anxiety results from disturbances in parent child relationships and in attempting to deal with basic anxiety, individuals develop a characteristic social orientation (dependent, submissive, inflated self concept, avoidant etc.).

Erik Erikson agreed with Freud that development occurred in stages but emphasised social as opposed to sexual development**.** He described that development occurs across the lifespan and believed that ego is relatively powerful part of personality that functions to establish and maintain a sense of identity (ego psychology)**.**

Carl Rogers Client Centered therapy's core focus is on analyst's patient, empathetic, uncritical and receptive approach.

Otto Rank**,** a devoted follower of Freud, rejected theories of Oedipus complex. He related all neurotic anxieties to birth trauma. The central part of his theory was separation anxiety and believed that all forms of separation reactivated the primal anxiety of birth trauma.

Sándor Ferenczi, a close colleague of Freud's, is known as one of the most daring experimenters of the early psychoanalysts. He anticipated the humanistic movement in psychotherapy by emphasising that the analyst could not be a mere detached observer. He felt that the analyst must have an attitude of genuine caring in order to assist the patient's healing caused by past abuse and the analyst cannot be in the position of an authority because it creates a hierarchal relationship between the analyst and client.

He experimented with a technique called "mutual analysis," where he and the patient would take turns lying on the couch and free-associating but this technique did not work out.

Melanie Klein's work is an extension of Freud's work, but also a transformation of Freud's original insights through her unique interpretive perspectives. Klein was also profoundly influenced by Sandor Ferenczi, her own psychoanalyst. Working with children, Klein felt she had observed processes in pre-Oedipal children that were very similar to oedipal conflicts in older children. Throughout her career, she attempted to theoretically justify these observations.

In turn, Klein and her followers applied her practice and theory to work with psychotic adult patients. Klein's technique, in all cases, involved a method of using "deep" interpretations which she felt communicated directly to the unconscious of the client, thus by-passing ego defenses. The term "object relations" ultimately derived from Klein, since she felt that the infant introjects the 'whole' other with the onset of the depressive position during the ontogenesis of the self.

As a therapy**,** psychoanalysis is based on the concept that individuals are unaware of the many factors that cause their behaviour and emotions. These unconscious factors have the potential to produce unhappiness, which in turn is expressed through a score of distinguishable symptoms, including disturbing personality traits, difficulty in relating to others, or disturbances in self-esteem or general disposition (American Psychoanalytic Association, 1998).

1.3.3 The Work of a Psychoanalyst

- The psychoanalyst basically helps the person to tell his or her story by establishing a solid working alliance with the client.
- He gathers background information and history and then selects the problem or issue to be worked on.
- He tries to explore the precipitating events and deals with resistance shown by client.
- He then collaborates with the client to form a diagnosis and treatment plan and increase the client's awareness regarding defensiveness.
- The psychoanalytic process helps in exploring the client's transference and monitors the therapist's counter transference.
- Psychoanalyst helps in examining how the past is impacting the present.
- The psychoanalyst helps the client to behave more effectively.
- He provides feedback and confronts discrepancies, negotiates with the client regarding homework assignments.
- The psychoanalyst reminds the client of the termination date and end therapy as agreed upon with the client.
- The psychoanalyst schedules follow-up too as needed.

1.3.4 Goal of Psychoanalysis

The goal of psychoanalysis varies according to the client, but they focus mainly on personal adjustment, usually inducing a reorganisation of internal forces within the person.

The primary goal in most cases is to help client in achieving insight which can consciously make them aware of the psychodynamics that underlie their problems.

This awareness helps the clients to make adjustment to their current life situations. People repeatedly encounter and deal with repressed emotions, motives and conflicts.

The second major goal is to help client work through a developmental stage, not resolved in primary goal. If accomplished, clients become unstuck and are able to live more productively.

The final goal is to help clients cope with the demands of the society in which they live.

The goal of psychoanalysis is to enable the person to deal with the unconscious urges in a realistic and mature manner. But the question arises how to penetrate the unconscious mind.

The ways to penetrate take on a variety of forms varying from practitioner to practitioner. Freud suggested certain methods to achieve the aim or goal of psychoanalysis. Some of these methods include the following:

- Free association
- dreams or fantasies

clients can learn how to interpret deeply buried memories or experiences that may be causing them distress.

1.4 TECHNIQUES IN PSYCHOANALYSIS

The six basic techniques of psychoanalytic therapy are:

1) Maintaining the Analytic Framework,
2) Free Association,
3) Dream Analysis,
4) Interpretation,
5) Analysis of Resistance,
6) Analysis of Transference.

Each of the above is being discussed in detail below

1.4.1 Maintaining the Analytic Framework

This refers to a whole range of procedural and stylistic factors such as the analyst's relative anonymity, the regularity and consistency of meetings and in time conclusion of the sessions. The psychoanalytic process stresses upon to maintain a particular framework to accomplish the therapy's goal. The consistent framework itself works as a therapeutic factor.

1.4.2 Free Association

Freud and subsequent psychoanalysts widely used this technique as they considered that it provides important clues to the workings of the unconscious mind. They believed that mental events are meaningfully associated with one another and those clues to the contents of the unconscious can be found in the ongoing stream of thoughts, memories, images and feelings that we experience. It consists of the individual lying on a couch in a partly darkened room producing an uncensored, non-calculated account of what they are thinking and feeling during the session.

The nature of responses made during a free association session indicate the concerns and preoccupations of a person's unconscious as there is no censorship by the conscious mind, the Ego. Client reports immediately without censoring any feelings or thoughts. The client is encouraged to relax and freely recall childhood memories or emotional experiences. In this way, unconscious material enters the conscious mind, and the counselor interprets it. At times clients resist free association by blocking their thoughts or denying their importance. Psychoanalysts make the most of these moments by attempting to help clients work through their resistance.

1.4.3 Dream Analysis

Dream analysis is a particular tool of the psychoanalytic school of thought proposed by Freud and Jung, and is considered as the first scientific approach to the study

of dreams. It gives an important set of clues to the unconscious mind, because dreaming is thought to express levels of unconscious wish fulfillment expressive of the individual's deepest conflicts and desires.

Freud was of the opinion that we can give expressions to our desires and impulses that we are unable to express during our waking hours because they are unacceptable by the society. Thus we can gratify illicit sexual desires and thoughts which we generally repress during the day. In this clients report dreams to counselor on regular basis.

Freud believed that dreams were a main avenue to understanding the unconscious. He reported that in this way he gained important insight into the causes of client's problems. But Freud did not provide any specific and clear rule to interpret dreams and there was no way of determining whether that interpretation is right or wrong.

Counselor uses the free association and other techniques to the bring unconscious material to the conscious. Clients are encouraged to remember dreams. The counselor analyses two aspects, viz., the manifest content and the other latent content.

1.4.4 Interpretation

Interpretation should consider part of all above mentioned techniques. It consists of the analyst's pointing out, explaining and teaching the client the meanings of behaviour that is manifested in dreams, free associations, and resistances. When interpreting, the counselor helps the client to understand the meaning of the past and present personal events.

Interpretation is grounded in therapist's assessment of the client's personality and of the factors in the client's past that contributed to his difficulties. Counselor points out, explains, and teaches the meanings of whatever is revealed. The therapist must be guided by a sense of client's readiness to consider it and it should be well timed.

Counselors must carefully time the use of interpretation for better understanding of unconscious influences and impulses. A general rule is that interpretation should be presented when the phenomena to be interpreted is close to conscious awareness.

Another rule is that interpretation should always start from the surface and go only as deep as the client is able to go. Also it is best to point out a resistance before interpreting the conflict that lies beneath it.

1.4.5 Analysis and Interpretation of Resistance

Anything which works against the progress of therapy and prevents the client to produce unconscious material is called Resistance. The client shows reluctance to bring unconscious material at the level of awareness. Freud viewed resistance as an unconscious dynamic that people used to defend against the anxiety and pain that would arise if they become aware of their repressed feelings. Resistance is a defense against anxiety that prevents clients and therapist from succeeding in their effort to gain insight into the dynamics of the unconscious. The therapist must respect the resistance of clients and assist them in working therapeutically with their defenses. If the therapist handles it properly It can be the most valuable tool to understand the client.

1.4.6 Analysis of Transference

Freud discovered and developed this psychoanalytic concept of transference which later on developed by many other analysts and professionals. The concept developed out of the inappropriate ending of a treatment. It is the client's response to a counselor as if the counselor were some significant figure in the client's past, usually a parent figure. Transference is a displacement of attitudes and feelings originally experienced in relationships with persons onto the analyst in the long past history of the patient.

It is a universal phenomenon. Patients are not aware at a conscious level of the displacement that has taken place. This allows the client to experience feelings that would otherwise be inaccessible. This is ambivalent in nature which can be positive (affectionate) as well as negative (hostile) towards the analyst. In positive transference, the patient has confidence in the doctor. If intense, the patient may over-idealise the doctor or develop sexual feelings toward the doctor. In negative transference, the patient may become resentful or angry toward the doctor if the patient's desires and expectations are not realised. This may lead to noncompliance Counter transference.

These phenomena increase emotionality and may thus alter judgment and behaviour in patients' relationships with their therapist (trans-ference) and therapist' relationships with their patients (counter-transference).

1.4.7 Counter Transference

This is an analyst's feelings that are thought to be related to what the patient is projecting onto the psychoanalyst. In this, feelings about a client and the reaction of the counselor towards the client who reminds the doctor of a close friend or relative may interfere with objectivity. The counselor encourages this transference and interprets positive or negative feelings expressed. Analysis of transference allows the client to achieve insight into the influence of the past. Analytically oriented therapists consider transference as the core of the therapeutic process as it aims in achieving awareness and personality change. It allows the clients to achieve insight into the influence of past on their present functioning and enables clients to work through old conflicts that are keeping them fixated and retarding their emotional growth. Through appropriate interpretation, clients become aware of their long standing inappropriate behaviours and gradually change some of them.

1.5 PSYCHODYNAMIC THERAPIES

Historically, psychodynamic therapies are based on the principles of psychoanalytic theory that mental disorders stem primarily from the kind of hidden conflicts first described by Freud. The term Psychoanalytic and psychodynamic have been used synonymously. Psychodynamic therapy or Psychoanalytic Psychotherapy is a general name for therapeutic approaches which try to get the patient to bring to the surface their true feelings, so that they can experience them and understand them. These therapies assume that the mental disorders occur because something has gone seriously wrong in the balance between these inner forces. These therapies assert that a person's behaviour is affected by his or her unconscious mind and past experiences. Both psychotherapeutic approaches derive from a set of principles

derived from psychoanalysis. Among these principles are the dynamic unconscious, transference, counter transference, resistance and psychic determinism.

Several different approaches to brief psychodynamic psychotherapy have evolved from psychoanalytic theory and have been clinically applied to a wide range of psychological disorders. There is a body of research that generally supports the efficacy of these approaches. Psychodynamic therapy is the oldest of the modern therapies. (Freud's psychoanalysis is a specific form and subset of psychodynamic therapy.) As such, it is based in a highly developed and multifaceted theory of human development and interaction.

There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are:

- Freudian,
- Ego Psychology,
- Object Relations, and
- Self Psychology.

1.5.1 Freudian School

Freudian psychology is based on the theories first formulated by Sigmund Freud. It is sometimes referred to as the drive or structural model. The essence of Freud's theory is that sexual and aggressive energies originating in the id or unconscious are modulated by the ego, which is a set of functions that moderates between the id and external reality. Defence mechanisms are constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The superego, formed during latency between age 5 and puberty, operates to control id drives through guilt.

1.5.2 Ego Psychology

Ego Psychology derives from Freudian psychology. It focuses upon enhancing and maintaining ego function in accordance with the demands of reality. Heinz Hartmann, the father of Ego Psychology, studied the ways in which the ego organises itself, adapts, and deploys ID drives. Ego Psychology stresses the individual's capacity for defence, adaptation, and reality testing. Heinz Hartmann-leader of ego therapy. It focuses on the ego's workings in creating defenses rather than focusing on the underlying id content. It engages the patient with less emphasis on uncovering hidden secrets but more on psychic structure-i.e. the relationships between the id, the ego, and superego (Mitchell and Black-1995)

1.5.3 Object Relations Psychology

Object Relations psychology was first articulated Melanie Klein, W.R.D. Fairbairn, D.W. Winnicott, and Harry Guntrip. According to this theory, human beings are always shaped in relation to the significant others surrounding them. Our struggles and goals in life focus on maintaining relations with others, while at the same time differentiating ourselves from others. The internal representations of self and others acquired in childhood are later played out in adult relations. Individuals repeat old object relationships in an effort to master them and become freed from them.

1.5.4 Self Psychology

Self Psychology, founded by Heinz Kohut, observed that the self refers to a person's perception of his experience of his self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). Self Psychology emphasises empathy which is used to describe an intra-psychic process in the therapist by which an understanding of the patient, particularly an emotional understanding, a capacity to feel what the other is feeling, is enhanced.

Each of the four schools of psychoanalytic theory presents discrete theories of personality formation, psychopathology formation, and change; techniques by which to conduct therapy; and indications and contraindications for therapy.

Like Psychoanalysis, Psychodynamic Psychotherapy uses the basic assumption that everyone has an unconscious mind and that feelings held in the unconscious mind are often too painful to be faced. Thus we come up with defenses to protect us knowing about these painful feelings. Psychodynamic therapy assumes that these defenses have gone wrong and are causing more harm than good. It tries to unravel them, as once again, it is assumed that once you are aware of what is really going on in your mind the feelings will not be as painful. Several forms of therapy are based on these assumptions, but the most famous is Psychoanalysis developed by Freud.

1.6 DIFFERENCE BETWEEN PSYCHODYNAMIC THERAPY AND PSYCHOANALYSIS

Although similar to Psychoanalysis as it was derived from a similar background, Psychodynamic therapy is distinguished from psychoanalysis in several particulars, including the fact that psychodynamic therapy need not include all analytic techniques and is not conducted by psychoanalytically trained analysts. It tends to differ in the following ways:

Psychoanalysis

Focuses on repressed childhood conflicts, Id content, Ego activity.

- Brings conflict to conscious awareness to overcome neurosis.
- All adult problems can be traced back to childhood
- An Interaction of ego, superego, and id.
- Tends to affect a lot more of your personality.
- Conducted more frequently over a longer period of time.

Psychodynamic

- Less emphasis on sexual and aggressive drives.
- Less emphasis on unconscious information.
- More emphasis on past relationships.
- Offshoot of the psychoanalytic school.
- Interpretation is main tool.
- Mediator, a conscience and a devil.

- Has more specific goal e.g. sorting out a phobia.
- Conducted over a shorter period of time with less frequency than psychoanalysis

1.7 LET US SUM UP

Psychotherapy is procedures in which persons with psychological problems and mental disorders interact with a trained psychotherapist who helps them change certain behaviours, thoughts and emotions so that they feel and function better. The outcome of psychotherapy depends upon the client, the therapist and the techniques used by the therapist. Many forms of psychotherapy exist, ranging from the techniques used by Freud through modern techniques base on learning and cognitions.

Psychoanalysis is a form of psychotherapy focuses on helping individuals gain insight into their hidden inner conflicts and repressed wishes. The goal of Freudian psychoanalysis is to achieve insight into the unconscious dynamics that underlie their behaviour disorders so that they can deal adaptively with their current environment. The chief means for promoting insight is the interpretation of the client's free associations, dream content, resistance and transference reactions. Psychodynamic therapists view maladaptive behaviours as symptoms of an underlying conflict that needs to be resolved if behaviour is to be changed.

1.8 UNIT END QUESTIONS

1) What is Psychotherapy? What are its essentials?
2) What is Psychoanalysis? Discuss the phases in its evolution.
3) Discuss the role of Dream analysis in Psychoanalysis.
4) Explain the techniques used by Psychoanalysts.
5) What are Psychodynamic therapies? How are they different from Psychoanalysis?
6) Discuss the schools of psychoanalysis which have influenced Psychodynamics.

1.9 SUGGESTED READINGS

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UNIT 2 BEHAVIOURAL THERAPY, COGNITIVE BEHAVIOUR THERAPY AND APPROACHES TO COUNSELLING

Structure

2.0 INTRODUCTION

This unit deals with behaviour therapy cognitive behaviour therapy and related issues. We start with Behaviour Therapy, how it started and with what purpose and proceed to give some of the techniques related to behaviour therapy. The techniques such as systematic desensitisation, exposure, flooding, and aversion therapy are all discussed in this unit. Then we take up operant conditioning techniques under which we discuss the positive reinforcement, participant modeling and assertiveness training etc. This is then followed by cognitive behaviour therapy in which we discuss its history, present the ABC model of CBT and describe the techniques of CBT in detail. We then present the hierarchical structure of ABC model of cognitive behaviour therapy and elucidate the principles underlying cognitive therapies.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour therapy;
- Describe classical conditioning procedures in behaviour therapy;

- Explain cognitive-behavioural therapy (CBT) and its principles;
- Describe A-B-C Model of CBT;
- Identify the difference between behaviour therapy and cognitive-behavioural therapy (CBT); and
- Explain the techniques involved in CBT.

2.2 BEHAVIOUR THERAPY

Behavioural psychology, or behaviourism, arose in the early 20th century in reaction to the method of introspection that dominated psychology at the time. John B. Watson, the father of behaviourism, had initially studied animal psychology. In the 1960s, behaviour approaches emerged as a dramatic departure from the assumptions and methods that characterised psychoanalytic and humanistic therapies. They argued that psychology should concern itself only with publicly observable phenomena i.e., overt behaviour. According to Behaviouristic thinking, as mental content is not publicly observable, thus it cannot be subjected to rigorous scientific inquiry.

The new practitioners of behaviour therapy denied the importance of inner dynamics, instead they insisted that

1) maladaptive behaviours are not merely symptoms of underlying problems but rather are problems;
2) problem behaviours are learned on the same ways normal behaviours are; and
3) maladaptive behaviours can be unlearned by applying principles derived from research on classical conditioning, operant conditioning and modeling.

Consequently, behaviourists developed a focus on overt behaviours and their environmental influences.

Behaviour therapy involves changing the behaviour of clients to reduce dysfunction and to improve quality of life. Behaviour therapy includes a methodology, referred to as *behaviour analysis,* for the strategic selection of behaviours to change, and a technology to bring about behaviour change, such as modifying antecedents or consequences or giving instructions. Behaviour therapy represents clinical applications of the principles developed in learning theory.

2.2.1 History

Around 1920s, the application of learning principles to the treatment of behavioural disorders began to appear, but it had little effect on the mainstream of psychiatry and clinical psychology. Behaviour therapy emerged as a systematic and comprehensive approach to psychiatric (behavioural) disorders in 1960s. Joseph Wolpe and his colleagues used pavlovian techniques to produce and eliminate neuroses in cats. From this research, Wolpe developed systematic desensitisation. At about the same time, Eysenck and Shapiro stressed the importance of an experimental approach in understanding and treating individual patients, using modern learning theory. A Harvard psychologist B. F. Skinner also inspired the origin of behaviour therapy. Skinner's students began to apply his operant conditioning technology, developed in animal conditioning laboratories, to human beings in clinical settings.

Classical conditioning procedures have been used in two major ways.

i) First, they have been used to reduce or de condition anxiety responses.

ii) Second, they have been used in attempts to condition aversive stimuli.

His most commonly used classical conditioning procedures are:

- Systematic Desensitisation,
- Exposure therapy, and
- Aversion therapy.

Let us take up each of these and discuss.

2.2.2 Systematic Desensitisation

In 1958 Joseph Wolpe introduced Systematic Desensitisation, This is actually learning based treatment for anxiety disorders. Wolpe viewed anxiety as a classical conditioned response. His goal was to eliminate anxiety by using a procedure called Counterconditioning. In this, a new response that is incompatible with anxiety is produced. For example relaxed state which is incompatible with anxiety state. This relaxed state is conditioned to the anxiety arousing conditioned stimulus (CS), like for instance fear of a closed room or fear of heights etc.

It is based on the behavioural principle of Counterconditioning, whereby a person overcomes maladaptive anxiety elicited by a situation or an object by approaching the feared situation gradually, in a psychophysiological state that inhibits anxiety.

In systematic desensitisation, patients attain a state of complete relaxation and are then exposed to the stimulus that elicits the anxiety response.

The negative reaction of anxiety is inhibited by the relaxed state, a process called *reciprocal inhibition.*

Instead of using actual situations or objects that elicit fear, patients and therapists prepare a graded list or hierarchy of anxiety provoking scenes associated with a patient's fears. The learned relaxation state and the anxiety provoking scenes are systematically paired in treatment. Thus, systematic desensitisation consists of three steps:

- Hierarchy construction
- Relaxation training
- Desensitisation of the fear evoking stimulus.

Step 1: Hierarchy Construction

When constructing a hierarchy, clinicians determine all the conditions that elicit anxiety, and then patients create a hierarchy list of 10 to 12 scenes that produce anxiety and these are then put in order of increasing anxiety. In the box below is given an example of a hierarchy construction used in the systematic desensitisation treatment of a Test Anxious College Student.

Scene: Hierarchy of Anxiety Arousing Scenes

Hearing about someone else who has a test (**Least anxiety provoking**)
Instructor announcing that a test will be given in three weeks
Instructor reminding class that there will be a test in two weeks
Overhearing classmates talk about studying for the test, which will occur in one week
Instructor reminding class of what it will be tested on in two days
Leaving class the day before exam
Studying the night before test
Getting up morning of the test
Walking toward the building where the exam will be given
Walking into the exam room
Instructor walking into the room with the test
Tests being distributed
Reading the test questions
Watching others finishing the test
Seeing a question I can not answer
Instructor waiting for me to finish the test (**High anxiety provoking**)

Step 2: Relaxation Training

Relaxation training can help people control their physiological responses in stressful situations. These techniques produce physiological effects opposite to those of anxiety, that is slow heart rate, increased peripheral blood flow, and neuromuscular stability.

A variety of relaxation methods have been developed. Most methods use progressive relaxation, also known as somatic relaxation training, developed by the psychiatrist Edmund Jacobson.

It provides a means of voluntarily reducing or preventing high level of arousal. Patients relax major muscle groups in a fixed order, beginning with the small muscle groups of the feet and working towards shoulders, neck, face and head etc. Moving from lowest extremities to the head is called cephalcaudal. Ofcourse one can also start with head muscles, face muscles and move down to neck etc. and then on to the extremities.

Some clinicians use hypnosis to facilitate relaxation or use tape-recorded exercise to allow patients to practice relaxation on their own.

Mental imagery is a relaxation method in which patients are instructed to imagine themselves in a place associated with pleasant relaxed memories.

Such images allow patients to enter a relaxed state or experience. The physiological changes that take place during relaxation are the opposite of those induced by the stress responses that are part of many emotions.

Muscle tension, respiration rate, heart rate, blood pressure, and skin conductance decrease. Relaxation increases respiratory heart rate variability, which is an index of parasympathetic tone. In the box below relaxation step by step are given

With its focus on full, cleansing breaths, deep breathing is a simple, yet powerful, relaxation technique. It's easy to learn, can be practiced almost anywhere, and provides a quick way to get your stress levels in check. Deep breathing is the cornerstone of many other relaxation practices, too, and can be combined with other relaxing elements such as aromatherapy and music. All you really need is a few minutes and a place to stretch out.

How to practice deep breathing

The key to deep breathing is to breathe deeply from the abdomen, getting as much fresh air as possible in your lungs. When you take deep breaths from the abdomen, rather than shallow breaths from your upper chest, you inhale more oxygen. The more oxygen you get, the less tense, short of breath, and anxious you feel. So the next time you feel stressed, take a minute to slow down and breathe deeply:

- Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
- Breathe in through your nose. The hand on your stomach should rise. The hand on your chest should move very little.
- Exhale through your mouth, pushing out as much air as you can while contracting your abdominal muscles. The hand on your stomach should move in as you exhale, but your other hand should move very little.
- Continue to breathe in through your nose and out through your mouth. Try to inhale enough so that your lower abdomen rises and falls. Count slowly as you exhale.

If you have a hard time breathing from your abdomen while sitting up, try lying on the floor. Put a small book on your stomach, and try to breathe so that the book rises as you inhale and falls as you exhale.

Progressive muscle relaxation for stress relief

Progressive muscle relaxation is another effective and widely used strategy for stress relief. It involves a two-step process in which you systematically tense and relax different muscle groups in the body.

With regular practice, progressive muscle relaxation gives you an intimate familiarity with what tension—as well as complete relaxation—feels like in different parts of the body. This awareness helps you spot and counteract the first signs of the muscular tension that accompanies stress. And as your body relaxes, so will your mind. You can combine deep breathing with progressive muscle relaxation for an additional level of relief from stress.

Progressive Muscle Relaxation Sequence

- Right foot
- Left foot
- Right calf
- Left calf
- Right thigh

- Left thigh
- Hips and buttocks
- Stomach
- Chest
- Back
- Right arm and hand
- Left arm and hand
- Neck and shoulders
- Face

Most progressive muscle relaxation practitioners start at the feet and work their way up to the face. For a sequence of muscle groups to follow, see the box to the right:

- Loosen your clothing, take off your shoes, and get comfortable.
- Take a few minutes to relax, breathing in and out in slow, deep breaths.
- When you're relaxed and ready to start, shift your attention to your right foot. Take a moment to focus on the way it feels.
- Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
- Relax your right foot. Focus on the tension flowing away and the way your foot feels as it becomes limp and loose.
- Stay in this relaxed state for a moment, breathing deeply and slowly.
- When you're ready, shift your attention to your left foot. Follow the same sequence of muscle tension and release.
- Move slowly up through your body — legs, abdomen, back, neck, face — contracting and relaxing the muscle groups as you go.

Step 3: Desensitisation of the Anxiety Provoking Stimulus

In the final step, called *desensitisation*, the patient proceeds systematically through the list from the least, to the most, anxiety provoking scene while in a deeply relaxed state. In fact they vividly imagine the situation as is given in the list and as they imagine and as they are in the relaxed state, the scene even if evokes anxiety the anxiety does not bother the individual. In case it does, then the patient is made to relax once again all the more and the same scene is imagined, until the anxiety is no more evoked when visualising the concerned anxiety provoking situation. Once the patient is totally relaxed even under the anxiety provoking situation, the patient is asked to move to the next item in the list that is anxiety provoking. The same process as above is repeated until the situation no more evokes anxiety. Then the patient moves on to the third item in the list and so on. The rate at which the clients progress through the list is determined by their responses to the stimuli. When patients can vividly imagine the most anxiety provoking scene of the hierarchy with equanimity, they experience little anxiety in the corresponding real life situation.

2.2.3 Exposure: An Extinction Approach

From a behavioural point of view, phobias and other fears result from classically conditioned emotional responses. The conditioning experience is assumed to involve a pairing of the phobic object (fear of heights let us say) with an aversive unconditioned stimulus (UCS). For example, if a person has a fear of heights, then put him at a height (UCS) where he has no way to come down except with the help of a ladder that you may provide him later. As a result, the phobic stimulus (Height) becomes a conditioned stimulus (CS) that elicits the conditioned response (CR) of anxiety. Continuously staying exposed to the aversive stimulus (heights) in course of time brings down the anxiety and the extremenegative reaction. As this process of exposure is repeated again and again, the patient does not react negatively or with fear when exposed to heights.

Thus, according to this formulation, the most direct way to reduce the fear is through a process of classical extinction of the anxiety response. The client may be exposed to real life stimuli or asked to imagine scenes involving the stimuli. These stimuli will evoke considerable anxiety, but the anxiety will be extinguished in time if the person remains in the presence of the fear evoking stimulus (heights) and the UCS (anxiety) does not occur.

Some critics of exposure treatment are concerned that the intense anxiety evoked by the treatment may worsen the problem or cause clients to flee from the treatment. But experimental research has proved this technique a very effective treatment for extinguishing anxiety in both animals and humans.

Advances in computer technology have made it possible to present environmental cues in Virtual Reality (VR) for exposure treatment. Virtual reality involves the use of computer technology to create highly realistic virtual environments that stimulate virtual actual experience so vividly that they evoke many of the same reactions that a comparable real world environment would. Beneficial effects have been reported with virtual reality exposure of patients with height phobia, fear of flying, spider phobia, and claustrophobia. Much experimental work is being done in the field.

2.2.4 Aversion Therapy

For some clients, the therapeutic goal is not to reduce anxiety but actually to condition anxiety to a particular stimulus that triggers deviant behaviour. In aversion therapy, the therapist pairs a stimulus (drinking alcohol) that is attractive to the client (the CS) with a noxious UCS (vomiting due to an injection given immediately before taking alcohol) in an attempt to condition an aversion to the CS (alcohol). When a noxious stimulus (vomiting as punishment) is presented immediately after a specific behavioural response, theoretically, the response is eventually inhibited and extinguished. Many types of noxious stimuli are used which include for instance, electric shocks, substances that induce vomiting, corporal punishment, and social disapproval. The negative stimulus is paired with the behaviour, which is thereby suppressed. The unwanted behaviour may disappear after a series of such sequences. Aversion therapy has been used for alcohol abuse, paraphilias (child molesters), and other behaviours with impulsive or compulsive qualities, but this therapy is controversial for many reasons. For example, punishment does not always lead to the expected decreased response and can sometimes be positively reinforcing.

2.2.5 Operant Conditioning Treatments

The term behaviour modification refers to treatment techniques that apply operant conditioning procedures in an attempt to increase or decrease a specific behaviour like positive reinforcement, extinction, negative reinforcement, or punishment.

i) **Positive Reinforcement:** When a behavioural response is followed by a generally rewarding event, such as food, avoidance of pain, or praise, it tends to be strengthened and to occur more frequently than before the reward. This principle has been applied in a variety of situations. In the inpatient hospital wards, patients with mental disorder receive a reward for performing a desired behaviour, such as tokens that they can use to purchase luxury items or certain privileges. The process, known as token economy, has successfully altered undesirable behaviours to desirable behaviours.

ii) **Flooding:** Flooding, sometimes called *implosion*, is similar to graded exposure in that it involves exposing the patient to the feared object in vivo; however, there is no hierarchy. It is based on the premise that escaping from an anxiety provoking experience reinforces the anxiety through conditioning. Thus, clinicians can extinguish the anxiety and prevent the conditioned avoidance behaviour by not allowing patients to escape the situation.

In a variant, called *imaginal flooding*, the feared object or situation is confronted only in the imagination, not in real life.

Many patients refuse flooding because of the psychological discomfort involved.

It is also contraindicated when intense anxiety would be hazardous to a patient (e.g., those with heart disease or fragile psychological adaptation). The technique works best with specific phobias.

iii) **Participant Modeling:** In participant modeling, patients learn a new behaviour by imitation, primarily by observation, without having to perform the behaviour until they feel ready. Learning by watching others' behaviour is also called Observational learning.

Just as irrational fears can be acquired by learning, they can be unlearned by observing a fearless model confront the feared object. The technique has been useful with phobic children who are placed with other children of their own age and sex who approach the feared object or situation.

With adults, a therapist may describe the feared activity in a calm manner that a patient can identify.

Or, the therapist may act out the process of mastering the feared activity with a patient.

Sometimes, a hierarchy of activities is established, with the least anxiety provoking activity being dealt with first. The participant modeling technique has been used successfully with agoraphobia by having a therapist accompany a patient into the feared situation. In a variant of the procedure, called *behaviour rehearsal*, real life problems are acted out under a therapist's observation or direction.

iv) **Assertiveness Training:** Assertive behaviour enables a person to act in his or her own best interest, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, and to exercise personal rights without denying the rights of others.

Two types of situations frequently call for assertive behaviours:

- setting limits on pushy friends or relatives and
- commercial situations, such as countering a sales pitch or being persistent when returning defective merchandise.

Early assertiveness training programs tended to define specific behaviours as assertive or nonassertive.

v) **Social Skills Training:** Social skills training have been found to be efficacious for depression and schizophrenics. These training programs cover skills in the following areas:

- conversation,
- conflict management,
- assertiveness,
- community living,
- friendship and dating,
- work and vocation, and
- medication management.

Each of these skills has several components. For example, assertiveness skills include the following:

- making requests,
- refusing requests,
- making complaints,
- responding to complaints,
- expressing unpleasant feelings,
- asking for information,
- making apologies,
- expressing fear, and
- refusing alcohol and street drugs.

Each component involves specific steps.

2.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

In 1960s, Cognitive revolution in Psychology occurred and by 1970 many behaviour therapists influenced by it began to call it Cognitive Behavioural therapy. Cognitive behavioural therapy (CBT) is an amalgam of two therapies: cognitive therapy (CT) and behavioural therapy. The term "cognitive behavioural therapy" is a very general term for a classification of therapies with similarities.

2.3.1 Brief History

CBT is a form of psychotherapy that emphasises the important role of thinking in how we feel and what we do. It does not exist as a distinct therapeutic technique. Beck and Ellis are two names associated with Cognitive Behavioural Therapy.

Albert Ellis's system, originated in the early 1950s, developed Rational Emotive Therapy (RET), the first discrete therapeutic approach to CBT. Aaron T. Beck, inspired by Albert Ellis, developed **cognitive therapy** in the 1960s.

Ellis developed and popularised the ABC model of emotions, and later modified the model to the A-B-C-D-E approach.

In the 1990's Ellis renamed his approach Rational Emotive Behaviour Therapy. Behavioural therapy focuses on a person's actions and aims to change unhealthy behaviour patterns.

In the 1960's, Aaron Beck, M.D. developed his approach called Cognitive Therapy. CT focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy. Aaron Beck proposed the basic principles of CBT which can be applied to variety of psychiatric and medical problems. It focuses on identifying and changing maladaptive patterns of information processing and related behaviours. CBT methods are rooted in a psychological understanding of symptoms. It shares three fundamental propositions:

1) Cognitive activity affects behaviour
2) Cognitive activity may be altered and monitored
3) Desired behaviour change may be effective through cognitive change

Beck's approach became *known for its effective* treatment of depression.

Cognitive behavioural approach is based on the assumption that anxiety, depression, and negative emotions develop from maladaptive thought processes.

2.3.2 ABC Model of CBT

This model records a sequence of events in terms of:

A – Activating Event (described as a 'Trigger')
B – Beliefs (e.g. the thoughts that occur when the Activating Event happens)
C – Consequences (how you feel and behave when you have those Beliefs)

This ABC technique of irrational belief has proven as the major tool in cognitive therapy. The main aim of this technique is to focus around the causes that develop irrational belief and has to be recorded during the therapy.

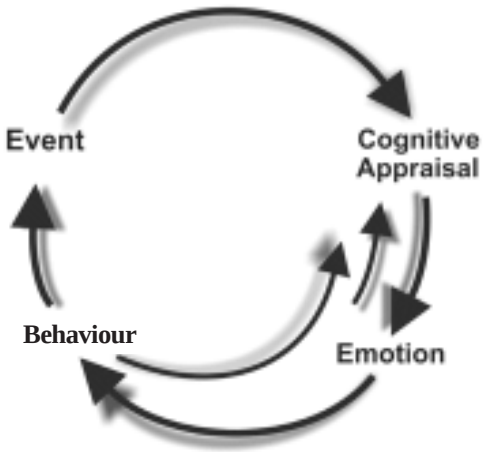


Fig.1: Basic Cognitive Behaviour Model

Source: From Wright JH. Basco MR. Thase ME: Learning Cognitive-Behaviour Therapy: An Illustrated Guide. Washington. DC. American Psychiatric Publishing. 2006, p 5

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognise and change inaccurate beliefs, relate to others in more positive ways, and change behaviours accordingly. There are several approaches to cognitive behavioural therapy, including the following:

1) Rational Emotive Behaviour Therapy,
2) Rational Behaviour Therapy,
3) Rational Living Therapy,
4) Cognitive Therapy, and
5) Dialectic Behaviour Therapy.

2.3.3 Goals of CBT

CBT focuses on A *Here and Now* orientation.

The goals of CBT are:

- To challenge the thoughts about a particular situation by identifying the cognitive traps
- To help the patient to identify less threatening alternative and
- To test out these alternatives in the real world.
- It also aims to leave clients at the completion of therapy with the freedom to choose their emotions, behaviours and lifestyle (within physical, social and economic restraints).
- To Finally effect profound and lasting change in the underlying belief system of the client, rather than simply eliminating the presenting symptoms.
- To make the client equipped with self help techniques that enable coping in the longterm future

2.3.4 Techniques/Principles of CBT

CBT is based on several principles. These are:

- It is brief and time-limited
- It is structured, directive, and problem-oriented
- It is based on the cognitive-behavioural model of emotional disorders.
- It is a collaborative effort between the CBT practitioner and the client seeking treatment and requires a sound therapeutic relationship. They work together to try to understand the person's difficulties and what may be contributing to them.
- The sessions of CBT are typically one hour in length.
- The clients are guided to discover new ways of thinking for themselves with specific questions.
- It is often based on an education model.

- It relies on the inductive method, a scientific approach using logic and reasoning.
- It uses between-session practice as a central feature (for people to put into practice what they have learned). New behaviours are initially tested in safe situations (for example, the practitioner's office).
- It focuses on the present. The past cannot be changed, but the way we think about the past can be changed

2.3.5 Levels of Cognition

Three major levels of cognition, relevant to the practice of CBT, were identified by Beck and his colleagues. These are (i) Full consciousness, (ii) Automatic Thoughts, and (iii) Schemas.

i) Consciousness is a state in which rational decisions are made with full awareness.

ii) Automatic thoughts are more autonomous, often private cognitions that flow rapidly in the stream of everyday thinking and may not be carefully assessed for accuracy or relevance.

iii) Schemas, the deepest level of cognition, are fundamental rules for information processing which are shaped by developmental influences and other life experiences. Schemas that play a major role in regulating self worth and behavioural coping strategies are a frequent target of CBT.

Examples of automatic thoughts and maladaptive schemas

Autiomatic Thoughts	**Maladaptive schemas**
I should be doing better in life	I must be perfect to be accepted
I have let him / her down	I am a fake
I always keep messing things up	If I choose to do something, I must succeed.
I cannot handle it	I am unlovable
It is too much for me	No matter what I do, I won't succeed
I don't have much of a future	The world is too frightening for me
Things are out of control	Others cannot be trusted
I feel like giving up	I must always be in control
I will never be able to get this done	I am stupid
Something bad is sure to happen	Other people will take advantage of me.

(Source: Wright e.t all (2011))

2.3.6 Techniques Used in CBT

The CBT techniques, described below, are useful in eradicating certain problems in a time bound manner which stem from maladaptive thoughts and behaviours. The techniques are given in the following section:

i) **Cognitive Rehearsal:** In this technique, the therapist asks the patient to recall a problematic situation of the past. The therapist and patient both work together to find out the solution to the problem.

ii) **Validity Testing:** This is one of the first cognitive therapy techniques. Every disorder or disease must have supporting evidence and the therapist asks the patient, to defend his feelings, thoughts and beliefs, with objective evidence. The faulty nature or invalidity of the beliefs of the patient is exposed if he is unable to produce any kind of objective evidence.

iii) **Writing in a diary / Journal:** It is the practice of maintaining a diary to keep an account of the situations that arise in day to day life. This is a detailed diary, which notes every emotion, thought and belief. The therapist and the patient, later, collectively assess the diary/ journal, to analyse how they actually affect the behaviour of the individual..

iv) **Guided Discovery:** The purpose of this technique is to enable the patient realise his cognitive distortions. The patient becomes aware of his cognitive distortions through a series of questions and answers.

v) **Systematic Positive Reinforcement:** Cognition can be changed over a period of time, by positive encouragements and small rewards. It is one of the cognitive behavioural therapy techniques in which 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, withholding the reinforcement is also equally important. It helps in eradicating a maladaptive behaviour.

vi) **Aversive Conditioning:** This technique makes use of dissuasion for lessening the appeal of a maladaptive behaviour. The patient is exposed to an unpleasant stimulus while engaging him in a particular behaviour or thought for which he has to be treated, thus, the unpleasant stimulus gets associated with such thoughts/behaviours and then the patient exhibits an aversive behaviour towards them.

vii) **Modeling:** In Modeling, the patient makes use of the behaviour of the therapist as a model in order to solve his/her problems. The therapist performs role playing exercises which are aimed at responding in an appropriate way to overcome difficult situations.

viii) **Homework:** The therapist gives a set of assignments to patients as homework. The patient take notes during the session, reviews the audiotapes of a particular session or reads article/books that are related to the therapy.

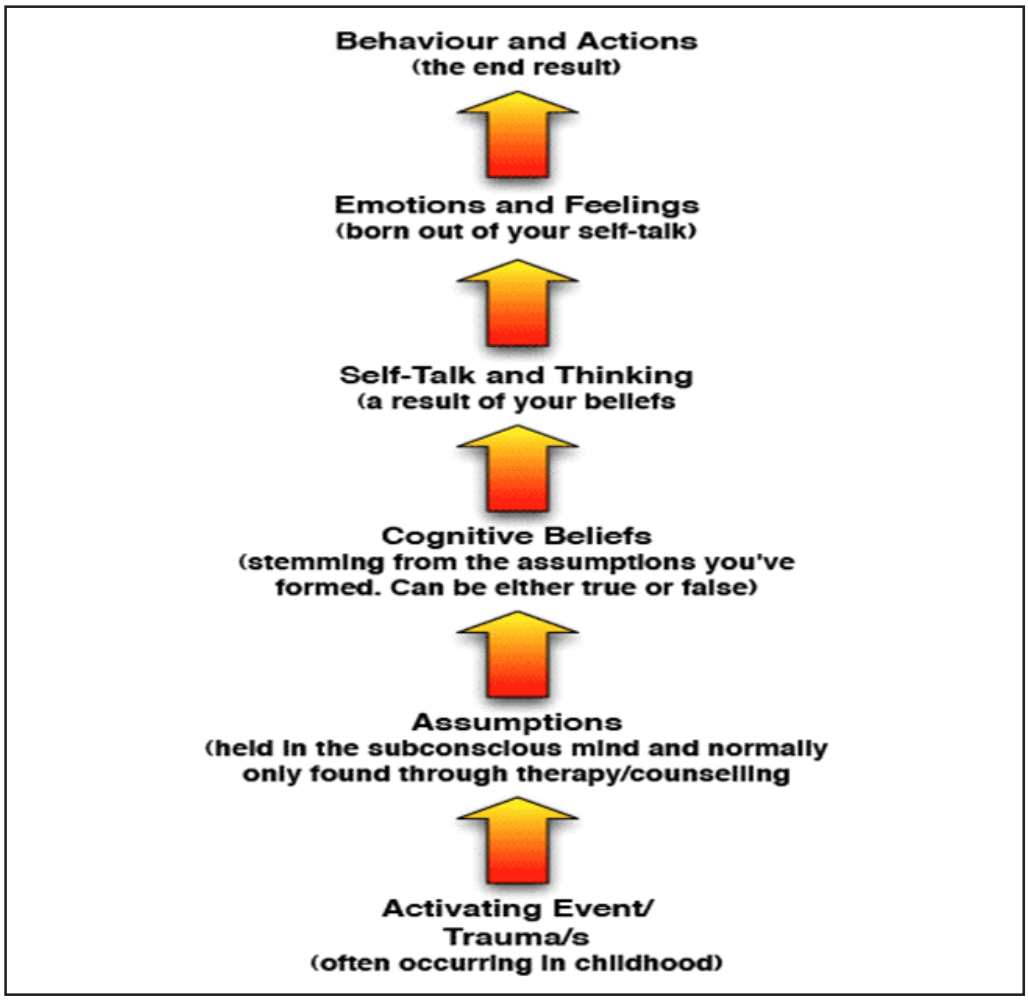
2.3.7 Hierarchical Structure of A-B-C

People experience events in their life. These events lead to assumptions (right or wrong) being made about that event. Once the assumption has been made, it gets placed into our subconscious mind. This assumption then generates beliefs or conclusions. These beliefs can either be true/accurate or false/inaccurate.

From these beliefs comes our thinking and self talk. From our thinking and self talk comes our feelings and emotions. Finally, our feelings and emotions give rise

to our behaviour and actions. The following diagram displays the way in which one wrong assumption can give birth to many beliefs, which in turn gives birth to many more self talk, emotional and behavioural issues.

Looking at this hierarchy structure, true change, that is life long and effective, can only happen if the core assumptions are uncovered and dealt with. The assumption is the base level which determines everything else in the hierarchy. If change was attempted by only addressing the behavioural level, sooner or later the emotions and self talk would cause that change to be negated. Will power can not override the internal feelings below the behavioural level. If change was attempted at the emotions and feelings level, then changed behaviour will follow, but at some point internal self talk, beliefs and assumptions will be too much to bear and cause the emotions then actions to revert back.



Thus Cognitive therapy involves getting down to the beliefs level.

Down at this level, lasting change can begin to occur.

Change in the belief system results in change in all the levels above it.

The only problem is that the underlying assumption that caused the false belief and then conflict is still lurking.

It means that if the assumption itself is incorrect/wrong/false, then it will generate other false beliefs.

What can occur in therapy then is that false belief upon false belief are traced, faced and replaced, but there always seems to be more.

The ONLY way to achieve true freedom from the shackles is to uncover the core assumption at the base level.

Once you find this and confront it, the false beliefs take care of themselves and no new ones are created, your self talk changes, your emotions and feelings turn positive and your actions follow suit.

2.4 LET US SUM UP

Behaviour therapy has been used successfully for a variety of disorders and can be easily taught. It requires less time than other therapies and is less expensive to administer. Although useful for circumscribed behavioural symptoms, the method cannot be used to treat global areas of dysfunction (e.g., neurotic conflicts, personality disorders).

Controversy continues between behaviourists and psychoanalysts, which is epitomised by Eysenck's statement: "Learning theory regards neurotic symptoms as simply learned habits; there is no neurosis underlying the symptoms, but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis."

Analytically-oriented theorists have criticized behaviour therapy by noting that simple symptom removal can lead to symptom substitution: When symptoms are not viewed as consequences of inner conflicts and the core cause of the symptoms is not addressed or altered, the result is the production of new symptoms. Whether this occurs remains open to question, however.

Whereas CBT is based on the concept that mental disorders are associated with characteristic alterations in cognitive and behavioural functioning and that this pathology can be modified with pragmatic problem-focused techniques. CBT is well established as a treatment for depression, anxiety disorders, and eating disorders. There is growing evidence that it can play an effective role in the clinical management of a large range of other disorders, including schizophrenia, bipolar disorder, and axis II conditions.

2.5 UNIT END QUESTIONS

1) What is Behaviour Therapy? Give a brief outline of its history.

2) What is modeling, and how it can be used in treating psychological problems?

3) Writ a note on Exposure as an extinction approach.

4) Construct a hierarchy of fear arousing situation of any animal.

5) Define CBT and discuss the levels of cognitions.

6) According to CBT, What is the primary cause of mental disorders?

7) Explain the hierarchical structure of A-B-C model of CBT.

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UNIT 3 DRAMA AND ART THERAPY IN COUNSELING

Structure

3.0 INTRODUCTION

Counseling is both an art and a science. It is scientific in its development of theoretical approaches to working with individuals and groups. It is artistic in the way in which it uses timing and emphasis to implement certain methods with particular individuals. For effective counseling, art and science must work together for the welfare of client as well as counselor. Artistic methods and therapies can be important and useful for the growth of counseling profession because it may promote new insight. The creative arts have a significant contribution to make to counseling theory and practice. Creative arts refers to art forms including visual representations like painting, drawing and sculpture, literary expressions, drama and music, that help the individuals become more aware of themselves or others. In counseling, creative arts are defined as arts that are employed in therapeutic settings to help facilitate relationships between counselors and clients. Various art forms have been employed in counseling. The most widely used are: Visual Art, Psychodrama, Poetry, Dance and Music. This unit will discuss art and drama therapy.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Discuss the concept of drama therapy;
- Define art therapy;
- Explain the steps involved in the process of art therapy;
- Describe five stage theory; and
- Explain art and drama therapy techniques.

3.2 DRAMA THERAPY

Drama therapy is defined by the National Association for Drama Therapy as "the systematic and intentional use of drama/theater processes, products, and associations to achieve the therapeutic goals of symptom relief, emotional and physical integration and personal growth."

The word 'drama' comes from ancient Greek and means quite literally "things done" (Harrison, 1913).

Drama therapy uses action techniques, particularly role play, drama games, improvisation, puppetry, masks, and theatrical performance, in the service of behaviour change and personal growth.

It is an active approach that helps the client tell his or her story to solve a problem, achieve a catharsis, extend the depth and breadth of inner experience, understand the meaning of images, and strengthen the ability to observe personal roles while increasing flexibility between roles.

The result is an active, experiential process that draws on the person's capacity for play, utilising it as a central means of accessing and expressing feelings, gaining insight, practicing successful approaches to difficult situations. It has its roots in religion, theatre, education, social action, and mental health/therapy

Early humans began to make art that is, paintings, sculpture, music, dance, and drama about 45,000 years ago. The origins of the arts and religion seem to be intertwined because the arts naturally provided effective symbolic ways to express abstract religious ideas. Dance and drama, in particular, were extremely useful in rites to create sympathetic and contagious magic as well as to embody myths and rituals.

The first written theoretical account of drama therapy can be found in connection with Greek theatre. In his Poetics, Aristotle says the function of tragedy is to induce catharsis which is a release of deep feelings (specifically pity and fear) to purge the senses and the souls of the spectators (Aristotle, trans. 1954). According to Aristotle, the purpose of drama is not primarily for education or entertainment, but to release harmful emotions in an individual which in turn will lead to harmony and healing to the individual as well as in the community (Boal, 1985).

Drama therapy applies techniques from theatre to the process of psychotherapeutic healing. It emerged as a field in the late 1970's from hospitals and community programs where it was first used with clients to produce plays and later was integrated with improvisation and process drama methods. The focus in drama therapy is on helping individuals grow and heal by taking on and practicing new roles. While much drama therapy aims at helping people who are in therapy, drama therapists have extended their applications beyond clinical contexts to enrich the lives of at risk individuals, to prevent problems, and to enhance wellness of healthy people. Many of the skills for such extensions require a measure of training psychological training as well as a strong basis in theatre.

Just as psychotherapy treats people who have difficulties with their thoughts, emotions and behaviour, drama therapy uses drama processes (games, improvisation, storytelling, role play) and products (puppets, masks, plays/

performances) to help people understand their thoughts and emotions better or to improve their behaviour.

The drama therapist is trained in four general areas:

i) drama/theatre,

ii) general and abnormal psychology,

iii) psychotherapy, and

iv) drama therapy.

The drama therapist's role is to facilitate the client's experience in a way that keeps the client emotionally and physically safe while the client benefits from the dramatic process. Depending on the goals and needs of the client, the drama therapist chooses a method that will achieve the desired combination of understanding, emotional release, and learning of new behaviour.

Some methods, such as drama games, improvisation, role play, developmental transformations, sociodrama and psychodrama are very process oriented and unscripted. The work is done within the therapy session and not presented to an audience.

Other methods, such as Playback Theatre, Theatre of the Oppressed, and the performance of plays are more formal and presentational, involving an audience. Puppets, masks, and rituals can be used as part of performance or as process techniques within a therapy session.

Certain techniques like drama games, role play, etc. involve fictional work. The client pretends to be a character different from him or herself. This can expand the client's role repertoire.

Other techniques, such as Psychodrama, Therapeutic Spiral Model, Playback Theatre, Theatre of the Oppressed and autobiographical performances, allow the client to explore his or her life directly. Clients need to have good ego strength to be able to do this kind of non-fiction work because it requires an honest, searching look at oneself.

3.2.1 Five Stage Theory

Renee Emunah (1994) has identified five stages through which most drama therapy groups progress. Her five stage theory parallels established wisdom from group dynamics on how successful groups form and grow.

1) The first stage is Dramatic Play where the group gets to know each other and the therapist through playing together develop trust, group cohesion, and basic relationship skills.

2) The second stage is the Scene Work Stage where they continue playing. The focus remains on developing dramatic skills which they will need as they continue in treatment. As they grow older and begin school, they are encouraged to develop their abstract reasoning skills and use them in their learning.

3) Stage Three focuses on Role Play, exploring issues through fictional means. Perhaps the group acts out a generic family conflict or a familiar character from a fairy tale or legend that goes through a crisis or challenge shared by group members. When the group is ready, they can move on to the next stage.

4) Stage Four: Culminating Enactments, where personal issues are acted out directly through psychodrama or autobiographical performance.

5) The final stage is Dramatic Ritual, which usually involves closure to the work of the group. This might be the sharing of a public performance that has been created by the group or the sharing of a private ritual within the group

3.2.2 Drama Therapy Techniques

Drama therapy techniques differ from therapist to therapist or from session to session, but certain concepts are common to all forms.

1) **Use of Metaphor:** The first is the use of metaphor through action. Behaviours, problems, and emotions can be represented metaphorically, allowing for symbolic understanding. An emotion can be represented with a metaphorical image: anger displayed as a volcano, an exploding bomb, or a smoldering fire. These images can be dramatised which allow the client to gain more insight into the qualities of the emotion and how it functions positively or negatively in his/her life.

2) **Concrete embodiment:** This technique allows the abstract to become concrete through the client's body. Embodiment allows clients to "experience" or "re-experience" in order to learn, to practice new behaviours, or to experiment with how to change old behaviours. Playing a role quite different from oneself often feels more comfortable than playing oneself directly.

3) **Dramatic Projection:** This technique is akin to concrete embodiment and employs metaphor. It is the ability to take an idea or an emotion that is within the client and project it outside to be shown or acted out in the drama therapy session.

4) A client's difficulty asking for help (an internal problem) can be dramatised in a scene with other members of the group, with puppets, or through masks, so the problem becomes an external problem which can be seen, played with, and shared by the therapist and the group.

5) **Creation of transitional space:** The creation of Transitional Space is an important component in many therapeutic and learning environments, but it is essential in drama therapy. Transitional space is the imaginary world that is created when we play or imagine together in a safe, trusting situation.

6) It is a timeless space in which anything we can imagine can exist. It is created jointly by the therapist and the clients playing together and believing in the possibility that anything can happen.

7) **Incorporating other Arts:** Drama therapy is like a crossroad, where all the arts come together and are allowed to work together. Drama therapists use music, movement, song, dance, poetry, writing, drawing, sculpture, mask making, puppetry, and other arts with their drama therapy activities. Drama therapists are required to have training in the other creative arts therapies and why many drama therapists have credentials in one of the other arts therapy modalities.

3.2.3 Applications of Drama Therapy

Drama therapy is primarily conducted in groups, but can be used in individual, couples, or family counseling. It can be found in a wide variety of settings with many different kinds of clients. Any kind of therapy group that uses talk therapy can use drama therapy. For some groups, the action methods of drama therapy are more effective. Drama therapy ignores the excuses and denial, getting right to the behaviour.

Other types of groups for instance, nonverbal clients or children who are not good candidates for verbal therapy can often participate successfully in drama because they can not verbalize rather show how they feel. It is practiced in clinical settings, residential settings, correctional facilities, educational situations, corporations and businesses, community action settings, and social and recreational centers.

3.3 ART THERAPY

Art therapy is a modality emerged from the interacting of art, creativity and psychotherapy. It uses art media to express internal images, feelings, thoughts and sensations in a concrete form. It provides the opportunity for non verbal expression and communication, which can assist in improving the client's functional abilities and resolving emotional issues. The use of art as therapy implies that the creative process can be a means both of reconciling emotional conflicts and of fostering self awareness and personal growth.

The use of art can be traced all throughout history, from prehistoric eras to the present, but art therapy first received significant attention due to the theories of Freud and Jung (Wadeson, 1980). These psychologists believed in the importance of symbolism, which is very prominent in art forms.

Art therapy has continued to evolve and became a recognised profession in the 1960's. According to Wadeson (1980), "the creation of the American Journal of Art Therapy and the establishment of the American Art Therapy Association" were responsible for art therapy's rise to a recognised profession and therapeutic intervention.

Art therapy is based on the idea that the creative process of art making is healing and life enhancing and is a form of nonverbal communication of thoughts and feelings (American Art Therapy Association, 1996). It is the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development.

Through creating art and reflecting on the art products and processes, people can increase awareness of self and others, cope with symptoms, stress, and traumatic experiences; enhance cognitive abilities; and enjoy the life affirming pleasures of making art. It is used to encourage personal growth, increase self understanding, and to assist in emotional reparation and has been employed in a variety of settings with children, adults, families and groups.

It is a modality that can help individuals of all ages create meaning and achieve insight, find relief from overwhelming emotions, resolve conflict and problems, enrich daily life and achieve an increased sense of well-being (Malchiodi, 1998).

Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight.

Art therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with models of counseling and psychotherapy. It is used with children, adolescents, adults, groups, and families to assess and treat anxiety, depression, and other mental and emotional problems; physical, cognitive, and neurological problems; and psychosocial difficulties related to medical illness. Art therapy programs are found in a number of settings including hospitals, clinics, public and community agencies, educational institutions, businesses, and private practices.

Art therapists are master's level professionals who hold a degree in art therapy or a related field. Educational requirements or syllabus include theories of art therapy, counseling, and psychotherapy, ethics and standards of practice, assessment and evaluation, individual, group, and family techniques, human and creative development, multicultural issues research methods, and practicum experiences in clinical, community, and/or other settings. Art therapists are skilled in the application of a variety of art modalities (drawing, painting, sculpture, and other media) for assessment and treatment. Art therapy combines traditional psychotherapeutic theories and techniques with an understanding of the psychological aspects of the creative process, especially the affective properties of the different art materials.

3.3.1 Basic Approaches

There are two basic ways in which an art therapist can approach the idea of art therapy. The first is to be process intensive. In this approach the art therapist, uses art as a means to help his/her patient(s) to discover something about him or herself. Art is used as a catharsis, an emotional journey to which self-actualisation and discovery are the end result. Edith Kramer was the first person to champion this school of thought. Kramer emphasised the healing qualities of art making, and was concerned with artistic quality.

The second approach is not to be so concerned with the process of making the art, but with what the person is consciously or unconsciously expressing through their art. Margaret Naumburg believed that this was the best way to utilise art therapy. In this way, the art therapist uses art as a window into the subconscious of the patient, and from there can attempt to figure out the underlying problems that the patient may be suffering from. It can be risky to look into art too closely, but in the case of children, who may not have the words to express how they are feeling; it is very beneficial to use art as a mode of expression.

3.3.2 Steps in Art Therapy

1) **Assessment:** Assessment often comes at the beginning of art therapy, and usually happens during the first session that the therapist has with the client. Assessment is used by the therapist to find out what the client is going through, and to gain any other information that he or she may wish to find out about

the client. It is important to be very up-front at this time with the client, being very clear that the session is not treatment oriented, but is for assessment purposes. Assessment at the beginning of therapy is an important first step because it is at this point that the therapist will decide if art therapy is a good option for the client or if it would be a waste of time.

2) **Treatment in the Beginning:** During the first session, the first thing for the therapist is to establish a good rapport with the client because it allows for the development of trust in the relationship. It is also essential for the art therapist to better grasp the framework from which the client is operating.

   After establishing a rapport with the client and getting a grasp on the client's vantage point, the art therapist can introduce art therapy to the client by giving back-round information about art therapy, and answering any questions that the client may have. At this point, the therapist may suggest doing some artwork.

   This first piece of art that the client creates is a very important one because it sets the tone for the rest of the session. Because many people have art anxiety in these beginning sessions, it is important that the therapist makes the client feel as comfortable as possible. This could be done by saying to the client that they should not worry about artistic accomplishment, but rather self-expression. Another important aspect of this first artistic work is the reaction of the therapist to it.

   After this first session, it is important for the art therapist to begin developing treatment goals, as well as to reflect on what initial reactions the therapist may have after the first meeting.

3) **Mid-phase of treatment:** It is hard to know when the treatment has moved from the beginning portion to the mid phase but there are a couple of key differences which are given below:

   - when the trust between the client and therapist has been established, and
   - the focus of the sessions becomes more goal oriented, that do mark the mid-phase.

   In the mid phase of treatment the therapist first establishes direction and boundaries, both personal and professional. There are many different techniques that are used in art therapy and knowing which one to use at what time is one of the art therapist's toughest jobs. Because each case is unique and each client is different, the art therapist must custom fit the art therapy for each individual client.

4) **Termination:** The termination of art therapy is initiated abruptly and clearly. Either the art therapist or the client can initiate the termination of the art therapy. Termination is generally decided upon when the therapist or the client realises that the therapy is finite. It is a very important part of the therapy process. The way in which therapy is brought to a close is crucial to the outcome of the treatment. If termination is handled incorrectly, the client or patient may regress as the end of therapy approaches.

The therapist should prepare the patient well in advance. This can be done by bringing up the issue of termination, focusing on its importance and discussing and interpreting feelings and behaviours due to the pending ending of the sessions. This is a difficult tightrope for the therapist to walk because focusing on the end often brings to mind other separations that client may have suffered.

When nearing the end of the therapy, the client and therapist should begin relooking at the art that the client has created throughout the sessions and talking about the progress that the client has made. It is also a good idea to use art in these last few sessions to help express feeling about the termination of the therapy sessions. The therapist often will join the client on these works of art.

The termination of the art therapy brings up a very practical question as well, what should be done with the art that the client created during the course of the sessions? This is a tricky question, but ultimately it is one that should be answered by the client. They could keep the art as a form of remembrance to the journey they went through, or give it to the therapist to show the importance of the therapeutic bond that they reached.

These are of course not the only two options that the client has, but two of the most common ones.

3.3.3 Art Therapy Techniques

The following are some techniques that art therapists use:

1) **Exploration Tasks:** An exploration task can be quite liberating. The goal is to encourage the patient/client to let go of conscious thoughts and controls, and to have them express themselves as freely and spontaneously as possible. In this way, exploration tasks are very much akin to verbal free associations. Exploration tasks are generally used in the beginning sessions of art therapy. Some examples of exploration tasks are:

   a) *Scribble Technique /Automatic Drawing*

   In this, the patient/client is asked to relax and begin to make draw free lines or scribbles on paper. In some cases the patient/client will be instructed not to remove his or her pen from the paper until the exercise is over. Automatic drawing provides an excellent way for the patient/client to let down their guards and thus is a good starting point for therapy.

   b) *Free Drawing*

   In free drawing all the choices are up to the patient/client. The patient/client is told to express him or herself freely, and not to worry about planning the picture. This technique is useful because the images that the patient/client creates are often mirrors into the person's present problems, strengths and weaknesses. Often at the end of free drawing, the patient/client is asked to share and explain what they drew about.

   c) *Drawing Completion*

   In the drawing completion technique, a patient/client is given one or more pieces of paper that already have a few lines or simple shapes on them. These shapes or lines act as a starting point for the art therapy artist, and they are to be incorporated into a larger picture. Because of the wide individual responses

to the same stimuli, this is an excellent technique for a group discussion topic. Kinget developed this approach for therapeutic purposes.

2) **Rapport-Building:** Rapport-building exercises are used in both individual and group art therapy settings. The basic idea behind rapport building exercises is to reduce the amount of isolation that the patients/clients may feel while they are creating their art. This includes isolation from the other patients/ clients in the group, and the distance they feel between themselves and the therapist. Some examples of Rapport-Building are:

   a) *Conversational Drawing*

   In conversational drawing, the group is broken up into pairs. The two people who are assigned to work together are seated across from one another. The only way of communication is with shapes, colours and lines. In this way, the pair is not only communicating, but sharing at the same time. This is a good way from patients to get to know one another a little better.

   b) *Painting Completion by the Group*

   In painting completion by the group, each member of the group is asked to name one thing, an object, feeling or event, and then depict it. From here, one or more of the group members begin adding to the collage, trying to improve upon what is already there. This technique better enables people to become aware of how it feels when they make something and have someone else "put upon you anything they want to." The patients/clients are encouraged to share what they are feeling about someone else adding to their work.

   c) *Painting with an Observer*

   In painting with an observer, one member of a pair tells the other one whatever comes to into his or her minds as he or she watches the other one paint. The painter can respond to what the other one is saying as he or she sees fit during their painting. This exercise promotes discussion of feelings of dependency and autonomy, as well as acceptance issues.

3) **Expression of Inner Feelings:** These techniques are designed to help the patient/client get in touch with inner feelings, desires and fantasies and to make visual representations of them. This is done in the hope that the patient will become increasingly aware of him or herself. The therapist will then attempt to help the patient/client deal with these feelings, and move in a direction toward a solution. An example of expression of inner feelings technique is called "three wishes".

   a) *Three Wishes*

   In the three wishes technique, the patient or client is asked to paint or portray three or more wishes. Responses tend to be of desires for things, personal security and so on. Responses to this exercise reflect maturity level, degree of egocentricity and so on. Discussion that follows this exercise focuses on the strength of the wish and whether or not these goals/wishes are attainable.

4) **Self Perception:** The self perception technique is aimed at moving a client toward a more complete awareness of personal needs and body image. Some examples of this technique are as follows:

Immediate States -Here the patient/client selects one or more of statements "I am", "I feel", "I have", or "I do" to paint about.

a) *Self-Portraits*

Self-portraits can vary from being realistic, done with or without a mirror to abstract. A variation of this technique is to give a time limit to the painter, such as one minute. In this way, the artist is forced to quickly decide what important feature about themselves they wish to draw.

b) *Draw Yourself as an Animal*

Here the patient/client is asked to draw themselves as any kind of animal, or as the animal that they see themselves as most similar to. This is a good group building technique because the discussions are usually funny as well as revealing.

5) **Interpersonal Relations:** The interpersonal relations technique is designed to make the patient/client more aware of others, and how others may perceive him or her. Some examples of this technique are as follows:

a) *Portraits of Groups Members*

Here group members are asked to depict each other. This exercise helps group members to more fully clarify their feelings toward each other.

b) *Group Mural*

Here the group works cooperatively on a large project. The choice in subject matter and materials may be left to the group or predetermined by the therapist. This exercise promotes cooperation, group unity, fitting in individually to a larger whole and self expression in a larger group setting.

6) **The Individual's Place in the World:** This technique is designed to help the patient/client to see where he or she fits into the world, and hopefully accept and deal with this realisation. Some examples of this technique are as follows:

a) *House-Tree-Person*

Here the patient/client is asked to depict a house, tree and a person in one picture. The patient/client is faced with the task of how to relate the human figure to the other two common environmental features.

b) *Collage and Assemblage*

Here the patient/client is allowed to create a personal world out of any materials that he or she may desire. The therapist may predetermine themes, or the patient/client may work until themes begin to appear by themselves.

It is important to keep in mind that although there are many techniques available to the art therapist and all of them are valid, no one technique should dominate. This is because the techniques discussed here are only loose guidelines that the art therapist should take into consideration. More important than these guidelines are that the approaches that the art therapist chooses to take are well designed and thought out to meet the specific demands and needs of the individual or group.

3.4 LET US SUM UP

Art and Drama therapies have benefited all areas of health care system. According to the American Art Therapy Association, Inc.'s professional definition of Art Therapy, Art Therapy is a human service profession that utilises art media, images, the creative art process and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns and conflicts. Defining art therapy is a daunting task because it is an evolving science, and because it is hard to come up with a definition that fully encompasses what art therapy is, but it doesn't mean that it is any less beneficial as a form of therapy. Art therapy is not just a stepping stone to a verbal exchange, and should not be treated in this way. The art therapist should be very careful of over or under reliance on the verbal amplifications of the art by the client or patient.

One of the great advantages of art therapy is it fosters use of both sides of the brain. The nonverbal art expression is primarily a right brain process; the writing is coming from the left-brain language centers.

Drama therapy is the systematic and intentional use of drama and theatre processes to achieve the therapeutic goals of symptom relief and personal growth. It is an active, experiential approach that facilitates the client's ability to solve problems, set goals, express feelings appropriately, achieve catharsis, improve interpersonal skills and relationships, and strengthen the ability to perform personal life roles. It increases flexibility between roles. Dance therapy is proving especially beneficial for the elderly to increase their range of mobility.

3.5 UNIT END QUESTIONS

1) What is art therapy?
2) Define drama therapy.
3) Explain the steps used in art therapy.
4) What is rapport building?
5) Illustrate with examples the exploration technique of art therapy.
6) Discuss Renee Emunah's stages in drama therapy.
7) What do you mean by Dramatic projection?

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UNIT 4 OTHER THERAPIES (PERSONS CENTER COUNSELING AND SOLUTION FOCUS COUNSELING)

Structure

4.0 INTRODUCTION

In this unit we will be dealing with person centered counseling and solution focused therapy. We start with person centered counselling in which we discuss the basic assumptions of person centered counseling followed by the core conditions needed for person centered counseling. Then we give a detailed account of the counseling process of person centered counseling. Then we elucidate the many techniques that are part of person centered counseling. This is followed by a detailed account of solution focused counselling . Here we put forward the basic assumptions of solution focused counseling, followed by the therapeutic process involved in the same. The next section presents the therapeutic goals of solution focused therapy and the various steps involved in the therapeutic process. The section also talks about the various tasks of solution focused therapy and the various techniques in carrying out the therapy. This therapy has certain typical questioning techniques which are then presented that involves miracle questioning, scaling question, coping question etc.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define person center counseling;
- Discuss the core conditions needed for person center counseling;
- Explain the assumptions and techniques of person center counseling;
- Describe the assumptions and therapeutic process in solution focus counseling;
- Identify the therapeutic goals of solution focus counseling; and
- Explain the techniques used in solution focus counseling.

4.2 PERSON CENTERED COUNSELLING

Person centered counseling, formerly known as client centered counseling and nondirective counseling, is a treatment approach developed by Carl Rogers in the 1940s. It has provided the basis for many more recent counseling approaches. The principle of person centered counseling is the idea that if the counselor can provide clients with a genuine relationship in which they feel understood, accepted, and valued, their self esteem will be enhanced and they will increasingly be able to draw on their own resources to help themselves. This humanistic approach views each person as unique and able to strive towards self actualisation and achievement of his or her full potential. This model has certain qualities:

1) Person oriented.
2) Advocates a holistic view of people as well as a belief in the human potential.
3) Emphasises the person's experience, perceptions, agenda, and goals.
4) Promotes a therapeutic alliance in which the counselor communicates empathy, acceptance, genuineness and congruence.
5) Focuses on life long development, self esteem, self awareness, and self actualisation.
6) Emphasises feelings and emotions.
7) Encourages concreteness and specificity as well as exploration.

4.2.1 Basic Assumptions of Person Centered Counseling

The basic assumptions of person centered counseling are as follows:

1) Human beings are growth oriented and tend towards self actualisation. This natural process of development towards higher stages of moral, emotional and behaviour evolution can be facilitated by professional helpers who are able to stimulate the inherent capacity for progress in clients who are temporarily faltering.

2) Every individual exists in a continually changing world of experience of which he is the center (Rogers, 1951). This proposition emphasises the central importance of the individual and the subjective nature of personal experience.

3) An important vehicle for change is the therapeutic relationship that exudes qualities of trust, openness, acceptance, permissiveness and warmth. The

degree to which the counselor is able to create this nurturing atmosphere will influence the client's possibility for growth.

4) The legitimate focus of counseling content is on affect and the exploration of feelings. Both interpersonal relationships and self- conception may be improved by becoming aware of feelings about oneself and others by learning to express these emotions in sensitive and self enhancing ways.

5) The universal goals of counseling are to help people to be more free, intentional, ethical, and human. This means that time is spent in sessions helping clients to examine their values and personal characteristics so that that may become more humane and caring in their relationship with self and others.

6) The client has the primary responsibility for the course of treatment. Thus a goal is shared by the client and the counselor; they both share a mutual understanding of the client's world.

7) Human beings are intrinsically good and trustworthy. They will intrinsically move, in a deliberate way, towards goals that are satisfying and socially responsible. Irresponsible or socially undesirable behaviour emerges from defensiveness that alienates human beings from their own nature.

4.2.2 Core Conditions

Carl Rogers has considered three main core conditions that are essential for effective counseling. These are:

1) **Unconditional Positive Regard:** This means that the counselor accepts the client unconditionally and non-judgmentally. The client is free to explore all thoughts and feelings, positive or negative, without fear of rejection. The therapist must show a positive approval of how they are feeling. It helps in building up or restoring the client's unconditional positive self regard (Iberg, 1996). The client is free to explore and to express without having to do anything in particular or meet any particular standards of behaviour to 'earn' positive regard from the counselor.

2) **Congruence:** Congruence or genuineness, involves letting the other person know "where you are" emotionally (Rogers, 1980). It means that the counselor is authentic and genuine, and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counselor is 'really like'. Congruence can be either positive or negative, and the therapist must express their feelings to be as genuine as possible. it is so important for the therapist to become congruent with their client so that a trusting relationship can be created in which the client can let the therapist into their lives. It is very crucial factor in establishing trust.

3) **Empathy:** Rogers defines empathy as "to sense the clients private world as if it were your own, but without ever losing the "as if" quality" (Rogers, 1992). Empathic understanding means that the counselor accurately understands the client's thoughts, feelings, and meanings from the client's own perspective. When the counselor perceives what the world is like from the client's point of view, it not only views its value, but also accepts the client as it is. A good counselor needs to show empathy during therapy, to be able to understand and accurately be aware of the problems that the client is conveying.

4.2.3 Process of Therapy

Rogerian counseling involves the counselor's entry into the person's unique phenomenological world. Phenomenological world means it is the study of the development of human consciousness and self awareness as a preface to philosophy or a part of philosophical world. In mirroring this world, the counselor does not disagree or point out contradictions. Neither does the counsellor attempts to delve into the unconscious. Rogers describes counseling as a process of freeing a person and removing obstacles so that normal growth and development can proceed and the person can become more independent and self directed.

During counseling, the client can move from rigidly self perceiving to fluidity. Certain conditions are necessary for this process. A 'growth promoting climate' requires the counselor to be congruent, have unconditional positive regard for the person as well as show empathic understanding. Congruence on the part of the counselor refers to the counsellor's ability to be completely genuine whatever the self of the moment. The counsellor is not expected to be a completely congruent person all the time, as such perfection is impossible.

The client and the counsellor will work towards the outcome, the product. But there is also something else going on, that is the process of counseling which affects the healing. This is the time the client spends with his counsellor, and during the period the process takes place and between the client and counsellor many issues are sorted out. The message that the client should be getting from this safe stranger in this secure place is an assurance that the client is worth taking seriously, and that the concerns of the client are real ones.

Here the therapist sees the strength in the client, and is optimistic about the client's future when the latter does not believe that he or she has any future. And yet the client believes that the counsellor is sincere and has some insights. So the client begins to realise that he is able to see in the therapist someone he or she dimly recognises from way back before the client was so worried about. In other words the client is a little more confident, a little surer of the direction in which he or she is proceeding.

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of person centered therapy: (i) congruence (ii) unconditional positive regard and (iii) empathy. Congruence refers to the therapist's openness and genuineness. In other words, the willingness of the therapist to relate to clients without hiding behind a professional facade. Therapists who function in this way have all their feelings available to them in therapy sessions and may share significant emotional reactions with their clients.

Congruence does not mean, however, that therapists disclose their own personal problems to clients in therapy sessions or shift the focus of therapy to themselves in any other way.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging, or giving advice. This attitude of positive regard creates a nonthreatening context in

which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy ("accurate empathetic understanding"). The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. In other systems of therapy, empathy with the client would be considered a preliminary step to enabling the therapeutic work to proceed; but in person-centered therapy, it actually constitutes a major portion of the therapeutic work itself.

A primary way of conveying this empathy is by active listening that shows careful and perceptive attention to what the client is saying. In addition to standard techniques, such as eye contact, that are common to any good listener, person-centered therapists employ a special method called reflection, which consists of paraphrasing and/or summarising what a client has just said.

This technique shows that the therapist is listening carefully and accurately, and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally, clients respond by elaborating further on the thoughts they have just expressed.

According to Rogers, when these three attitudes (congruence, unconditional positive regard, and empathy) are conveyed by a therapist, clients can freely express themselves without having to worry about what the therapist thinks of them. The therapist does not attempt to change the client's thinking in any way.

Even negative expressions are validated as legitimate experiences. Because of this nondirective approach, clients can explore the issues that are most important to them—not those considered important by the therapist. Based on the principle of self-actualisation, this undirected, uncensored self exploration allows clients to eventually recognise alternative ways of thinking that will promote personal growth. The therapist merely facilitates self actualisation by providing a climate in which clients can freely engage in focused, in-depth self-exploration.

Thus the process of therapy is:

1) Client's communications about externals and not self
2) Client describes feelings but not recognise or "own" them personally
3) Client talks about self as an object in terms of past experiences
4) Client experiences feelings in present-just describes them with distrust and fear
5) Client experiences and expresses feelings freely in present-feelings bubble up
6) Client accepts own feelings in immediacy and richness
7) Client trusts new experiences and relates to others openly and freely

4.2.4 Techniques Used in Person Centered Therapy

It is not technique-oriented. This approach is simply to restate what the client just said or the technique of reflection of feelings. The therapeutic relationship is the primary agent of growth in the client. Therapist's presence is being completely engaged in the relationship with clients. The best source of knowledge about the client is the individual client. Caring confrontations can be beneficial. The general techniques used in this therapy are:

1) **Listening:** Active listening involves summarising the person's emotions back to them, asking questions to help them express what they feel or believe or asking questions to achieve a better understanding of what they are saying. The feeling of being valued as a human being creates the sense of safe space for their deeper internal explorations. In listening the counselor:

   - Invites the client to describe his/her reasons for coming to talk.
   - Allow the client time to respond – this behaviour is called as attending or active listening.
   - Helps create true intimacy between the counselor and the client – trust, comfortable with each other.
   - Tells the client that you are interested in him/ her, wants to listen to him, and will try to understand both the spoken and the unspoken message in the communication.

2) **Accepting**

   - The counselor accepts the client unconditionally for who he/she is- Unconditional Positive regard.
   - Being professional, the counselor is not prejudice towards the client.

3) **Respecting**

   - The counselor respects the client's view of his/her life.
   - Helps the client towards a greater degree of independence and integration of the individual with respect towards his/her multicultural background.

4) **Understanding**

   - The counselor understands the client's feeling sensitively and accurately.
   - Empathetic understanding help the counselor sense client's feeling as if they were his/her own without becoming lost in those feelings.

   Empathetic understanding helps the counselor to reflect the client's experiences.

5) **Responding**

   - The counselor responds to the client's story.
   - Also responds to seek clarification about the client's feelings and thoughts.
   - Respond by giving advices and suggestions that can help for the client's personal growth.

Roger's Person Centered Counseling technique has certain strengths. It is a Phenomenological approach which focuses on empathy, unconditional positive regard and acceptance. It helps in increasing self-understanding. It is very genuine and reflective. But it has certain weaknesses too. In this technique, client is not challenged and not all clients are able to find their own answers. It is too simple and undirected. As such it has no interventions/techniques. Despite its limitations, still it has been used widely as it focuses on inner and subjective experience.

4.3 SOLUTION FOCUSSED COUNSELING

Solution focused Counseling developed by Steve De Shazer, Insoo Berg, Eve Lipchek and Michele Weiner-Davis, is post Modern approach that emphasises the client's strengths and focuses on solutions. It is also known as Solution focused brief therapy (SFBT) or Brief Therapy (BT). The emphasis of SFBT is to focus on what is working in client's lives in contrast to the traditional models of therapy that tend to be problem- focused. These therapists assist clients in paying attention to the exceptions to their problem patterns. They promote hope by helping client discovering exceptions, times when the problem is less intrusive in their lives (Metcalf, 2001). SFBT looks at the positive side of problems and what works. It believes that all people are free to make choices.

It is a competency based model, which minimizes emphasis on past failings and problems, and instead focuses on clients' strengths and previous successes. There is a focus on working from the client's understandings of her/his concern/situation and what the client might want different. Differing from skill-building and behaviour therapy interventions, this model assumes that solution behaviours already exist for clients. Clients' solutions are not necessarily directly related to any identified problem by either the client or the therapist. It can be used in a variety of settings with a variety of problems.

Solution-focussed therapy focuses on people's strength, competence, and possibilities instead of their deficits, weaknesses and limitations (O'Hanlon & Weiner Davis 1989).

The solution focussed approach builds upon clients' resources. It aims to help clients achieve their preferred outcomes by evoking and co-constructing solutions to their problems (O'Connell, 2001).

Solution Focussed Brief Therapy differs from traditional treatment in that traditional treatment focuses on exploring problematic feelings, cognitions, behaviours, and/or interaction, providing interpretations, confrontation, and client education (Corey, 1985). In contrast, SFBT helps clients develop a desired vision of the future wherein the problem is solved, and explore and amplify related client exceptions, strengths, and resources to co-construct a client-specific pathway to making the vision a reality. Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources.

4.3.1 Basic Assumptions

Different therapists have described assumptions in different ways:

Walter and Peller (1992, 2000) described SFT as a model that explains how people change and how they can reach their goals. They gave following basic assumptions:

- Individuals who come to therapy do have the capability of behaving effectively, even though this effectiveness may be temporarily blocked by negative cognitions. Problem focused thinking prevents people from recognising effective ways they have dealt with problems.

- There are advantages to a positive focus on solutions and on the future. If clients can reorient themselves in the direction of their strengths using solution talk. There is a good chance that a therapy can be brief.
- There are exceptions to every problem. By talking these exceptions, clients can get control over what had seemed to be an insurmountable problem. The climate of these exceptions allows the possibility of creating solutions. Rapid changes are possible when clients identify exceptions to their problems.
- Clients often present only one side of themselves. This therapy invites clients to examine another side of the story they are presenting.
- Small changes pave the way for larger changes. Small changes are all that are needed to resolve problems that clients bring to therapy.
- Clients want to change, have the capacity to change and are doing their best to make changes happen. Therapist should adopt a cooperative stance with clients rather than devising strategies to control resistive patterns. With therapist's cooperation, resistance does not occur.
- Clients can be trusted in their intentions to solve their problems. There are no right solutions to specific problems that can be applied to all people. Each individual is unique and so, too is each solution.

O'Hanlon & Weiner Davis (1989): They provided several powerful assumptions as the foundation of solution-focused therapy:

- Individuals who come to therapy have strengths, resources, and the ability to resolve the challenges they face in life.
- Change is always possible and is always happening.
- The counselor's job is to help clients identify the change that is happening and to help them bring about even more change.
- Most problems do not require a great deal of gathering of historical information to resolve them.
- The resolution of a problem does not require knowing what caused it.
- Small changes lead to more changes.
- With rare exceptions, clients are the most qualified people to identify the goal of therapy. (Exceptions include illegal goals [e.g., child abuse] and clearly unrealistic goals.)
- Change and problem resolution can happen quickly.
- There's always more than one way to look at a situation

General Assumptions

- Clients are their own experts who know what is best for them.
- The therapist accepts the client's view of reality.
- Therapy is collaborative and cooperative.
- Uses the resources available to the client.

- Goals are specific, behavioural and obtainable.
- Problems are reframed in a more positive way.
- Focus on what is right and what is working.
- Goals are always set in positive terms.
- People are highly susceptible and dependent.
- Don't ask a client to do something that he or she has not succeeded at before.
- Avoid analysing the problem.
- Be a survivor not a victim.

4.3.2 Therapeutic Process

S**olution focused brief therapy (SFBT).** "What SFBT does is that instead of digging somewhere deep it mainly focuses on client strengths and resiliencies examining previous solutions and exceptions to the problem, and then, through a series of interventions, encouraging clients to do more of those behaviours". In this case it is important what are the effective therapeutic principles implemented in SFBT. It is important to mention that principle is ' a set of rules that guides the therapy', than a technique is 'a specific procedure to get a specific result'. So principles are something what will be followed during all the therapy than technique is something used to achieve a well defined goal at a certain time. These might be distinguished as the main principles of Solution Focused Therapy:

Principle 1: **Start where the client is, or adapt to the stage in which the client finds himself**

There can be three different types of people who end up in front of the ones offering professional health:

- A Complainant – a person who does not have a clear request for help (a drinking housewife who says that no way she can cope without drinking as long as her husband works long hours and she has to take care of home on her own)
- A Visitor – the one sent to seek for help by the doctors, friends, relatives
- A Buyer – a person who actively seeks for help on his own (contacts a therapist about the drinking problems on his own and not influenced by anyone)

In scientific literature these mentioned types of people seeking for help can also be defined as three stages which change during the process of relationship between the therapist and the client. It is very important that therapist would correctly identify at what stage is the person seeking for help than he first contacts him. In this case therapist can use correct principles to move a client along the stages and get the result more effective. A client can very easily turn from a Visitor to Complainant and then a Buyer.

Principle 2: Use and enhance the client's competence

Every person has abilities and coping strategies prior to any therapeutic intervention. Therefore, the therapeutic process should consist of bringing forward and implementing solutions that are already present in clients and their systems.

Therapy works better if the solution suggested by the therapist is based on the natural healing processes of the patient, in this way all the best competences of the client can be used.

Principle 3: Defining clear goals and obtaining the client's collaboration

Solution focused approach gives a very important meaning to the clear definition of the goal which a person coping with various problems should achieve. Client needs to define the goal using the details and concrete examples regarding how his life should be rather than how he has been coping with this problem or is at the certain stage of the therapy.

Principle 4: Change client's perception and experience

Promoting corrective emotional experience is another basic principle in SFBT. Corrective emotional experience refers to 'exposing the patient under more favourable circumstances to emotional situation which he could not handle in the past under less favorable circumstances '(Alexander, French & al., 1946). Nowadays this principle is considered as an efficient. It is described as an ability to create experiences where the client has the opportunity to learn something new is an essential ingredient in brief therapy.

Principle 5: Solution oriented language

Solution focused approach helps the clients to discover their own solutions and expects the therapist to adopt a trusting and respectful attitude. In the solution focused therapy it is very important that a therapist adopts the language of the patient: words, intonation, speed of talking and reflex. This, firstly, will build the trust and secondly, will help to communicate. In solution focused approach therapy the one who knows the solution is patient himself, just a therapist needs to help out while bringing that solution to the day light, while being supportive and respectful. There should not be any confrontation, denials, only the suggestions and alternatives.

Principle 6: Restore and enhance hope and positive expectation

Hope and positive expectation have a strong influence on final outcome of any therapy. Solution focused approach in therapy seeks of the ways to enhance hope, as a willing to improve into the healing process. Positive expectations in solution focused approach is something that stimulates the patient to focus more on the healing process.

To sum up: solution focused approach in therapy is a process during which the clear goals are defined by the patient and a therapist is the one trying to engage the best of patient's skills and competences in order to achieve these goals. Also This is the kind of therapy which focuses only on the positive factors: hope, healing, improvement, goals and dismisses the negative things: problems and fails. In this case therapist is like a silent advisor who never is to persuasive and instead of telling the patient what to do only suggests alternatives in the way patient thinks it was actually his idea.

Solution focused counseling assumes a collaborative approach with clients in contrast to the educative stance that is associated with most traditional models of therapy. If clients are involved in the process from beginning to end, the therapy will be successful. Collaborative and cooperative relationships are more important

than hierarchical relationship in therapy. Walter & Peller described four steps that characterise the process of SFBT:

1) Find out what clients want rather than searching for what they do not want.

2) Do not look for pathology and do not attempt to reduce it by giving them a diagnostic label. Instead look for what clients are doing that is already working and encourage them to continue in that direction.

3) If what clients are doing is not working encourage them to experiment something different.

Principle 4: Keep therapy brief by approaching each session as if it were the last and only session.

SFBT is an approach that focuses on how clients change, rather than one which focuses on diagnosing and treating problems. As such, it uses a language of change. The signature questions used in solution-focused interviews are intended to set up a therapeutic process where in practitioners listen for and absorb clients' words and meanings, then formulate and ask the next question by connecting to clients' key words and phrases. Therapists then continue to listen and absorb as clients again answer from their frames of reference, and once again formulate and ask the next question by similarly connecting to the client's responses. It is through this continuing process of listening, absorbing, connecting, and client responding that practitioners and clients together co-construct new and altered meanings that build toward solutions.

4.3.3 Therapeutic Goals of SFBT

The solution focused therapist believes that people have the ability to define meaningful goals and that they have the resources required to solve their problems. Each client is unique and constructs unique goals for better future. The therapists focus on small, realistic and achievable changes that can lead to additional positive outcomes. Modest goals are viewed as the beginning of the change. SBF therapists use similar words, pace and tone in the same language as of the clients. Clients must feel that their concerns are heard and understood before they can formulate meaningful personal goals. Walter and Peller (1992) emphasised the importance of assisting the clients in creating their well defined goals that are:

1) Stated positively ion the client's language;

2) Are process or action oriented;

3) are structured in here and now;

4) are attainable, concrete and specific;

5) are controlled by the client.

O'Hanlon & Weiner- Davis (2003) offers several forms of goals: Changing the viewing of a situation or a frame of reference, changing the doing of problematic situation, and tapping client strength and resources.

4.3.4 Steps in SFBT

The structure of solution building differs greatly from traditional approaches to problem solving as can be seen in brief description of steps involved (De Jing & Berg, 2008):

1) Clients are given opportunity to describe their problems. The therapist listens respectfully and carefully as clients answer the therapist's question, "How can I be useful to you"?

2) The therapist works with clients in developing well- formed goals as possible. The question is posed, "What will be different in your life when your problems are solved"?

3) The therapist asks clients about those times when they were problem free. Clients are assisted in exploring these exceptions, with special emphasis on what they did to make these events happen.

4) At the end of each solution building conversation, the therapist offers clients summary feedback, provides encouragement and suggests what clients might observe or do before the next session to further solve their problem.

5) The therapist and the client evaluate the progress being made in reaching satisfactory solutions by using a rating scale. Clients are asked what needs to be done before they see their problem as being solved and also what their next step will be.

4.3.5 Solution Focused Tasks

Molnar and de Shazer (1987) discussed a list of five tasks and corresponding rationales. These tasks represent a simple attempt to realise the objectives of solution-focused counseling.

Task 1: The client is told and asked, "Between now and the next time, I would like you to observe, so that you can tell me next time, about those times when you are able to make it (the goal) happen."

Rationale: This task is given if the client is able to construct a problem and goal, and identify and amplify exceptions.

Task 2: The client is told and asked, "Between now and the next time, I would like you to pay attention to and make note of what you do when you are able to effectively cope with or deal with the problem."

Rationale: This task is given if the client is able to construct a problem and goal and identify exceptions, but is unable to amplify exceptions.

Task 3: The client is told and asked, "Between now and the next time, I would like you to observe, so that you can tell me next time, what happens in your life (relationship, family, work situation) that you want to continue to have happen."

Rationale: This task is given if the client is able to construct a problem and goal, and potential exceptions, but is unable to identify exceptions.

Task 4: The client is told and asked, "Try to avoid making any drastic changes. If anything, think about what you will be doing differently when things are improved."

Rationale: This task is given if the client is able to construct a problem, but is unable to construct a goal.

Task 5: The client is told and asked, "The situation is very volatile. Between now and the next time, attempt to think about why the situation is not worse."

Rationale: This task is given if the client is in severe crisis.

4.3.6 Solution Focused Techniques

1) **Mapping the Influences of the Problem:** This technique, developed by Michael White, refers to a line of questioning aimed at helping the client understand how the problem has influenced his or her life. When mapping the influences of the problem, counselors ask how the problem has affected various aspects of the client's life, including relationships, work, and daily functioning, e.g. in the problem of depression, the counselor might ask the client to identify ways in which depression has affected aspects of their life. The purpose of this technique is to use the influences as a basis from which to later identify exceptions.

2) **Scaling:** In this clients are asked to rate their subjective experiences, such as how they feel, how they deal with their problems, and so forth on a scale from 0 to 10. Molnar and de Shazer (1987) developed a reverse scale which can be effective Scaling techniques are useful for clients who find it difficult to discern exceptions and notice differences. The therapist asks the clients to keep a written record of their ratings. Then, review the ratings with your client, and focus on the client's best days and highlight the other information that was recorded as these are exceptions that can be amplified.

3) **Journaling:** Journaling, also known as the structured log, is a useful exercise for clients who are unable to identify exceptions or unable to develop goals at all. The client might be asked to keep track of times when the problem does not happen or when the goal happens. The client is asked to describe in detail what they did, how they coped, what was different, and so forth. The structured log often leads to helping the client identify exceptions and set more attainable and realistic goals.

4) **What is Better?:** De Shazer (1994) proposed a simple question that counselors can use during follow-up sessions aimed at identifying exceptions: "What's better? Starting off the next session with the variations in question like "What's better?" or "What's new?" or "What's up?" or "What do you want to talk about?" can get you and the client in a solution- focused direction from the start. These types of questions might help in identifying exceptions that were missed in prior sessions or raise new problems and exceptions.

5) **The Surprise Task:** When working with couples and families, the surprise task can serve to identify positive outcomes that might otherwise not have been produced in counseling. In this task, one family member is instructed to surprise another family member on two occasions. The other family member is instructed to observe for times when the other surprises them.

6) **Strategic Eclecticism:** Solution focussed counseling allows for the compatible application of diverse theories and techniques within its own clinical theory. Eclecticism can be understood in terms of a strategic approach. The term strategic refers to an effort on the part of counselors to tailor conceptualisations and interventions to account for the uniqueness of each client, thereby facilitating the change process in an effective manner and often in a brief period of time.

4.4 DIFFERENT QUESTIONING TECHNIQUES

4.4.1 The Miracle Question (MQ)

This is powerful in generating the first small steps of 'solution states' by helping clients to describe small and realistic steps they can take as soon as the next day involves asking the client to imagine how their future would look in an ideal world, with particular attention to the absence of the problem that brought them to therapy in the first place.

4.4.2 Scaling Questions

These are used to monitor change in the client, who rates their position on a scale, usually ranging from one (the worst scenario) to ten (the best scenario). **Scaling questions (**SQ) can be used when there is not enough time to use the Miracle Question. It is used in many ways, including with children and clients who are not verbal or who have impaired verbal skills. Careful exploration enables clients to identify resources that enable movement along the scale towards their rating of a better future.

4.4.3 Exception Seeking Questions

These assume that there are always times when the problem is less acute, and investigate what enables this to be so. The client can then use this knowledge to improve their situation and gain confidence in their own autonomy.

4.4.4 Coping Questions

*These a*re used to elicit examples of times when the client coped with even the direst of situations, so that a problem-focused narrative can be challenged and transformed into a more positive and solution focused alternative. This question is a powerful reminder that all clients engage in many useful things even in times of overwhelming difficulties. Coping questions such as, "How have you managed to carry on?"; "How have you managed to prevent things from becoming worse?" open up a different way of looking at client's resiliency and determination.

4.4.5 Problem-Free Talk

This focuses on areas outside of the problem and enables both therapist and client to establish an atmosphere in which the strengths and positive qualities of the latter is emphasised and drawn upon to help improve other areas of life e.g. Hobbies and social activities.

4.5 LET US SUM UP

Rogers has developed a person centered approach to create an environment at which clients are able to hash out their problems in a self directed way. The therapist is merely a listener, there to make the client feel that what they are feeling is ordinary. Rogers states it, "people are essentially trustworthy, that they have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapists part, and that they are capable of self directed growth.

Brief solution-focused counseling (BSFC) offers great promise to practitioners seeking an efficient and research-supported approach to school problems and the young people who experience them. The BSFC approach presented in this article is derived from four decades of psychotherapy outcome research on the essential ingredients or "common factors" of therapeutic change—client, relationship, hope, and model-technique factors. Outcome research can be translated into practical strategies for resolving problems including the "ambassador approach" to client–practitioner relationships, the strategic use of language, and the emphasis on client strengths and resources.

4.6 UNIT END QUESTIONS

1) Define Person Centered Counseling.
2) What do you understand by Congruence?
3) Describe the general techniques involved in Person Centered Counseling.
4) What is Solution-Focused Brief Therapy? Write down its steps.
5) Describe O'Hanlon & Weiner Davis basic assumptions.
6) Explain mapping the Influences technique of SFBT. Also discuss different questioning techniques.

4.7 SUGGESTED READINGS

Gerald Corey (2009): *Theory and Practice of Counseling and Psychotherapy.* Publisher: Thompson Brooks.

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UNIT 1 HIV/AIDS COUNSELLING

Structure

1.0 INTRODUCTION

AIDS stands for Acquired Immune Deficiency Syndrome, a disorder in which immune system is gradually weakened and eventually disabled by the Human Immunodeficiency Virus (HIV).

HIV testing and counseling services are a gateway to HIV prevention, care and treatment. The benefits of the knowledge of HIV status include the following;

1) **At the individual level:** Enhanced ability to reduce the risk of acquiring or transmitting HIV; access to HIV care, treatment and support; and protection of unborn infants.

2) **At the community level:** A wider knowledge of HIV status and its links to interventions can lead to a reduction in denial, stigma and discrimination and to collective responsibility and action.

3) **At the population level:** Knowledge of HIV epidemiological trends can influence the policy environment, normalize HIV/AIDS and reduce stigma and discrimination.

In the communities that have been longest and hardest hit by the epidemic, an increasing number of people with HIV are becoming ill and need care, treatment and support. However, most people with HIV are unaware of their HIV status. Scaling up HIV testing and counseling services is a critical step for scaling up a range of interventions in HIV/AIDS prevention, care, treatment and support.

In September 2003, WHO made a call to action for a target of providing access to ARV treatment for three million people in resource-limited settings by 2005

and of working towards universal access. This requires that many more millions of people be tested for HIV and counseled in order to identify those who can benefit from immediate access to treatment, and to prevention and support services. Indeed, the increased availability of ARV treatment is likely to generate a dramatically increased demand for HIV testing and counseling.

In June 2006, a number of documents relating to the policy and provision of HIV testing and counseling to infants and children were added to the toolkit. They include a selection of documents covering policies, child's rights and strategic frameworks, child-focused counseling, consent, confidentiality and disclosure, clinical diagnosis and laboratory issues, monitoring and evaluation and case studies.

WHO and UNAIDS released in May 2007, the Guidance to Provider-initiated HIV Testing and Counseling in Health Facilities, which articulates recommendations developed over the course of a year-long consultation with many different stakeholders. This guidance which builds on previous policy positions of both WHO and UNAIDS encourages health care providers to routinely recommend HIV testing and counseling to all patients who present with conditions that suggest underlying HIV infection.

HIV/AIDS is one of the most serious diseases. However, since the modes of transmission are well known, awareness is the best method to reduce the occurrence of this disease. At present prevention is the only way to handle this crisis which has become a global menace.

1.1 OBJECTIVES

At the end of the unit, you will be able to:

- Know the meaning of HIV and AIDS;
- Understand how does HIV and AIDS occur;
- Recognise the sign and symptoms of HIV/AIDS;
- Aware of the myths and facts about HIV/AIDS;
- Explain the diagnosis of HIV;
- Describe the aims of HIV counseling; and
- Understand the importance of prevention of HIV.

1.2 WHAT IS HIV/AIDS?

HIV is a virus, which cause impairment to the immune system in the humans. HIV stands for Human Immunodeficiency Virus. These belong to the family of virus called retrovirus. This looks like a sunflower in a full bloom which is thousand times smaller than the thickness of hair.

AIDS stands for Acquired Immuno Deficiency Syndrome. HIV is the virus that causes AIDS.

Redfield, Wright and Tramont explain AIDS as –

A-Acquired means which is taken from some body else and there is no genetic inheritance

ID- Immune deficiency that is, the immune system becomes so weak and inadequate that the body is unable to fight against the disease

S- Syndrome when group of diseases or symptoms are present and a person is unable to cope with it.

The HIV attacks our immune system which is our body's "security force" to fight off infections. Once the HIV enters the body, it weakens the body's immune system. HIV mostly infects T-cells, also known as CD4+ cells, or T-helper cells. These cells are white blood cells that activate the immune system to fight disease. Once inside the cell, HIV starts producing millions of little viruses, which eventually kill the cell and then go out to infect other cells. With the breakdown of the immune system the body becomes susceptible to numerous infections. These are called "opportunistic infections" because they take advantage of the body's weakened defenses. Thus HIV virus itself does not cause death. It is the opportunistic infections that cause death. AIDS is the condition where many opportunistic infections take hold of the body.

When the person is infected with HIV, s/he may remain asymptomatic for several years; that is, s/he does not suffer from any illnesses as a result of lower immunity. It may develop into AIDS after a number of years. People with HIV may not know that they have the virus, but can pass on the virus to others.

1.2.1 How does it Transmit?

There are three main modes of transmission:

1) **Unprotected sex:** Engaging in unprotected/unsafe sex,i.e. not using condome or any other barrier devices leads to the risk of HIV infection. In fact, heterosexual transmission is the route by which most people with AIDS have become infected with HIV worldwide. A significant portion of HIV infection among women in the World is acquired through heterosexual contact. HIV can be found in the blood, semen, pre-seminal fluid, or vaginal fluid of a person infected with the virus.

2) **Blood exposures:** Various blood exposures that carry risks of HIV transmission include injections (intramuscular, subcutaneous, intravenous), blood tests, infusions, dental care, surgery, other medical procedures, tattooing, piercing, shaving, manicures, and pedicures (when cuts occur), and needle-stick accidents. Sharing of syringes, needles or injecting equipments carry high risks of HIV infection.

   HIV can also be transmitted through other body fluids such as semen, vaginal fluid, breast milk, cerebrospinal fluid (which surrounds the brain and the spinal cord), synovial fluid (which surrounds bone joints) and amniotic fluid (which surrounds a fetus). Though HIV is also present in other body fluids such as saliva and sweat, it is present in such low quantities that transmission through these routes is impossible.

   Thus, HIV is not spread through these body fluids:

   - Sweat
   - Tears
   - Saliva (spit)

3) **Mother to baby transmission:** HIV can be transmitted through an infected pregnant woman to her baby during pregnancy or delivery, as well as through breast feeding.

Thus, transmission of HIV most often occurs through unprotected sex, through the transfer of contaminated blood from one infected person to another, through infected pregnant women.

However, HIV is not transmitted through casual contacts like hugging, kissing (between people with no significant dental problems), dancing, sharing food or drinks, sharing exercise equipment, using a shower, bath, or bed used by an HIV+ person , insect bites.

The counselor must be clear of the fact that no matter how a person became infected, they are facing a serious and life threatening disease. Therefore the counselor must have an objective and empathetic attitude towards the HIV affected person. Counselor must take each case separately and must make a preparation for the counseling program to help the patient.

1.2.2 Signs and Symptoms of HIV/AIDS

Most people with HIV are asymptomatic for eight to ten years although it only takes three to ten weeks for the body to initially respond to infection by the HIV virus by producing antibodies. The progression of HIV in the body is:

- **HIV infection:** Entry of virus in the body through any of routes
- **Window period:** Few weeks to few months
- **Silent infection**: No symptoms seen for five to eight years.

The 'window period' is a term used to describe the period of time between HIV infection and the production of antibodies. During this time, an antibody test may give a 'false negative' result, which means the test will be negative, even though a person is infected with HIV. To avoid false negative results, antibody tests are recommended three months after potential exposure to HIV infection.

A negative test at three months will almost always mean a person is not infected with HIV. If an individual's test is still negative at six months, and they have not been at risk of HIV infection in the meantime, it means they are not infected with HIV.

It is very important to note that if a person is infected with HIV, they can still transmit the virus to others during the window period.

HIV may lead to AIDS. The symptoms of AIDS vary widely depending on the specific constellation of disease, that one develops (Cunningham&Selwyn, 2005). Unfortunately, the world wide prevalence of this deadly disease continues to increase at an alarming rate so the counselor must be aware of the following symptom which can be classified into ***major*** and ***minor***.

The *major* symptoms are as following:

1) Chronic or recurring diarrhea
2) Unexplained low grade fever more than a month's duration
3) Dry cough

4) Fatigue
5) Progressive dementia
6) Progressive involuntary weight loss of 10% of the known body weight
7) Recurrent respiratory infections with poor response to microbial

The *minor* symptoms are as following:

1) Oral thrush
2) Recurrent or multi dermatomes Herpes Zoster recurrent skin infection
3) Severe seborrhea dermatitis
4) Pneumonia

NACO Guidelines

Below is given the NACO (National AIDS Control Organization) guidelines for Case Definition of AIDS in India.

Case definition for AIDS in India was revised in October, 1999. The new case definition is as follows:

I) **Case Definition of AIDS in Children (up to 12 years of age)**

1) The positive tests for HIV infection by ERS (ELISA/RAPID/SIMPLE) in children above 18 months or confirmed maternal HIV infection for children less than 18 months.

AND

2) Presence of at least two major and two minor signs in the absence of known causes of immuno-suppression.

Major Signs

a) Loss of weight or failure to thrive which is not known to be due to medical causes other than

HIV infection.

b) Chronic diarrhea (intermittent or continuous) > 1 month duration.

c) Prolonged fever (intermittent or continuous) > 1 month duration.

Minor Signs

a) Repeat common infections (e.g. Pneunonitis, ottitis, pharyngitis etc.)

b) Generalised lymphadenopathy

c) Oropharyngeal candidiasis

d) Persistent cough for more than 1month

e) Disseminated maculo - papular dermatosis

II) **Case Definition of AIDS in adults (for persons above 12 years of age)**

1) Two positive tests for HIV infection by ERS test (ELISA/RAPID/ SIMPLE)

AND

2) Any one of the following criteria:

a) Significant weight loss (> 10% of body weight) within last one month/ Cachexia (not known to be due to a condition other than HIV infection).

AND

Chronic diarrhea (intermittent or continuous) > 1 month duration or prolonged fever (intermittent or continuous) > 1 month duration

b) Tuberculosis: Extensive pulmonary, disseminated, miliary, extra-pulmonary tuberculosis.

c) Neurological impairment preventing independent daily activities, not known to be due to the conditions unrelated to HIV infection (e.g. trauma)

d) Candidasis of the oesophagus (diagnosable by oral candidiasis with odynophagia)

e) Clinically diagnosed life -threatening or recurrent episodes of pneumonia, with or without etiological confirmation

f) Kaposi Sarcoma

g) Other conditions:

- Cryptococcal meningitis
- Neuro Toxoplasmasis
- CMV retinitis
- Pencillium marneffei
- Recurrent Herpes Zoster or multi-dermatomal herpes infection

Self Assessment Questions

1) What is HIV?

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2) Differentiate between HIV and AIDS.

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3) How can a baby be affected by HIV?

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4) What is a window period?

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1.3 DIAGNOSIS OF HIV/AIDS

HIV test involves detecting antibodies of the virus or the genetic material (DNA or RNA) of HIV in the blood or other sample. If this is present the person is called HIV positive.

After the original infection, it takes between 2 weeks and 6 months for antibodies to HIV to appear in the blood. The period between becoming infected with HIV and the point at which antibodies to HIV can be detected in the blood is called the seroconversion or "window" period. During this period, an HIV-infected person can still spread the disease, even though a test will not detect any antibodies in his or her blood.

Several tests can find antibodies or genetic material (RNA) to the HIV virus. These tests include:

- **Enzyme-linked immunosorbent assay (ELISA):** This test is usually the first one used to detect infection with HIV. If antibodies to HIV are present (positive), the test is usually repeated to confirm the diagnosis. If ELISA is negative, other tests are not usually needed. This test has a low chance of having a false result after the first few weeks that a person is infected.
- **Western blot:** This test is more difficult than the ELISA to perform, but it is done to confirm the results of two positive ELISA tests.
- **Polymerase chain reaction (PCR):** This test finds either the RNA of the HIV virus or the HIV DNA in white blood cells infected with the virus. PCR testing is not done as frequently as antibody testing, because it requires technical skill and expensive equipment. This test may be done in the days or weeks after exposure to the virus. Genetic material may be found even if other tests are negative for the virus. The PCR test is very useful to find a very recent infection, determine if an HIV infection is present when antibody test results were uncertain, and screen blood or organs for HIV before donation.

Testing is often done at 6 weeks, 3 months, and 6 months after exposure to find out if a person is infected with HIV.

1.4 MISCONCEPTIONS

Misconception about AIDS is wide spread. A great many people have unrealistic fears that AIDS can be readily transmitted through casual contact with infected person. These people worry unnecessary about contracting AIDS from a handshake, a sneeze, or from a utensil.

Many young heterosexuals who are sexually active with a variety of partners foolishly downplay their risk for HIV, naively assuming that they are safe as long as they avoid IV drugs use and sexual relation with gay or bisexual men. They generally underestimate the probability that there sexual partners may have previously used IV drugs or unprotected sex with an infected individual.

People generally think that AIDS is usually accompanied by discernible symptoms, their prospective sexual partners who carry HIV virus will carry telltale signs of illness. However, having AIDS and being infected with HIV are not the same thing, and HIV carriers often remain healthy and symptom -free for many years after they are infected. Hence there is a crucial need to create public awareness and educate them about AIDS.

Below are given some of the myths bout the AIDS and the facts.

Myth: Having HIV means you have AIDS

Fact: Human immunodeficiency virus (HIV) is a virus that destroys the body's CD4 immune cells, which help fight disease. With the right medications, you can have HIV for years or decades without HIV progressing to AIDS. AIDS (acquired immunodeficiency syndrome) is diagnosed when you have HIV as well as certain opportunistic infections or your CD4 cell count drops below 200.

Myth: HIV/AIDS can be acquired through casual contact

Fact: HIV/AIDS cannot be acquired through hugging , using the same towel, or sharing the same glass or utensil. However, the risk of infection comes form having unprotected sex, sharing needles, or getting a tattoo from unsterilized equipment.

Myth: An HIV infected person has just a few years to live

Fact: Everyone with HIV experiences it differently. Some people may develop AIDS within a few months as the virus quickly weakens their immune system. Many others can live for decades with HIV and have a normal life expectancy. You can help prevent HIV from progressing to AIDS by seeing your doctor regularly and following your doctor's recommendations.

Myth: HIV always shows off through its symptoms

Fact: Some people don't show any signs of HIV for years after being infected. Many can have some symptoms within 10 days to a few weeks after infection. These first symptoms are similar to the flu or mononucleosis and may include fever, fatigue, rash, and sore throat. They usually disappear after a few weeks and you may not have symptoms again for several years. The only way to tell you have HIV is to get tested.

Myth: HIV can be cured

Fact: There is no cure for HIV, but treatment can keep virus levels low and help maintain the immune system. Some drugs interfere with proteins HIV needs to copy itself; others block the virus from entering or inserting its genetic material into your immune cells. Your doctor will consider your general health, the health of your immune system, and the amount of virus in your body to decide when to start treatment.

Myth: HIV cannot affect me and my family

Fact: Anyone can get HIV – men, women and children. Many people are silent carriers of HIV; even they themselves are unaware of this. HIV gets spread through unsafe sex, infected syringes and blood and from infected mothers.

Myth: Sex is safe when both partners have HIV

Fact: Just because you and your partner both have HIV, doesn't mean you should forget about protection when you have sex. Using a condom or other latex barrier can help protect you from other sexually transmitted diseases as well as other strains of HIV, which may be resistant to anti-HIV medication. Even if you are being treated and feel well you can still infect others.

Myth: You cannot have a baby if you are HIVpositive

Fact: Infected mothers can indeed pass HIV to their babies during pregnancy or delivery. However, you can lower the risk by working with your doctor and getting the appropriate care and medication. Pregnant women with HIV can take medications to treat their infection and to protect their babies against the virus.

1.5 PREVALENCE OF HIV/AIDS IN ASIAN COUNTRIES

Statistics reported the rise in incidence of HIV/AIDS in the Asian Countries by the surveys done by various international organizations (UN, UNICEF, etc.) after the late 80's. Facts rate that around 31000 children below the age of 15 are surviving with HIV/AIDS in the Asian countries in east and the pacific with 11000 newly infected in the year 2007 and the number could exceed around 25000 in 2015.

According to global action for children (NGO):

- Approximately 2.2 million children are affected form HIV/AIDS world wide.
- Largest number of HIV/AIDS orphans in the world.
- 2/3 of the India's cases are reported in the 6 of 28 states e.g. Maharashtra, AP, Manipur, Karnataka TN, Nagaland.

The figures above suggest the need for awareness regarding HIV/AIDS and taking preventive measures through counseling and large scale awareness generation program and by conducting workshops for the teenagers. Women are biologically and socially more prone to HIV infection than men, the low status of women in society inhibits their ability to protect themselves from HIV infection coming either from their husbands or other sex partners.

Self Assessment Questions

1) Describe the diagnostic tests for HIV/AIDS.

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2) Mention the various misconceptions about HIV/AIDS.

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1.6 AIMS OF HIV/AIDS COUNSELING

Counseling in HIV and AIDS has become a core element in a holistic model of health care, in which psychological issues are recognised as integral to patient management. It concentrates specifically on emotional and social issues related to possible or actual infection with HIV and to AIDS. With the consent of the client, counselling can be extended to spouses, sex partners and relatives (family-level counselling, based on the concept of shared confidentiality). HIV counselling has as its objectives both prevention and care (UNAIDS Technical Update, Geneva, 1997).

HIV and AIDS counseling can have two general aims:

1) Prevention of HIV transmission

2) Provision of counselling services to the AIDS patients and their family

1.6.1 Prevention of HIV Transmission

It is vital that HIV counseling should have these dual aims because the spread of HIV can be prevented by changes in behaviour. One to one prevention counseling 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 counseling can minimize both morbidity and reduce its occurrence. All counselors in this field should have formal counseling training

and receive regular clinical supervision as part of adherence to good standards of clinical practice.

Thus prevention will include in the first place, creating awareness among the public about the HIV/AIDS. Then, after a person is infected with HIV, prevention can focus on providing counselling to the person on how to live his life being a HIV carrier.

1.6.1.1 General Awareness

A public awareness is the need of the hour to control the spread of this serious infection and disease which has physical, social, emotional and occupational implications. The behavioural changes that minimize the risk of developing AIDS are fairly straight forward, although making the changes is often more easier said than done (Coastes and Collins). The more sexual partners a person has, the higher the risk that he or she will be exposed to the HIV virus. Thus, people can reduce their risk by following the practice of safe sex and being careful in matters of blood transmission, use of syringes etc.

Counselling can aim at the following points to spread the awareness about HIV/ AIDS:

- Determining whether the lifestyle of an individual places him or her at risk
- Behaviour that put people at risk for AIDS /HIV
- Working with an individual so that he or she understands the risks
- Helping to identify the meanings of high risk behaviour
- Information about myths and facts for HIV/AIDS
- How AIDS/HIV is transmitted
- Civic right issues related to HIV/AIDS
- Prevention and treatment for HIV/AIDS

1.6.1.2 Counselling to HIV Affected Persons

Diagnosis of HIV infection brings with it profound social, emotional and medical consequences. The adjustment to HIV infection involves constant stress management in family life and work place. The counselor need to be very sensitive about the feelings of the patients' and should have empathic and positive attitude towards AIDS patients. A good rapport must be made which will help in breaking the diagnostic news of HIV in a positive way. The counselor must discuss and remove the misunderstandings about HIV transmission.

Victims of HIV usually believe that nothing can be done now. These people have to be helped by developing a strong self- image, to cope with the hard ship of life without taking recourse to faulty methods of finding happiness or depression. Counseling should be given to prevent further deterioration or onset of full blown AIDS, so as to remain healthy and live longer, by taking good personal care in terms of food, medicines etc.

People are likely to be distressed when informed that they are HIV positive. The primary challenges that they face are a changed new life style they have to follow such as accepting the possibility of shortened life span; coping with stigmas attached to the illness; reactions of others; coping with the personal relationships,

adopting methods to remain emotionally healthy; initiating changes in behaviour to prevent HIV transmission. Therefore behavioural and psychological services are an integral part of health care for HIV infected people.

Whenever a person comes for HIV testing, there should be a pre test and post test counseling.

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 counseling expertise.

The following are some of the points which the counselor may cover in the pre test and post test discussion with the person who has come for HIV testing.

Pretest discussion checklist:

- What is the HIV antibody test (including seroconversion)
- The difference between HIV and AIDS
- The window period for HIV testing
- Medical advantages of knowing HIV status and treatment options
- Transmission of HIV
- High risk sexual behaviour
- High risk injecting drug practices
- Safer sex and risk reduction
- Safer injecting drug use
- If the client were positive how would the client cope: personal resources, support network of friends/partner/family?
- Who to tell about the test and the result
- Partner notification issues
- HIV status of regular partner: is partner aware of patient testing?
- Confidentiality
- Does client need more time to consider?
- Is further counseling indicated?
- How the results of the test are obtained (in person from the counselor)

Post-test counseling

HIV results should be given in a simple and straightforward manner 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.

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 counselor 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 counseling follow up should be given. Counseling may be of help for the patient's partner and other family members.

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 counselor 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. Counseling support should be available to the patient in the weeks and months following the positive test results.

Coping Strategies give below may be suggested:

- Using counseling
- 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

The following are the different psychological responses to a HIV positive test result.

Shock is seen in terms of diagnosis, recognition of mortality, loss of hope for the future etc.

Fear and anxiety is a common feature which is seen in terms of uncertain prognosis, effects of medication and treatment/treatment failure , isolation and abandonment and social/sexual rejection, infecting others and being infected by them, partner's reaction etc.

Depression is seen in adjustment to living with a chronic viral condition, absence of a cure, limits imposed by possible ill health, possible social, occupational, and sexual rejection if treatment fails etc.

Anger and frustration is expressed over becoming infected, having to adopt new and involuntary health/lifestyle restrictions, incorporating demanding drug regimens, and possible side effects.

Guilt is the result of interpreting HIV as a punishment; for example, for being gay or using drugs, over anxiety caused to partner/family.

Counseling patients and partners together:

Counseling can also be offered to patients and their partner 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 safe 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 counseling 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 counseling 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 counseling sessions required during any of these periods largely depends on the individual presentation of the patient and the clinical judgment of the counselor.

1.6.2 Counselling the AIDS Patients and Family

AIDS is the final stage of HIV infection process, typically manifested about 7-10 years after the original infection (Carey & Vanable, 2003). With onset of AIDS, one is left virtually defenseless against a host of opportunistic infectious agents. The stages of AIDS/HIV and its treatment are divided into three parts where the counselor should be very vigilant.

The first stage is known as asymptomatic stage, second is known as symptomatic stage and third is known as end of life stage.

1) **Asymptomatic stage:** At this stage the counselor must remember to treat the patient on food and nutrition, support, treatment with antiretroviral drugs prevention of onward transmission.

2) **Symptomatic stage**: At this stage the counselor must remember to help the patient on management of nutritional effects; treatment of HIV related infections, medical care and psychological support.

3) **End of the life stage:** In this stage, the counselor's role is very important because the counselor not only helps the patient but the family also. As the patient and family is under depression and grief. The counselor should make the patient emotionally strong for the truth (death) and prepare him for death by which, he/she not only enables the family to accept the fact of life but also help the patient to live the remaining life to the fullest.

AIDS cannot be cured. The only way out is the prevention. Various treatments are given to the AIDS patient to fight with the infections. The antiretroviral treatment has been found to be useful. However, patient adherence is an important factor in the efficacy of drug regimens. The presence of side effects can often make patients feel more unwell and some may be unable to cope with the side effects. Counseling 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.

It is very crucial to provide support to those affected directly and indirectly by HIV. Hence, individual, relationship, family counseling and support groups are of great help to enable the patient and his/her family to adjust and cope up with the various aspects and issues of life.

Self Assessment Questions

1) How will you provide counselling to a HIV affected person?

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2) Explain the different psychological responses to a HIV positive test result.

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3) Discuss the importance of counselling patients and partners together.

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1.7 LET US SUM UP

In this unit you learned about the HIV/AIDS and understood the serious threat it poses to our society. However, if we can spread the awareness, it can be prevented well. Counsellors need to play an important role in creating awareness through writing, role plays, film, talks, lectures, campaign i.e. educative programs about AIDS/HIV. You learned the different ways of transmission of HIV and the signs and symptoms of HIV/AIDS. The various myths prevalent on HIV were described. Finally the need and importance of HIV/AIDS counselling is discussed. This is crucial in terms of making the patient as well as the family members cope up with life changing disease. Even with the significant medical advances in patient management, counseling remains an integral part of the management of patients with HIV, and their partners and family.

"HIV testing and counseling services are a gateway to HIV prevention, care and treatment".

1.8 UNIT END QUESTIONS

1) Describe the different modes of transmission of HIV.
2) What are the different signs and symptoms of HIV/AIDS?
3) Explain the myths and facts related to HIV/AIDS.
4) Discuss the role of counselling in the prevention of HIV/AIDS.
5) Discuss the various ways in which an awareness programme can be developed.

1.9 SUGGESTED READINGS

Counselling and HIV/AIDS: UNAIDS Technical Update (UNAIDS Best Practice Collection: Technical Update). Geneva: UNAIDS, November, 1997.

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UNIT 2 EDUCATIONAL AND VOCATIONAL COUNSELLING

Structure

2.0 INTRODUCTION

Most people have dreams about what they would like to be when they grow up. Sometimes these dreams or images start at a very early age. Or, as it often happens, a person may finish high school and still not really know what they want for a career.

Everyone is different. We all are special and unique. You have your own skills and abilities, strengths and weaknesses, likes and dislikes – about what you want to do with your life. This is reflected in the choices you make, decisions you take and plans you make for your life with regard to the educational and vocational aspects. However, sometimes you may not be very clear about what you want in your life. You may not even be aware of your strengths and limitations, interests and abilities. In the absence of these, you may make a wrong decision or inappropriate educational and vocational choice.

Working toward a career involves a process. It is like taking a journey to a certain destination. You just don't arrive at a destination automatically. It takes planning and time before you get there. There can be many stops or the plan may change along the way. It takes planning, time, and effort to make proper educational and vocational planning. Counselling plays a crucial role to help you make appropriate educational choices keeping in mind your abilities and interests and arrive at a suitable career choice. Hence it is important to understand the concept, meaning and nature of educational and vocational counseling.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Understand the meaning of educational and vocational counseling;
- Explain the need for educational and vocational counseling; and
- Identify the goals of educational and vocational counseling.

2.2 MEANING OF EDUCATIONAL AND VOCATIONAL COUNSELING

Counselors work in diverse community settings designed to provide a variety of counseling, rehabilitation, and support services. Their duties vary greatly, depending on their specialty, which is determined by the setting in which they work and the population they serve. Although the specific setting may have an implied scope of practice, counselors frequently are challenged with children, adolescents, adults, or families that have multiple issues, such as mental health disorders and addiction, disability and employment needs, school problems or career counseling needs, and trauma. Counselors must recognise these issues in order to provide their clients with appropriate counseling and support.

School counselors help students evaluate their abilities, interests, talents, and personalities to develop realistic academic and career goals. Counselors use interviews, counseling sessions, interest and aptitude assessment tests, and other methods to evaluate and counsel students. They also operate career information centers and career education programs. Often, counselors work with students who have academic and social development problems or other special needs.

Educational counseling helps the individual with problems related to education. It is basically concerned with helping the students in choosing/selecting appropriate courses of study. The counselor takes into account the aptitude, interest, abilities and specific background of the student to provide educational counseling.

Vocational counseling aims at helping the person select a proper vocation and prepare for it. Deciding on a career/vocation is crucial as it involves lots of time, effort and money. Entering into a career which turns out to be inappropriate for the person will lead to job dissatisfaction, unhappiness and maladjustment in work life. All these will affect negatively the personal life of the individual. Hence deciding on a vocation is very important task. Vocational counseling facilitates this decision by providing appropriate counseling to the individual. Placement counseling is an important part of vocational counseling. The counselor makes the individual aware about his abilities, aptitude, attitude and interests; and helps him in a proper placement suitable to his abilities and from which he derives job satisfaction.

Thus the goals of educational and vocational counseling can be described as follows:

- Explore, analyse and develop the factors constituting their self-concept (interests, personal qualities and characteristics, values, skills etc.).
- Explore, evaluate, process and classify information and alternative education and vocation pathways with respect both to their needs and choices and to labour market requirements.
- Integrate information about education and vocation/career with information derived from self-observation so that they develop to decision-making capabilities both with respect to their orientation in education and choices in occupation(s) befitting their particular psychosocial make up.
- Create and implement own education and vocation plans.

Ultimately, the individuals will be able to make the correct choices with respect to their future occupation/vocation through educational and vocational counseling.

2.2.1 Educational, Vocational and School Counselors

Educational and vocational counseling is provided by the school counselors, educational counselors, vocational counselors and career counselors. They provide individuals and groups with career, personal, social and educational counseling. The counselor needs to take into account the personal social aspect of the individual in order to provide educational and vocational counseling.

A **school counselor** is a counselor and an educator who works in elementary, middle, and high schools to provide academic, career, college access, and personal/ social competencies to K-12 students. The interventions used include developmental school counseling, curriculum lessons and annual planning for every student, and group and individual counseling. School counselors assist students of all levels, from elementary school to postsecondary education. They advocate for students and work with other individuals and organisations to promote the academic, career, personal, and social development of children and youth.

Elementary School Counselors provide individual, small-group and classroom guidance services to students. Counselors observe children during classroom and play activities and confer with their teachers and parents to evaluate the children's strengths, problems, or special needs. In conjunction with teachers and administrators, they make sure that the curriculum addresses both the academic and the developmental needs of students. Elementary school counselors do less vocational and academic counseling than high school counselors do.

High School Counselors counsel students regarding subjects/courses to choose at the senior secondary/college level, admission requirements, entrance exams, financial aid, training/technical schools, and apprenticeship programs. They help students develop job search skills, such as resume writing and interviewing techniques. College career planning and placement counselors assist students/ alumni with career development and job-searching techniques.

School counselors at all levels help students to understand and deal with social, behavioural, and personal problems. These counselors emphasise preventive and developmental counseling to enhance students' personal, social, and academic growth and to provide students with the life skills needed to deal with problems before they worsen. Counselors provide special services, including alcohol and drug prevention programs and conflict resolution classes. They also try to identify cases of domestic abuse and other family problems that can affect a student's personal development and thereby affecting his career development.

Counselors interact with students individually, in small groups, or as an entire class. They consult and collaborate with parents, teachers, school administrators, school psychologists, medical professionals, and social workers to develop and implement strategies to help students succeed.

Vocational Counselors also called *employment counselors* or *career counselors*, usually provide career counseling outside the school setting. Their chief focus is

helping individuals with career decisions. Vocational counselors explore and evaluate the client's education, training, work history, interests, skills, and personality traits. They may arrange for aptitude and achievement tests to help the client make career decisions. They also work with individuals to develop their job-search skills and assist clients in locating and applying for jobs. In addition, career counselors provide support to people experiencing job loss, job stress, or other career transition issues.

Rehabilitation Counselors also provide vocational counseling to persons with disabilities.

They help people deal with the personal, social, and vocational effects of disabilities. They counsel people with both physical and emotional disabilities resulting from birth defects, illness or disease, accidents, or other causes. They evaluate the strengths and limitations of individuals, provide personal, educational and vocational counseling, offer case management support, and arrange for medical care, vocational training, and job placement. Rehabilitation counselors interview both individuals with disabilities and their families, evaluate school and medical reports, and confer with physicians, psychologists, employers, and physical, occupational, and speech therapists to determine the capabilities and skills of the individual. They develop individual rehabilitation programs by conferring with the client. These programs often include training to help individuals develop job skills, become employed, and provide opportunities for community integration. Rehabilitation counselors are trained to recognise and to help lessen environmental and attitudinal barriers. Such help may include providing education, and advocacy services to individuals, families, employers, and others in the community. Rehabilitation counselors work toward increasing the person's capacity to live independently by facilitating and coordinating with other service providers.

2.3 NEED FOR EDUCATIONAL AND VOCATIONAL COUNSELING

The modern day has thrown numerous challenges. In this era of internet and global competition, going for relevant and suitable educational and vocational options has become a crucial decision. There are a plethora of choices available in the vocational market. In addition there is the pressure and expectation from the parents as well as the peer group. The society also has an influence on the types of courses and vocations chosen. In the process the individual – his abilities, interests, aptitude and values – are lost sight of. In this scenario counseling and consultancy services have become the need of the hour.

With many options in the field of education there has always been felt a need to have a professional guidance which could provide the right direction to a student. The issues relating to career opportunity are one of the most important concerns of a young mind. Education in India in earlier times in the decades of 60s, 70s and 80s used to be mostly detached from career and job opportunities. There was also lack of organised guidance except possibly from parents and senior family members. Therefore, we see a large number of cases where type of job and basic qualification a person possesses are totally divorced. This sometimes has raised serious concern about the utility of education. However, during last decade things have started changing dramatically. Today's youth are

more focused, knowledgeable, inquisitive, and ambitious. One of the strengths of India as a country is existence of a huge working force whose median age is in 20s. This very demographic profile has created a significant opportunity as well as concern for all. This is significant as this strong and huge workforce can change the destiny of the country. But at the same time the large manpower can itself lead to disastrous consequence if not channelised properly. It may lead to rising unemployment rate, waste of precious human resource, increase in crimes and antisocial activities, depression and other mental health problems. We have the world's largest population with one of the highest number of young people but majority of them are without right skills needed for modern jobs. The people living in rural places also have inadequate resources, knowledge and skills rendering them not fit for the growing challenges of the job market.

Hence there is a great need to equip the vast majority of our young people with right vocational skills. Developing the right work attitude and work values, providing training in right skills, promoting entrepreneurial spirit in huge urban and rural young population who come out of the schools / colleges (10^{th} & 12^{th} standard) is a major challenge. It is in this context that the concept of educational and vocational counseling is increasingly assuming more importance. Educational and vocational counseling in an organised manner is relatively a new phenomenon in India. One requires huge exposure to the world as a whole to be an effective counselor. Besides being a person with substantial understanding on a global scale of the economy, educational fields, emerging areas of opportunity, and a good psychologist, a good counselor is one who has execution ability of:

a) Aligning a student's career goals and objectives with available economic opportunities not only in India but on a global basis,

b) Assessing basic competencies / skill sets of a student and aligning them with job functions and / or higher education in the right field,

c) Suggesting the most important field of study or career suitable for a candidate considering all facts of the case.

There is nothing right or wrong in an absolute context in the parlance of counseling. Counseling is nothing but an expert opinion given to a particular student in response to his / her query on a specific question (career or education related). The student needs to consider the option carefully, weigh pros and cons, discuss with family members and then take final decision. If necessary, the student should approach counselor with another round of queries.

2.4 SCOPE OF EDUCATIONAL AND VOCATIONAL COUNSELLING

Counseling refers to a specialised assistance provided to the students in the area of educational and vocational counseling. It is a continuous and comprehensive process of helping students to become more efficient, adjusted and realise their true potential. In this process the educational and vocational counseling largely derives from personal counseling also. The counselor provides assistance in a variety of fields like employment, education, scholarships and other financial assistance, social life and personal adjustment. The students are helped to choose courses/training programmes, develop efficient study skills and get necessary

remedial assistance in educational related matters. The counselor also helps the students in pre-employment activities, job placement services and successful adjustment to the work situation and work colleagues in the field of vocational counseling.

Broadly educational and vocational counseling activities target individuals who are:

- about to make a choice with respect to their education and vocation,
- in search of new fields of study/training,
- already employed but dissatisfied with their current occupation, hence in search of new areas of training and professional development,
- unemployed or have lost their jobs for whatever reason and wish to resume employment, and
- the marginalised sections of the society and need proper educational and vocational counseling to realise their potential and establish themselves in the society.

Self Assessment Questions

1) What do you mean by educational counseling?

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2) Describe the meaning of vocational counseling

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3) Who is a vocational counselor?

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4) Why will a student need educational counseling?

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5) Describe the scope of educational and vocational counseling.

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2.5 EDUCATIONAL COUNSELING

Education is not only about teaching, but also about learning. Education is "Learning to Know, Learning to Do, Learning to be and Learning to Live Together." It should aim at expanding the mental horizons and broaden the outlook of the students through training in cooperation, consideration, team spirit and service. Education should help channelise the youthful energies towards creativity and self actualisation. Counseling plays a very significant role in fulfilling these goals of education. Education counseling aims at making learning a joyful experience for the children. It helps them understand their abilities and personality dispositions so that they can perform at their best in the school.

Education has become an indispensable part of modern day life in view of the rising competitive market and the complexities of the present day world. In the present scenario, education only can ensure a bright future for our children. However, education itself has become so much complex and demanding that counseling has become a necessity in order to successfully adjust to the requirements of the educational setting, realise one's goals and aspirations and achieve them.

Educational counselors make use of the psychological principles of learning, remembering, motivation and emotion to understand and explain different problems faced by the students with regard to learning, remembering, adjusting to the teaching-learning situation and the curriculum load. As Rao (1991) points out, education, viewed in the context of its counseling function, is concerned with the kind of activities, which if implemented, would best accomplish the educational goal of harmonious individual growth. The purpose of education is to make the person competent. Educational counseling by helping the students how to learn and developing an understanding of themselves enables them to adjust with the academic pressure and promotes the academic development of the students.

Educational counseling can broadly comprise of the following three sub-areas (Rao, 1991).

a) appraisal of the strengths and weaknesses of the student through administering objective tests, talking to the teachers; and then discussing these with the student in the light of his choices, interests and aspirations. This helps provide a proper choice of courses and co-curricular activities leading to successful adjustment to the educational setting.

b) identifying the strengths and weaknesses of the study skills and providing the necessary remedial services. Study skills and practices followed by the students is crucial to their scholastic achievement. Many students fail because of their faulty or inappropriate study skills. Improvement of these will benefit the students tremendously in their academic success.

c) resolving personal problems and improving inter-personal relations, leading to better mental health and thereby helping the student to achieve academic success. The relationship of the student with the teachers and the peer group is vital as it affects the mental health of the student. If the student is anxious, worried, feels inferior, withdrawn, harassed and prejudiced against, then it adversely affects his scholastic progress. Hence the educational counselor needs to take care of these issues while addressing the educational concerns of the student.

The objectives/goals of educational counseling at the elementary stage (std. I to VIII), secondary (Std. IX & X) and senior secondary stage (Std. XI &XII) are mentioned described as follows.

i) **Elementary Stage**

Counseling elementary school children is critical in the sense that this sets the stage for a positive or negative attitude of the child towards the school and academic activities. The goal of counseling at this stage is to make the transition from home to school a smooth experience for the child and learning a joyful exercise for the child. The major goal of counseling

Here is to help the child in making proper adjustment to the school situation. Counseling elementary school children involves helping them with their learning problems, and providing them with an engaging and enjoyable learning experience at the school. It also involves helping them to adjust with the teacher and peers. The following can be mentioned as the aims of counseling at the elementary stage.

- adjustment of students to the school
- improvement of teacher-student relationship
- acquisition of effective study habits and practices
- developing student potential
- inculcating basic academic skills
- improving test taking skills

ii) **Secondary Stage**

This stage marks a transition from childhood to adolescence. With the onset of adolescence, there comes the accompanied physical and physiological changes,

leading to an identity crisis. There is a need for greater independence from the parents and at the same time dependence on the peer group. The adolescents have their individualistic ideas,interests and emotions, and they desire recognition and acceptance and encouragement of these.During this stage, students face many academic and social pressures which creates stress in them. In this context, the goals of counseling lies in expressing warmth, understanding and friendliness towards the adolescents and the counselor tries to help the adolescent gain insight into his problems, and develop appropriate attitudes, interests and goals. Mentioned below are a few of the goals of counseling at the secondary stage.

- Development of proper academic skills
- Assisting in academic achievement
- Improving test taking skills
- Developing critical thinking skills
- Improve the decision making capacity of students

iii) **Senior Secondary Stage**

Students at the senior secondary stage are in their late adolescence stage/phase. They are progressing towards adulthood, but are not yet adults. They are in a crucial stage of life where it is high time for them to think consciously about their further educational pland and vocational avenues. They need to take concrete steps to decide and pursue their educational and vocational plans.

The goals of counseling at this stage are as follows:

- helping the student to obtain, organise and apply academic information from a variety of sources
- develop positive interest in learning through involvement in active and practical learning
- helping the student to make further educational planning taking into account his abilities, aptitude, interests and attitudes.
- Helping to develop critical thinking and decision making skills
- Assisting student to make successful school-to-work or school-to-higher studies transition.

2.6 VOCATIONAL COUNSELING

The choice of a vocation is one of the crucial decisions in one's life. It determines the type of people one would work with, the nature of the environment in which one would work and the type of work one is going to do. All these should commensurate with the type of person one is, i.e., the abilities, interests, aspirations, attitudes and the values one has and the particular situation and family environment one has. Hence a career should be chosen with utmost care, thought and planning. However, it is often found that this crucial decision is taken very lightly and not enough consideration and planning is given to it. Since it has a significant repercussion on the future life affecting one's own and his family's happiness, vocational counseling is the need of the hour. Vocational counseling should be an integral part of the total educational process.

There are a number of theories of vocational development which explains how does vocational choices and preferences develop in an individual. For example, Ginzberg suggests three stages: fantasy, tentative and the realistic stages in vocational choice. First, the individual makes choice at the fantasy level that is he wishes to be an artist or space scientist without taking into account the reality. At the tentative stage the person thinks about certain vocations on a tentative basis, but at the realistic stage he takes a decision based on his real abilities, aptitude, interest etc. A vocational counselor should know about the different theories of vocational development in order to provide better and comprehensive counseling to the individual.

Vocational guidance and counseling is a process of assisting the individual to choose an occupation, prepare for it enter in it and progress in it. It is primarily concerned with assisting the individual in acquiring an increased maturity for making vocational choices, helping the individual make decisions involved in planning a future and building a career. The problem is not solved once for all when an individual makes a choice. Counseling is required further also in terms of helping the person to adjust in the work place and deriving job satisfaction. So the process of vocational guidance is a life long process. It is a continuous process of effecting satisfactory vocational adjustment.

In the early days of vocational counseling, the counselor's function was chiefly that of supplying information on training programs, or providing guidance leading to specific employment. More recently the recognition that psychological and social factors affect the choice of a vocation as well as the adjustment to it, and that personal and emotional problems often interfere with vocational planning, made it mandatory that the counselor be concerned with personality development, the counselor also must learn to understand and evaluate the student's psychological adjustment level. Out of these new concepts, a different role for the vocational counselor emerged.

Vocational counseling today has become a process in which the experienced and trained person assists an individual:

1) to understand himself and his opportunities,
2) to make appropriate adjustments and decisions in light of his understanding,
3) to accept the responsibility for his choice,
4) to follow a course of action in harmony with his choice.

Some other goals of vocational counseling can be listed as follows:

- **Helping student in reaching optimal development:** A student at secondary level has interest in reading about and in investigating various occupations. School can do a lot to develop this interest e.g. a boy shows interest in mechanics. Simple machine may be given to him, which he may open, and put the parts together. He may be interested in getting knowledge of the underlying principals used in the machine .Information about the mechanical processes may be passed on to him by taking him to the factory and work shops. Interests, which have a vocational values, should thus be encouraged in all possible ways.
- **Helping student learn effective decision-making skills:** One can be expected to learn decision-making skills only when one has complete

information about his own capacities and weaknesses and also the information of vocational field of his choice. Skill in making a decision comes through following certain steps. He should learn to withhold a decision until he has examined all aspects of situation, that is, he must consider his own abilities and the world of work around him. He must arrive at a complete knowledge of the occupational fields of his choice through his own efforts. He should be able to reject all advice and information offered to him by his superiors and come to his own decision. The counselor's responsibility is to enable the student in this decision making.

- **Helping student in selecting maturely and objectively a vocation:** Once the student is able to decide independently what occupation he/she should follow, they can benefit from the assistance given to them for selecting the best vocation. The counselor helps the student in choosing the career/vocation according to the interest, qualification etc.

Vocational counseling is often mistaken with vocational guidance. The latter is concerned largely with providing occupational or career information to the students. It consists of collection, classification, filing and dissemination of occupational information by use of several media of communication such as bulletin board, career corner, career pamphlets, films, documentaries, individual and group discussions. Vocational counseling is closely related to these functions. However, vocational counseling is basically more concerned with the vocational development of an individual. The main focus in vocational counseling is the student or the client. It is concerned with the discovery of his potentialities, interests and attitudes such that he is helped to actualise himself in the pursuit of his vocation. Vocational counseling uses several techniques of client appraisal and assessment and assists the individual in his self actualisation.

Self Assessment Questions

1) Describe the three sub-areas of educational counseling.

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2) Discuss the importance of educational counseling at the elementary stage.

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3) Differentiate between vocational counseling and vocational guidance.

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2.7 LET US SUM UP

In this unit you learned about two important types of counseling, that is, educational counseling and vocational counseling. Although these two can be treated as separate types of counseling, both are interdependent and overlap. Educational considerations have implications for vocational development and vocational counseling derives largely from the attitudes, values and interests acquired through the educational process. The meaning and scope of educational and vocational counseling were described. The present unit developed an understanding in you about the importance of educational and vocational counseling in the challenging and competitive environment prevalent in the current education arena and career field.

2.8 UNIT END QUESTIONS

1) Discuss the goals of educational and vocational counseling.

2) Discuss the importance of educational counseling in the present day school context.

3) Describe the roles and functions of a school counselor.

4) Explain the need for educational and vocational counseling.

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UNIT 3 CHILD PROTECTION AND CHILD RIGHTS COUNSELLING

Structure

3.0 INTRODUCTION

India has made tremendous progress with regard to different aspects of development. It has taken large strides in addressing issues like child education, health and development. However, child protection has remained largely unaddressed.

India is home to almost 19 percent of the world's children. More than one third of the country's population, around 440 million, is below 18 years. According to one assumption 40 percent of these children are in need of care and protection, which indicates the extent of the problem. In a country like India with its multicultural, multi-ethnic and multi-religious population, the problems of socially marginalised and economically backward groups are immense. Within such groups the most vulnerable section is always the children. (Study on Child Abuse: India 2007 by Ministry of Women and Child Development, Government of India, 2007). In this context protection of the child and ensuring the rights of the children will not only protect the child, but also provide him/her opportunities to achieve all round growth and development.

Traditionally in India, the responsibility of care and protection of children has been with families and communities. However, this very same situation also has made the children vulnerable to many kinds of neglect, abuse and exploitation;

in the process violating the child's rights. Our society is yet to become fully aware and understand the rights of the children. When we talk about the various rights of the children, then the gaps in child protection become obvious.

Let us see the following statistics reported by the Ministry of Women and Child Development, India.

2.5 million Children die in India every year, accounting for one in five deaths in the world, with girls being 50% more likely to die. One out of 16 children die before they attain one year of age, and one out of 11 die before they attain five years of age. India accounts for 35% of the developing world's low birth weight babies and 40% of child malnutrition in developing countries, one of the highest levels in the world. Although India's neo-natal mortality rate declined in the 1990s from 69 per 1000 live births in 1980 to 53 per 1000 live births in 1990, it remained static, dropping only four points from 48 to 44 per 1000 live births between 1995 and 2000.

The 2001 Census data and other studies illustrate the terrible impact of sex selection in India over the last few decades. The child sex ratio (0-6 years) declined from 945 girls to 1000 boys in 1991 to 927 in the 2001 Census. Around 80% of the total 577 districts in the country registered a decline in the child sex ratio between 1991 and 2001. About 35% of the districts registered child sex ratios below the national average of 927 females per 1000 males. In the 1991 Census, there was only one district with a sex ratio below 850, but in the 2001 Census, there were 49 such districts.

India has the second highest national total of persons living with HIV/AIDS after the Republic of South Africa. According to National Aids Control Organization (NACO), there were an estimated 0.55 lakh HIV infected 0-14 year old children in India in 2003. UNAIDS, however, puts this figure at 0.16 million children.

According to the 2001 Census report, amongst all persons living with disabilities, 35.9% were children and young adults in the 0-19 age group. Three out of five children in the age group of 0-9 years have been reported to be visually impaired. Movement disability has the highest proportion (33.2%) in the age group of 10-19 years. This is largely true of mental disability also.

Source: Ministry of Women and Child Development (2007): Working Group Report on Women and Children for the Eleventh Five Year Plan (2007-2012)

This shows the extent to which our children face neglect, discrimination and exploitation in our society. This also reflects our lack of knowledge and understanding of the rights of our children. Violations of the child's right to protection take place in every country and are massive, under-recognized and under-reported barriers to child survival and development, in addition to being human rights violations. Adopting rights based approach with regard to children at various administrative and policy levels will help generate awareness and observation of these rights for the benefit of our children.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Know the status of child rights in India;

- Define a 'child';
- Describe the different rights of the children;
- Understand the concept of child protection;
- Differentiate between child rights and child protection;
- Understand violation of child rights in its various forms; and
- Describe the importance of providing counseling to children whose rights are violated.

3.2 CHILD RIGHTS IN INDIA

India is a party to the UN declaration on the Rights of the Child 1959. Accordingly, it adopted a National Policy on Children in 1974. The policy reaffirmed the constitutional provisions for adequate services to children, both before and after birth and through the period of growth to ensure their full physical, mental and social development. It has also developed appropriate monitoring procedures to assess progress in implementing the Convention, involving various stake holders in the society.

In order to ensure child rights practices and in response to India's commitment to UN declaration to this effect, the government of India set up a **National Commission for Protection of Child Rights** (NCPCR). The Commission is a statutory body notified under an Act of the Parliament on December 29, 2006. Besides the chairperson, it will have six members from the fields of child health, education, childcare and development, juvenile justice, children with disabilities, elimination of child labour, child psychology or sociology and laws relating to children.

The National Commission for Protection of Child Rights emphasises the principle of universality and inviolability of child rights and recognizes the tone of urgency in all the child related policies of the country. For the Commission, protection of all children in the 0 to 18 years age group is of equal importance. Policies define priority actions for the most vulnerable children. This includes focus on regions that are backward or on communities or children under certain circumstances. The NCPCR believes that while addressing only some children, there could be a fallacy of exclusion of many vulnerable children who may not fall under the defined or targeted categories. In its translation into practice, the task of reaching out to all children gets compromised and a societal tolerance of violation of child rights continues. Therefore, it considers that it is only in building a larger atmosphere in favour of protection of children's rights, that children who are targeted become visible and gain confidence to access their entitlements.

India is also a signatory to the World Declaration on the Survival, Protection and Development of Children. In pursuance of the commitment made at the World Summit, the Department of Women and Child Development under the Ministry of Human Resources Development has formulated a National Plan of Action for Children. Most of the recommendations of the World Summit Action Plan are reflected in India's National Plan of Action-keeping in mind the needs, rights and aspirations of 300 million children in the country. The priority areas in the Plan are health, nutrition, education, water, sanitation and environment. The Plan gives special consideration to children in difficult circumstances and aims at

providing a framework, for actualisation of the objectives of the Convention in the Indian context.

3.3 WHO IS A 'CHILD'?

According to international law, a child means every human being below the age of 18 years. This is a universally accepted definition of a child and comes from the United Nations Convention on the Rights of the Child (UNCRC), an international legal instrument accepted and ratified by most of the countries. India has always recognised the category of persons below the age of 18 years as distinct legal entity. That is precisely why people can vote or get a driving license or enter into legal contracts only when they attain the age of 18 years. Marriage of a girl below the age of 18 years and a boy below 21 years is restrained under the Child Marriage Restraint Act, 1929. Moreover, after ratifying the UNCRC in 1992, India changed its law on juvenile justice to ensure that every person below the age of 18 years, who is in need of care and protection, is entitled to receive it from the State.

According to psychologists, a child is a person, not a *sub person*, and the parents have right and responsibility to take care of them. As a child (minor), by law, children do not have autonomy or the right to make decisions on their own for themselves in any known jurisdiction of the world. Instead their adult caregivers, including their parents, teachers and others, are vested with that authority, depending on the circumstances. Some believe that this state of affairs gives children insufficient control over their own lives and causes them to be vulnerable.

What makes a person a 'child' is the person's 'age.' Even if a person under the age of 18 years is married and has children of her/his own, she/he is recognized as a child according to international standards**.**

3.4 WHAT ARE CHILDREN'S RIGHTS?

Children's rights are the rights of special protection and care afforded to the young including their right to association with both of biological parents, their identity as well as the basic needs for food, universal state-paid education and health care. Interpretations of children's rights range from allowing children the capacity for autonomous action to the enforcement of children being physically, mentally and emotionally free from abuse.

A right is as an agreement or contract established between the persons who hold a right (often referred to as the "rights-holders") and the persons or institutions which then have obligations and responsibilities in relation to the realisation of that right (often referred to as the "duty-bearers".) Child rights are specialised human rights that apply to all human beings below the age of 18.

According to the United Nations Convention on Rights of Child (UNCRC), Child Rights are minimum entitlements and freedoms that should be afforded to all persons below the age of 18 regardless of race, color, gender, language, religion, opinions, origins, wealth, birth status or ability and therefore apply to all people everywhere. The purpose of the UNCRC is to outline the basic human rights that should be accorded to children. The following four broad categories of rights cover all civil, political, social, economic and cultural rights of every child.

3.4.1 Right to Survival

A child's right to survival begins before a child is born. According to Government of India, a child's life begins after twenty weeks of conception. Hence the right to survival is inclusive of the child's right to be born, right to nutrition, health & care, shelter and clothing and the right to live with dignity.

3.4.2 Right to Protection

This includes right to protection from abuse, exploitation and neglect. A child has the right to be protected from neglect, exploitation and abuse at home and outside the home. Every child has a right to lead a well protected and secure life away from neglect.

3.4.3 Right to Participation

A child has the right to participate in any decision-making that involves him/her directly or indirectly. There are varying degrees of participation as per the age and maturity of the child. Right to participation also includes right to expression, right to information and right to Name and Nationality.

Every child has a right to know his basic rights and his position in the society. High incidence of illiteracy and ignorance among the deprived and underprivileged children, however, prevents them from having access to information about them and their society. Every child also has a right to identify himself with the nation, but a vast majority of underprivileged children in India are treated like commodities and exported to other countries as labor or prostitutes.

3.4.4 Right to Development

Children have the right to all forms of development - Emotional, Mental and Physical. Emotional development is fulfilled by proper care and love of a support system, mental development through education and learning and physical development through recreation, play and nutrition. Thus right to education and right to recreation are two important rights of children.

The Constitution of India guarantees all children certain rights, which have been specially included for them. These include:

- Right to free and compulsory elementary education for all children in the 6-14 year age group (Article 21 A).
- Right to be protected from any hazardous employment till the age of 14 years (Article 24)
- Right to be protected from being abused and forced by economic necessity to enter occupations unsuited to their age or strength (Article 39(e)).
- Right to equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and guaranteed protection of childhood and youth against exploitation and against moral and material abandonment (Article 39 (f)).

Besides these they also have the following rights as equal citizens of India, just as any other adult male or female:

- Right to equality (Article 14).
- Right against discrimination (Article 15).
- Right to personal liberty and due process of law (Article 21).
- Right to being protected from being trafficked and forced into bonded labour (Article 23).
- Right of weaker sections of the people to be protected from social injustice and all forms of exploitation (Article 46).

3.5 WHAT IS CHILD PROTECTION?

UNICEF considers child protection as the prevention of or responding to the incidence of abuse, exploitation, violence and neglect of children. This includes commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage. Protection also allows children to have access to their other rights of survival, development, growth and participation. UNICEF maintains that when child protection fails or is absent, children have a higher risk of death, poor physical and mental health, HIV/AIDS infection, educational problems, displacement, homelessness, vagrancy and poor parenting skills later in life.

According to the Integrated Child Protection Scheme (ICPS), protection is about keeping children safe from a risk or perceived risk to their lives or childhood. It is about recognising that children are vulnerable and hence reducing their vulnerability by protecting them from harm and harmful situations. Child protection is about ensuring that children have a security net to depend on and if they happen to fall through the holes in the system, the system has the responsibility to provide the child with the necessary care and rehabilitation to bring them back into the safety net.

Research, documentation and interventions by government and the civil society groups in the past have clearly brought forth some of the following child protection issues that deserve special attention: 1) Gender Discrimination, 2) Caste discrimination, 3) Disability, 4) Female foeticide, 5) Infanticide, 6) Domestic violence, 7) Child sexual abuse, 8) Child marriage, 9) Child labor, 10) Child prostitution, 11) Child trafficking, 12) Child sacrifice, 13) Corporal Punishment in schools, 14) Examination Pressure and Student Suicides, 15) Natural disasters, 16) War and conflict, 17) HIV/AIDS.

3.5.1 Difference between Child Rights and Child Protection

It is important to understand the difference between these two concepts. *Child rights* are a set of principles or ideals. They are entitlements and some of them are justifiable in a court of law, but they are not tangible. Protection is one of these rights. But *Child Protection* is more than a right. It is a framework or system by which the rights of a child can be exercised. The framework consists of various duty bearers such as the departments of the government, police, school, civil society, who all have roles to play to ensure that a child's rights are met; and in the case that a child's rights are violated that the violator be brought to justice and care be provided to the child. Child protection is not only treatment, but should also be preventive. Risk management needs to take place to reduce the risk of violation of child rights in any given circumstance or space.

Child protection is hence the means through which all other rights of a child can be upheld. For example a child has a right to live a normal childhood in a family environment. The child protection framework need to first take steps to ensure families are able to survive by providing them health, education, and food for free or at minimal cost. The next step is to address the needs of children who have fallen through the cracks such as destitute, abandoned, and orphan children. The framework includes the mechanisms to relocate these children into caring families either through adoption or foster care and provide these children with access to health and education services. Hence the framework is not a single ministry or single government body; it is the interlinking functions of all ministries and sectors.

Self Assessment Questions

1) What is NCPCR?

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2) Define a 'Child'.

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3) Explain the Right to Participation.

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4) Describe the rights of children mentioned in the constitution of India.

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5) Differentiate between child protection and child rights.

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3. 6 CHILD RIGHTS COUNSELING

3.6.1 Vulnerable Child

A "vulnerable child" means a child who is unable to protect himself or herself. This includes a child who is dependent on others for sustenance and protection. A vulnerable child is defenseless; exposed to behaviour, conditions or circumstances that he or she is powerless to manage; and is susceptible and accessible to a threatening parent or caregiver. Vulnerability is judged according to physical and emotional development, ability to communicate needs, mobility, size and dependence.

All children due to their age are considered to be at risk for exploitation, abuse, violence and neglect. But vulnerability cannot be defined simply by age. Though age is one component, vulnerability is also measured by the child's capability for self-protection. The question that arises is, are children capable of protecting themselves. Can children provide for their basic needs, defend against a dangerous situation or even recognize a dangerous situation.

A child's vulnerability comes from various factors that hinder a child's ability to function and grow normally. The following factors further compound children's vulnerability:

i) **Age within age:** Younger children, especially those below the age of six, are much more dependent on the protection system.

ii) **Physical disabilities and mental disabilities:** Children become more vulnerable to abuse and neglect if they are suffering from any physical or mental disability.

iii) **Powerlessness:** comes of the situations and people that surround the children. If a child is given the power by the state, family or community to participate and fulfill their own rights and responsibilities they are less vulnerable.

iv) **Defenselessness:** comes from the lack of protection provided by the state or parents or community. If there is no child abuse law than how is a child suppose to defend himself/herself against abuse.

v) **Passivity:** due to situation or treatment of the child. For example a child who is enslaved or oppressed does not have the ability to seek help or protection.

vi) **Invisible:** Children who the system doesn't even recognize are highly vulnerable.

The Integrated Child Protection (ICPS) defines vulnerability in two categories:

1) Children in need of care and protection

2) Children in conflict with law

A child in need of care and protection is defined as a child who:

Doesn't have a home or shelter and no means to obtain such an abode

Resides with a person(s) who has threatened to harm them and is likely to carry out that threat, harmed other children and hence is likely to kill, abuse or neglect the child.

Is mentally or physically handicapped, or has an illness, terminal or incurable disease and has no one to provide and care for him/her.

Has a parent or guardian deemed unfit or unable to take care of the child.

Is an orphan, has no family to take care of him/her, or is a runaway or missing child whose parents cannot be located after a reasonable search period.

Is being or is likely to be sexual, mentally, emotionally or physically abused, tortured or exploited.

Is being trafficked or abusing drug substances.

Is being abused for unthinkable gains or illegal activities.

Is a victim of arm conflict, civil unrest or a natural disaster

Children in Conflict With Law are juveniles who have allegedly committed a crime under the Indian Penal Code.

The ICPS also recognises a third category of children: Child in contact with law. These children are victims of or witnesses to crimes. ICPS lastly outlines that vulnerable children groups also include but are not limited to the following: "children of potentially vulnerable families and families at risk, children of socially excluded groups like migrant families, families living in extreme poverty, scheduled castes, scheduled tribes and other backward classes, families subjected to or affected by discrimination, minorities, children affected by HIV/AIDS, orphans, child drug abusers, children of substance abusers, child beggars, trafficked or sexually exploited children, children of prisoners, and street and working children."

Thus vulnerable children are those who are susceptible to abuse, exploitation, and neglect. Child protection is derived out of the duty to respond to the needs of vulnerable groups of children.

Let us now discuss the following groups of vulnerable children whose rights are violated and providing counseling to them.

3.6.1.1 Child Abuse

The growing complexities and challenges of life coupled with changes in the socio-economic conditions of people have played a major role in increasing the vulnerability of children to various forms of abuse. Child abuse is a violation of the basic human rights of a child. It is a state of emotional, physical, economic and sexual maltreatment meted out to a person below the age of eighteen.

According to the World Health Organization (WHO), "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.''

Thus child abuse is the physical, sexual, emotional mistreatment, or neglect of children. Child abuse has serious physical and psycho-social consequences which adversely affect the health and overall well-being of a child.

Child abuse has many forms: physical, emotional, sexual, neglect, and exploitation. Any of these that are potentially or actually harmful to a child's health, survival, dignity and development are abuse.

Physical abuse is when a child has been physically harmed by kicking, punching, beating, biting, hitting, stabbing, burning or otherwise harming the child.

Emotional abuse is also known as verbal abuse, mental abuse, and psychological maltreatment. It can be seen as a failure to provide a supportive environment and primary attachment figure for a child so that they may develop a full and healthy range of emotional abilities. Emotional abuse consists of acts such as insulting, rebuking, restricting movement, threatening, scaring, discriminating, ridiculing, belittling, etc.

Sexual abuse is inappropriate sexual behaviour with a child. It is engaging a child in any sexual activity that he/she does not understand or cannot give informed consent for or is not physically, mentally or emotionally prepared for. This includes using a child for pornography, sexual materials, prostitution and unlawful sexual practices. To be considered 'child abuse', these acts have to be committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a daycare provider), or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Neglect is the failure to provide for the child's basic needs. Neglect can be Physical: not providing adequate food, clothing or shelter; Medical: lack of appropriate medical and mental health care; Educational: failure to provide appropriate schooling or take care of special educational needs; Psychological: lack of any emotional support and love, not attending to the child's emotional and psychological needs.

Counseling for Child Abuse

The problem of child abuse and human rights violations is one of the most critical matters on the international human rights agenda. In the Indian context, understanding and acceptance of child rights as primary inviolable rights is still to catch up. Counseling to such children can be provided in the following ways.

Using Props: Hugging a doll or favorite stuffed animal or blanket is a way to calm the fears and anxieties of the abused child. They dramatize trauma and abuse by symbolically setting up fantasy worlds, using structured or unstructured play situations, artwork, music, puppets, or clay. Their stories emerge as they set up parallel worlds to their own, allowing the counselor to observe and hypothesize, and begin to piece together an appropriate treatment plan.

In this safe setting, children can experience challenging emotions and traumas in stages, allowing them also to find ways to adapt to these traumas and regain a sense of control in their lives. As the relationship between counselor and child matures, the child senses unconditional acceptance, and begins to build new worlds, ones that offer hope and promise. The counselor addresses any maladaptive behaviours that could put the child at risk for further abuse, and even possibly future mental health issues.

Educating Caregivers: And once the counselor has a solid understanding of the child's issues and needs, then educating the child's caregivers becomes imperative. Counselors also support caregivers in implementing the treatment plan, which takes many weeks or months, and involves many frustrations and setbacks – even in the most loving and accepting environments. The counselor becomes a teacher as well as therapist, advising the child and caregivers about the course of recovery, which challenges both the child and caregiver at each major developmental stage – from starting school, to the teen years, dating, self-sufficiency, and parenting.

The child abuse counselor also conducts group sessions for abused children. Young children, for example, benefit from participating in developmental play groups. And children and youth who are sexually abused benefit from group counseling, seeing that they are not alone, and processing their feelings of shame and guilt with others who feel the same.

Victim's of sexual abuse, depending on the child's age, and the type and extent of abuse, also benefit from different therapeutic techniques. These techniques, ranging from psychotherapy to trauma-focused play therapy, and trauma-focused cognitive-behavioural therapy, guide victims through processing the experience to normalising reactions. The counselor works with the child to develop healthy coping patterns while addressing associated conditions of depression, anxiety, panic attacks and symptoms of post traumatic stress disorder.

Biofeedback, eye movement desensitisation, and relaxation techniques are also tools that the counselor employs when working with sexually abused children and youth. The therapist also counsels the family or individual family members on adaptive strategies for overcoming abuse and developing healthy family functioning.

3.6.1.2 Street Children

Street children are considered to be an urban problem. Children can be found in railway stations, near temples and dargahs, in markets, under bridges, near bus stops etc. Hence the definition of street is not in the literal sense, but refers to those children without a stable home or shelter. There are three major categories of street children:

a) children who live on the street with their families and often work on the street. These may be children from migrated families, or temporarily migrated and are likely to go back to their homes;

b) children who live on the street by themselves or in groups and have remote access or contact with their families in the villages. Some children travel to the cities for the day or periods of time to work and then return to their villages;

3) children who have no ties with their families such as orphans, refugees and runaways.

It is the second and third category of children who are most vulnerable as they are easy victims of abuse, and inhuman treatment. They often engage in petty theft or prostitution for economic survival. Children run away from their homes for a variety of reasons. Some may have faced traumatic experiences in their homes. Their parents may be abusive or have problems with alcoholism, poverty and unemployment. Some children leave home drawn by the glamour of the big cities.

"Children of the street" are homeless children who live and sleep on the streets in urban areas. They are on their own and do not have any parental supervision or care though some do live with other homeless adults. *"Children on the street"* earn a livelihood from street such as street urchins and beggars. They return home at night and have contact with their families. The distinction is an important one because children of the street lack emotional and psychological support of a family.

Counseling for Street Children

Street children have many problems related to substance use and sexual and reproductive health including HIV/AIDS and other STDs. As different individual and social factors contribute to these problems, a variety of responses are required. For the most part, as a street educator the interventions you will be implementing will focus on changing or influencing the life of the street child. However, to be effective you will have to:

- Ensure that street children participate as key players in these interventions.
- Coordinate groups or individuals in the community who work with street children.
- Ensure that services and resources are available to street children.

Interventions should also aim at providing information, building basic skills, providing counseling, improving access to health services, creating a more positive and safe environment and involving the street children themselves in various activities.

Street children need various resources to meet their physical and emotional needs. Resources can be internal (inside a person), e.g. intelligence, capacity to work etc., or they can be external (outside the person i.e. in the environment), e.g. schools, health services, community organisations and people who care. Even though street children usually have many internal resources, they usually lack external ones. Without these external resources, they may have a hard time learning new skills that would help improve their lives. It may be more difficult for them to develop healthy ideas and practices about substance use if they do not have the benefit of resources such as street education and informational campaigns. If they have fewer ways of coping with stress, they may fall back on substances to relieve it. Your task involves identifying these resources and making them available or accessible to street children.

The question of prevention or treatment of substance use and sexual and reproductive health-problems and providing support to street children can be approached at three levels:

1) Individual level (street children)
2) Local community level
3) Beyond the community

Life skills can enable the street children to:

Be assertive: e.g. the ability to state one's dislike for sex or substance use clearly. This skill helps street children to communicate their needs and to resist social pressures.

Negotiate: the ability to discuss and get others to agree to what one wants. A street child could negotiate to use a contraceptive method such as condoms during sexual intercourse.

Think critically: street children can learn to assess potential risks in various situations ahead of time, and think about why they engage in risk behaviour. A street child who knows the problems that may arise from substance use and realises that he or she uses substances as a way of making friends or coping with stress may try to find other ways of addressing those needs and avoid getting involved in using substances.

Develop self-awareness and self-esteem: increasing understanding of personal strengths, interests, personal priorities and goals. This can decrease the attitude of 'just letting it happen'.

Make and build friendships: having real friends can be a source of support and protection and may help street children resist pressure from adults who try to exploit them.

Life skills are not applied in isolation, rather they depend on each other. For example, to learn decision making, street children should be able to identify their feelings about their situation and what they want out of life (self-awareness). The learning and application of life skills also need to be closely linked to the reality of the street children's lives.

3.6.1.3 Disability in Children

Disability in children –physical as well as mental disability- leads to neglect and abuse of children. The main causes of disability in children are:

- Communicable disease
- Infection in early childhood
- Early motherhood
- Nutritional deficiencies
- Insufficient or inaccessible health care services
- Inadequate sanitation
- Inter-family marriages

There are many protection issues that also lead to disability. Children who are trafficked, abused and sexually exploited are at risk for psychological effects as well as physical problems. Other forms of violence against children can also lead to a disability such as corporal punishment in schools, children living on the streets, and purposefully created disabilities for begging. Children from poor families face a double disability.

Disability is still functioning in the realm of social welfare instead of a rights perspective. Teachers are not trained and schools don't have the infrastructure to deal with children with disabilities.

Treatment for Disability in Children

Comprehensive counseling interventions for children include individual and group therapy, case management, rehabilitation counseling, and psychiatric consultation with a family and child psychiatric physician. Individual consultation for parents is also available to better prepare them to help their children, teens, and transition age adolescents. Additional services are as follows:

i) **Therapeutic Behavioural Services (TBS):** TBS is available for children with extreme needs who have required hospitalisation in the past couple of years. These children may qualify for intensive behavioural treatment in the home, school, or community. Significant parental consultation may also be provided.

ii) **Behavioural Life Coaching:** Adolescents and transitional age young people benefit from Behavioural Life Coaching, as it helps foster integration into the community and the development of skills leading to independence within the context of their diagnoses.

iii) **Transitional Youth Program:** These programmes help young people deal with emerging developmental and psychological issues post-high school. It fosters behavioural skill development for a smoother transition to community life.

iv) **Behavioural Consultation:** This helps parents, supervisors at care homes and others learn about using effective reward systems to teach young clients how to achieve success in their home and community settings.

v) **Family Support and Education:** Monthly meetings can provide information and much-needed support to parents or significant others, including care workers who serve children with developmental disabilities who have mental health needs.

3.6.1.4 Drug Abuse

"If current trends continue, 250 million children alive today will be killed by tobacco." - W.H.O.

The incidence of drug abuse among children and adolescents is higher than the general population. This is notably because youth is a time for experimentation and identity forming. In developed countries drug abuse among youth is generally

associated with particular youth subcultures and lifestyles. The use of tobacco is a major concern amongst children. The use of certain drugs such as whitener, alcohol, tobacco, hard and soft drugs is especially wide spread among street children, working children and trafficked children.

Drug Addiction Treatment Methods

Drug addiction is a treatable disorder. Through treatment that is tailored to individual needs, patients can learn to control their condition and live normal, productive lives. Like people with diabetes or heart disease, people in treatment for drug addiction learn behavioural changes and often take medications as part of their treatment regimen.

Behavioural therapies can include counseling, psychotherapy, support groups, or family therapy. Treatment medications offer help in suppressing the withdrawal syndrome and drug craving and in blocking the effects of drugs.

The ultimate goal of all drug abuse treatment is to enable the patient to achieve lasting abstinence, but the immediate goals are to reduce drug use, improve the patient's ability to function, and minimize the medical and social complications of drug abuse.

Counseling plays an important role in this. Counseling techniques have been shown to be most effective in bringing positive changes in addiction behaviours. Counseling aims at the following: cognitive (understanding the problem and solution), behavioural (making new habits more comfortable than the old destructive habits), family systems (realising the dynamics formed in childhood that affect adult actions; and involving family members to strengthen new response patterns).

Positive reinforcement, comfortable social attachments within the new activities and direction away from old cycles of abuse must be part of any therapy. Alcoholics Anonymous and similar groups offer a place for self-examination, mutual support and growth at the patient's own pace. Success may lie in the motivation and resolution of the patient to effect positive change.

Thus counseling can be provided to the abused children and their caregivers to help them come out of the trauma, sufferings and anxieties. Treatment may include psychotherapy, rehabilitation counseling, cognitive behaviour therapy, supportive therapy, behaviour therapy, play therapy, and other modalities as necessary to assist the individual in overcoming anxiety, fear and depression.

However, most important is that counseling can adopt a preventive approach and create awareness and understanding regarding the rights of the children. This will help protect the children so that they can develop in a healthy way. Counseling strategies can aim at developing a protective environment for children emphasising the importance of knowing, understanding, accepting and enforcing legal standards in child protection. Further community-based approaches can be used that promote and strengthen the capacity of families and communities to address child protection issues.

Self Assessment Questions

1) What do you mean by a vulnerable child?

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2) Describe the categories of vulnerability by ICPS.

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3) Analyse the definition of child abuse given by WHO.

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4) Describe the counseling interventions for the disabled children.

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3.7 LET US SUM UP

In this unit you learned about the issues related to child rights and child protection. The meaning of child rights and child protection was discussed. You also came to understand the different forms of child rights violation. Building a protective environment for children will help prevent and respond to this child rights violation, abuse and exploitation. Counseling strategies to deal with all these were described. A comprehensive approach to address the issue of child protection and child rights should include the following: Strengthening **government commitment** and **capacity** to fulfill children's right to protection; promoting the establishment and **enforcement** of adequate **legislation**; addressing harmful **attitudes, customs and practices**; encouraging **open discussion** of child

protection issues that includes media and civil society partners; developing **children's life skills, knowledge and participation**; building **capacity of families and communities**; providing **essential services for prevention, recovery and reintegration**, including basic health, education and protection; and establishing and implementing ongoing and effective **monitoring and reporting.**

3.8 UNIT END QUESTIONS

1) What do you mean by rights of children? Describe the different types of rights of children.

2) Discuss the issue of child protection in the context of India.

3) Describe child abuse. Discuss the counseling techniques for such children.

4) What are the strategies of counseling you'll adopt for street children?

3.9 SUGGESTED READINGS

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UNIT 4 ADDICTION/ANXIETY COUNSELLING

Structure

4.0 INTRODUCTION

Addiction and anxiety often go hand in hand. Depression may be the reason an addict begins using drugs or alcohol or, it may develop as the addiction progresses. Dual diagnosis of addiction and anxiety is, when a person has an addiction plus a psychiatric illness such as anxiety, doctors say that they have a “dual diagnosis”. The term is a reminder for the counselors, physicians, and other medical professionals that this client has extra challenges on the road to recovery. Depression and other psychiatric illnesses increase the risk of addiction. Of all people who are diagnosed as having a psychiatric illness, roughly 29% are alcohol or drug abusers. As many as 37% of people who abuse alcohol and 53% of people who abuse drugs, have at least one serious mental illness. Depression, already common in the general population, is even more common among alcoholics and drug abusers.

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Understand the meaning of addiction / anxiety disorder;
- Describe the symptoms of addiction/anxiety;
- Explain the causes of addiction and anxiety disorder;
- Know the factors leading to development of addiction; and
- Discuss the various counseling techniques useful for addiction/anxiety.

4.2 MEANING OF ANXIETY DISORDER

Anxiety is a combination of both psychological and physiological symptoms that can lead to stress, physical discomfort, persistent worrying and obsessing, fear of social situations and other phobias, as well as panic attacks. People with anxiety often experience an unpleasant feeling that is typically characterised as uneasiness, apprehension, fear, or worry. Anxiety is experienced in numerous forms, ranging from the concretely physical to the intensely emotional. A common physical manifestation of anxiety is a panic attack, which is experienced as a combination of a pounding heart, sweating, shaking, and a shortness of breath.

4.2.1 Symptoms of Anxiety Disorders

The symptoms of the anxiety disorders are as follows:

1) Feelings of nervousness and/or fear
2) Excessive or irrational worry
3) Panic attacks
4) An urge to avoid a situation, place or person
5) Paranoid thinking and behaviours
6) Intrusive and negative thoughts about self or others
7) Nausea
8) Dizziness
9) Depression, anger management, loneliness or despair
10) Problems with an important relationship.
11) Stress, anxiety or panic.
12) Communication issues
13) Life transitions like separation, divorce, career change, job loss, or a major illness.
14) Struggling with a mental illness like bipolar disorder or major depression.
15) Substance abuse or other addiction in yourself or someone you love.
16) Grief over the loss of a loved one, including a pet.
17) Caregiver stress.
18) Unresolved trauma.
19) Spiritual issues or crises of faith.

4.3 ALCOHOL AND DRUG ADDICTION

For thousands of years, human beings have taken mind-altering substances as a way to alter their perceptions and play with their minds. Natural herbs, manufactured drugs, and alcohol have all been used in this way. Many people are able to take such substances only occasionally and without interference to their relationships or general wellbeing. But there have also always been people who have had difficulty moderating their use of drugs or alcohol, and it is these people who may go on to suffer from addiction.

Drug addiction can be seen in the people who are non adjustable and not able to cope-up with the problems to greater extent. In the 21th century the drug abuse has increased in an enormous proportions and is becoming a serious problem of the people of by which the survival of the society is in a threat too.

The drugs consumed by the people can vary in various forms, from taking of direct drugs to indirect forms of the drug e.g. alcoholism poses a serious social problem which involves teen age to old age people.

Today the use of drugs and even addiction have increased even at the school and college level. So is the case of anxiety. In other words because of the anxiety factors, use of drugs is rising; therefore today the importance of the role of the teachers and the counselors has increased as they not only have to educate the students, help to make wise choices but also to educate them, help them to know about the substance abuse/drug addiction and the danger related to it.

Addiction may occur at any age but the onset is more during young adulthood and the adolescent too (APA, American Psychological Association). The use of drugs /substances in today's youth may be because of anxiety, natural curiosity, impact of westernization, peer pressure, to express their own indentify, by experimentation and may be because of environmental and hereditary factors. Other reason for being addicts may be that today more youth is becoming unemployable and competition is increasing day by day, expectancy age is increasing that is wellness of health, by which the retirement age is also increasing. The increase in population is also one of the cause of frustration among the youth and to release their frustration, stress, anxiety the youth is becoming drug addicted to substances or drugs. The use of drugs is becoming the means of escape from feelings of void and helplessness.

4.3.1 Meaning of Substance/Abuse

Substance abuse is the over indulgence and dependence on the drugs or other chemicals leading to the effects that are detrimental to the individual's physical, mental health or the welfare of others (Mosby's medical, nursing and allied health dictionary, 1998)

Addictive behaviour is based on the pathological need for a substance or activity may involve abuse of substance such as nicotine, alcohols etc.

The disorder is characterised by a continuous use of medication, psycho-active substances; non -medically indicated drugs that result in failure to meet the social/ personal responsibilities such as work, family, interpersonal relation.

Two categories of drugs are commonly used, which the counselor must keep in mind which are the tranquilizers and sedatives. The counselor should also keep in mind, the individual's (client's) lifestyle and personality as it also plays an important role in the development of addictive disorder and are the central themes in some type of treatment.

The most commonly used problem substances are the psycho-active drugs .The psycho-active drugs are those drugs that directly affect mental functioning: alcohol, nicotine, barbiturates, minor tranquilizers, amphetamines, heroin, and marijuana.

4.3.2 Addictive Behaviour

Behaviour based on pathological needs for a substance or an activity is one of the most pervasive and intransigent mental problems which our society is facing. Therefore the need to treat them is also very important, so the counselor must look into the diagnostic classification of addictives or psychoactive substance related disorder which are divided into two major category—

1) Psychoactive substance including mental disorder, are those conditions which involve in chronic problems that is organic impairment resulting from the ingestion of psychoactive substances.

   These conditions stem from toxicity in the brain due to vitamin deficiency.

2) Second category, focuses on the maladaptive behaviour resulting from regular and consistent use of a substance and includes substance dependence disorder and psychoactive substance abuse.

The classification of substance abuse disorder by DSM IV and ICD- 10 given by WHO is divided into two categories –

a) Substance dependence disorder

b) Substance abuse disorder

Substance dependence is seen by marked physiological need for increasing amount of drug or withdrawal symptoms, when the drugs are not available.

Increased drug use leads to increased physical dependence, and users may find that they get sick if they do not take drug.

- Increased drug use leads to increased tolerance to the drug, and users may find that they need to take more of the drug to get the same effect.
- Drug users may harm themselves or others while intoxicated (e.g. drinking and driving) or by the actual act of drug taking (e.g. catching or passing on an infectious disease such as AIDS or Hepatitis, through shared needle use).
- Drug addicts may resort to criminal activities such as theft or prostitution to fund their drug taking, particularly if their drug addiction has forced them to lose their job.
- Drug addicts may overdose, die of drug related disease or suicide.

Self Assessment Questions

1) What do you mean by anxiety disorder?

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2) Describe the symptoms of anxiety disorder.

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3) Define substance abuse.

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4.4 DEVELOPING AN ADDICTION

Addiction to drugs (including marijuana, heroin, cocaine, ICE or alcohol) rarely happens instantaneously. The process of drug addiction is generally a slow one which builds up over time. People might, initially, use drugs only in a recreational way – they might use it to chill with some friends, make more of a dance party, or as a way to enhance the experience of sex. Alternatively, people might start using drugs initially for a specific purpose – a glass of wine after work to help unwind from the day, some lines of coke to aid a student cramming for an exam.

Using drugs in a contained way might seem fairly harmless, and certainly some people are able to use drugs sporadically or only in particular and limited circumstances. But for many others, drug taking can become habitual, desensitization leads to increased use, and the addiction takes hold.

Drug addicts typically spend a lot of time (and money) thinking about, purchasing and taking drugs – the process of buying and taking drugs becomes the central interest in their lives. Other pursuits and responsibilities, such as work, study, friends and family, often fall by the wayside – jobs get lost, exams failed, and relationships fail.

4.4.1 The Hallmarks of Addiction

Addiction can be characterised as a state in which the person or their relatives and friends come to experience their drug use as a hindrance to the quality of their everyday life. This interference to one's life may come in many forms; but often involves an experience of depression or anxiety, for some people issues with violence or loss of control, for others loss of good judgment or a loss of a significant relationship. Counselors and psychologists have developed a number of evidence based approaches for the treatment of addiction.

4.4.2 How Anxiety can Lead to Addiction

Some people use alcohol and illegal drugs to deal with the symptoms of anxiety. Doctors call this "self-medicating". The effects of alcohol or drugs can provide temporary relief from feelings of sadness, guilt or worthlessness. When the effects wear off, the bad feelings return. This cycle can lead to continuing use and eventual addiction.

Another link involves the consequences of anxiety. Depressed people often withdraw from social contacts and may even have trouble holding jobs. They may find themselves spending more time alone, without a supportive social network and turning to drugs or alcohol for comfort. It may even be easier to spend time with others who abuse alcohol and drugs instead of pursuing healthier relationships because social expectations may be lower.

Even for people who aren't using alcohol or drugs to self-medicate and haven't lost their social connections, anxiety appears to increase the risk of addiction. Many doctors think that whatever makes people vulnerable to anxiety also makes them more likely to abuse alcohol or drugs. Someone without anxiety may be able to try an illicit drug or drink alcohol regularly without any long-term problems; for a depressed person, these same activities may be more likely to lead to addiction.

4.5 SYMPTOMS OF ADDICTION AND ANXIETY

Symptoms of addiction and anxiety can be very similar. When anxiety is directly connected to the drug or alcohol abuse and isn't present independently, it's not considered a "dual diagnosis" but just a consequence of the addiction. For example, several psychiatric problems are directly related to cocaine. Cocaine abuse can lead to hallucinations, anxiety, sleep problems, sexual dysfunction and a mood disorder that includes anxiety. However, once the person stops using cocaine, the psychiatric problems generally get better. Amphetamines, heroin and inhalants can all have similar effects.

In order to ensure prevention and effective counseling, a counselor should know these varieties of drug that are been consumed by the people.

Symptoms of Addiction/Anxiety

Early recognition of the symptoms of addiction/anxiety increases chances for successful treatment and favorable out come. The role of counselor is preventive, remedial and educative.

Addiction/anxiety leads to changes in behaviour which can be seen in terms of psychological and physiological conditions of individual.

The symptoms can be described as follows:

- Sudden mood change
- Anger
- Irritation
- Low self esteem
- Loneliness
- Depression
- Lack of interest
- Change of priorities
- Personality changes
- Poor judgment
- Negative attitude
- Dishonesty
- Starts arguments
- Withdrawal symptoms
- Family relation problem
- Lacks intimate relationship

Certain physiological changes are also seen in the client such as,

- loss of memory
- Restlessness and fatigue
- Distortion in health
- Increase in heart rate
- Sweating
- Palpitation
- Confusion
- Irritation
- Weak immune system
- Chances of suffering major disease (Cancer, HIV AIDS)
- Difficulty in speaking

Self Assessment Questions

1) Anxiety leads to addiction. Explain.

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2) Describe the symptoms of addiction/anxiety.

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4.6 CAUSES FOR THE ADDICTION AND ANXIETY ABUSE

As addiction is a complex phenomenon it has various causes. The causes can range from psychological to social, biological and cultural. The psychological causes can be tension, anxiety, fear, stress, frustration etc. The social can be friend circle, society, economic status, etc. The biological can be the heredity factor, various diseases, etc. The cultural can be the traditional culture, demographic condition, etc.

Some of the causes are listed below:

- Repressed desires
- Repeated failure and striving for success
- Mal-adjustment /adaption with the environment e.g. new surrounding, new jobs/friends.
- Personal cause- the type of personality (type A/B), emotional instability.
- Too much of fear for examination, inability to prepare.
- Ineffective parenting e.g. lack nurturing and parental attachment, poor social coping skills inappropriately aggressive and shy behaviour, neighborhood conditions, negative attitude towards life.

4.6.1 Other Causes for Addiction/Anxiety

Why is it that some people seem prone to drug addiction, while others are not? It seems that certain factors are predictors of addictive personalities:

1) **Genetics:** Vulnerability to some forms of drug addiction often seems to be hereditary (this does not mean that if your parent was a drug addict, you will be too). It simply means that you might be predisposed, genetically, to addictive behaviour.

2) **Childhood Abuse or Trauma:** There is much evidence to suggest that addiction has a great deal to do with childhood experiences, so if you were subjected to abuse as a child (sexual, emotional or physical), or you experienced neglect or some sort of trauma, or you were the child of addicted parents, these are all indicators that you might be more susceptible to developing a drug addiction in later life.

3) **Mental Illness:** There is some evidence to suggest that people who are mentally ill or affected by other psychological issues (such as anxiety or depression) may use drugs as a way to manage their condition.

4) **Chronic Pain:** Sufferers of chronic pain can become addicted to drugs as they search out solutions to their constant pain.

While these factors might predispose people to becoming addicts, it is clear that these are not essential criteria on which to develop an addiction. Drug addiction affects people of all races, classes, backgrounds and cultures. Anyone can suffer addiction, and all addicts are likely to suffer some kind of negative consequences to their addiction.

4.7 TREATMENT FOR ADDICTION AND ANXIETY

Treatment on the psychological level by the counselor involves the personality assessment which focuses on the client's present mental state, the role of personality and emotional stress in development of disorder within the client. The assessment procedure involves the subjective, objective and projective use of personality assessment of the client. By this the information regarding each and every aspect of behaviour of the client in known to the counselor e.g. information regarding occupation, family relations, education, marital and other data concerning the client's life situation is obtained.

When a person has both addiction and anxiety, one of the first steps in treatment is to figure out which came first. That may be possible from the patient's history. The person may be able to describe depressed feelings that preceded the addiction. Or, they may describe self-medicating with alcohol or drugs. Sometimes, it's necessary to help the person quit drinking or doing drugs first, and then evaluate for anxiety.

If it's clear that the anxiety is a consequence of the addiction, treating the addiction is usually all that's needed. If the anxiety is a separate issue, it must be addressed as well. Treatment may include special counseling and antidepressant medicines.

The combination of addiction and anxiety can make it more difficult to recover. When a person feels sad, hopeless or exhausted, battling an addiction is a special challenge that may be difficult to face. However, knowing about the link between addiction and anxiety, being aware that dual diagnosis is possible and seeking treatment to address both issues can help make recovery possible.

The counselor should keep in mind the psychological treatment which aims at alleviating the individual's maladjusted behaviours and strive to bring about personality change to foster more effective adjustment. The counseling techniques which are used generally are as follows –

1) Group therapy
2) Behaviour therapy
3) Environmental interventions
4) Supportive psycho therapy
5) Re educated psycho therapy
6) Self control training technique
7) Cognitive behaviour therapy
8) Individual Counselling

4.7.1 Group Therapy and Counseling

Group therapy and Counseling aims at releasing of emotions and perception through sharing. The goal of group therapy is to modify attitude and behaviour .It provides the clients with incentive and motivation to make changes by themselves, because in anxiety/drug addiction group counseling may be used for resolving problems which the individuals have developed. They have inadequate understanding of one self, not aware of harmful effect of faulty habits, dealing with rejection and abuse. Group psychotherapy is considered to be remedial, supportive and reconstructive. The focus is on the conscious, unconscious and subconscious aspect of personality of the people.

The selected group members should be of same age, same problem and having same socio-economic status. The aim of group counseling is to make each member take on responsibility to put forth his /her experience by sharing and listening. The members are able to express their views and ideas.

In group counseling self help groups are formed by interested individuals that come together, to deal with common problems, for example, smoking, alcoholism, drugs etc. The counselor should keep in mind to generate community feeling within the members which is one of the important parts of the healing process.

The steps and skills followed by a counselor, in group counseling are as follows:

1) planning the group
2) selection of members
3) stages of group process

1) **Planning the group in counseling process comprises of following**:

   i) **Purpose:** The counselor first identifies and clarifies the purpose of counseling, i.e. why group counseling is required for the addictives.

   ii) **Size:** The counselor should look into the size i.e. number of clients. The average group size should be of 5-7 members who are having same problem.

   iii) **Length and frequency:** The duration of session must be decided well in advance looking into the severity of addiction, in the starting the session should be of 45 minutes to 60 minutes and later can be adjusted according to the need.

   iv) **Time for counseling:** Time should be set well in advance by the counselor looking into the mood of the clients.

   v) **Physical sitting:** The group session is best conducted in a room or open place with minimum noise, comfortable sitting arrangement in a circle with good ambience.

2) **Selection of members** – While providing group counseling the selection of group members is very important. This will depend on the addiction level i.e. mild, moderate, and severe of the clients.

   i) **Level of commitment:** Before counseling a good rapport must be established among the members so that they know each other which will facilitate their sharing of their problems.

ii) **Acceptance and trust:** In order to develop trust, the counselor must remember his/her role, so that clients will trust him and a positive therapeutic force is seen in the group.

3) **Stages of group process:**

i) **Beginning stage**: starts in rehabilitation center .In the beginning of counseling session the group may take rather longer couple of sessions to develop trust for working in sharing environment.

ii) **Working stage:** This is the main stage of group discussion. At this stage the problems are redefined and causes for addiction/anxiety is known. Not only this, the group members try to find out solutions by themselves with the help of counselor .Conscious efforts are made to solve the problems. At times group situation can be very difficult for alcoholics, who are, engrossed in denial of their own responsibilities but at the same time, they also provide the opportunity to see new possibilities for coping with circumstances that have led to their difficulties.

iii) **Closing stage:** It is the stage where the members share what they have learnt. The counselor summarizers the outcome. This stage takes 1-2 session, the bonding is seen amongst the group member and the counselor. The counselor should note that if required the parents/ relatives/spouse/children must also be counselled.

Follow up: Follow up enables the group members to keep in touch. The counselor should take the feed back so that follow up plans could be discussed before termination.

4.7.2 Behaviour Counseling

Behaviour counseling/ therapy plays an important role in the treatment of addictives .There are several sub type of behaviour therapy which are very effective, e.g. aversion therapy which involves the presentation of aversive stimuli with alcohol consumption in order to suppress drinking behaviour.

Anxiety level and other symptoms can be cured by various other behavioural therapies such as token economy, positive reinforcement, systematic desensitization, flooding etc. Not only this, exposure therapy is used for reduction of anxiety, negative feeling, emotions etc. This exposure is usually done in gradual manner under safe and control conditions in the presence of therapist. Training and muscular relaxation given by Jacobson is one of the popular method for effective anxiety management. Moreover yoga and meditation is also useful in reducing anxiety/addiction.

Constructing an Anxiety Hierarchy

Systematic desensitization makes use of an anxiety hierarchy. It consists of listing of all situation, events that evokes fear in the clients. The counselor must help the clients to place them in rank order by arranging the items of hierarchy from the least to the most anxiety provoking.This rating is called as the subjective unit of distress (SUD). The client is asked to imagine each SUD in a relaxed state which gradually helps the client to reduce his anxiety/addiction.

4.7.3 Environmental Therapies

For counseling environmental interventions are also important, rightly stated by Booth et al "Environment supports have shown to be an important component to an alcoholic recovery."

Therefore preventive interventions can provide skills and support to high risk people to enhance level of protective factors and prevent drug abuse. The prevention program should address all form of drug addiction whether legal drug such as alcoholism, tobacco etc. and use of illegal drugs like heroin, marijuana or inappropriate use of drug e.g. inhalants.

Preventive programs should be of long duration with repeated interventions. These environmental interventions include peer discussion, role play, advertisement, etc which helps the client to overcome the problems.

4.7.4 Supportive Psycho Therapy

The aim of supportive psychotherapy is to help the addictives suffering from anxiety to feel more adequate in facing his/her problem more effectively and confidently. This is inter-personal psychodynamic approach to treat the client, where all efforts are made to make the individual more confident with the help of counselor. The counselor tries to orient the client to increase clients' awareness related to the positive aspect of life. Luborsky's (1984) Supportive/ expressive psycho-analytically oriented therapy can be used by counselor in treating addictive anxiety clients. It is based on the assumptions that a ***Core Conflictural Relationship Theme*** (CCRT) is at the center of person's problem. This relationship theme develops from the early childhood experience, but the client is unaware of it and its connection to childhood experiences. Therapy/counseling is oriented towards increasing the client's awareness of the theme. It is assumed that the client will have better control over behaviour if he/she knows more about what is going on at the level of unconscious. The transference relationship is important that the CCRT will be lived out and enacted in relationship to the counselor and the problem faced by the client will be resolved.

4.7.5 Re-Educated Psycho Therapy

Re- educated psychotherapy is one of the important therapy to treat the addictives/ anxiety. It helps the client to gain an insight into oneself and modify or change the faulty assumptions and attitude paving the way to fundamental changes in personality. It is also necessary to deal with the individual's social environment and his/her adjustment to it. In most of the cases, changes in family situation help the client to make effective adjustment. According to Hoyt (1995) it is precise and well time intervention technique.

4.7.6 Self Control Training Technique

Self control training technique (Miller Brown et al 1995) suggests that the goal of the counselor/therapist is to reduce addictive intake without abstaining all together. There is now even a computer based self control training program available that has been shown to reduce alcohol intake (Hester 1997)

In addition to the above, some psychologists have designed various written material, work book and exercises to help the client with specific problems.

In this self help group mutual supporter can be seen online. Self help and mutual support group can exchange written messages on specific topics.

4.7.7 Cognitive Behaviour Therapy

CBT primarily focuses on helping the client to overcome unproductive thoughts and belief's and replace them with constructive ones. People suffering from anxiety and addiction undergo change in their thought, behaviour, and emotions. All these three play an important role in the functioning of an individual. Cognitive behaviour therapy which focuses on the thought pattern proves an effective intervention. The counselor may use the cognitive therapy by Aron Beck (1950,1976), rational emotive behaviour therapy (REBT) by Alberst Ellis (1960), stress inoculation training by Meichenbaun (1977). These approaches are based on the premise that people experiencing negative emotions such as anger, depression, anxiety etc. have negative belief about themselves and their future. The counselor tries to alter these negative beliefs. The counselor makes the client aware of their cognitive distortions, help the client to understand how these distortions in perception and thinking are the result of anxiety, depression and stress. The counselors also help the clients to bring about changes through corrections to the distortions in perception and thinking. The counselor also helps the clients to search for alternative solutions to the problem.

4.7.8 Individual Counseling

Individual counseling is an inner journey of self exploration that is focused on one's goals. It is a collaborative effort that will help the client to shift out of the patterns that no longer serve them and steer them toward the life they desire. Following are some of the aims:

1) Develop more fulfilling relationships
2) Heal past hurts and traumas
3) Manage anger, depression and anxiety
4) Cope more effectively with life changes
5) Increase self esteem
6) Feel more balanced and whole

Self Assessment Questions

1) Describe the role of genetics in contributing to the development of addiction/anxiety.

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2) How can cognitive behaviour therapy help in the treatment of addiction/ anxiety?

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3) Explain Individual Counselling.

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4.8 LET US SUM UP

In this unit you learned about the meaning of anxiety disorders and substance abuse. The symptoms of addiction/anxiety were also described. You also came to know how is an addiction developed and the role of anxiety in the development of an addiction. The various symptoms of addiction/anxiety were described in detail. The different causes such as personal, biological, social, psychological and cultural factors were also described as leading to addiction/anxiety disorder. Finally you learned about the variety of counselling techniques and therapies to deal with addiction/anxiety.

4.9 UNIT END QUESTIONS

1) What do you mean by Addictive behaviour? How does one develop addiction? Discuss.
2) Describe the causes of Addiction/Anxiety.
3) Critically discuss the effectiveness of group therapy in overcoming addiction/ anxiety.
4) Explain the importance of anxiety hierarchy in dealing with anxiety/addiction.
5) Describe the environmental therapies.

4.10 SUGGESTED READINGS

Diana Sanders (2003). *Counselling for Anxiety Problems*. Sage Publications NY

Veeraraghavan, V and Singh, Shalinig (2000) *Treatment of Anxiety Disorders.* Sage Publications.

UNIT 1 DEPRESSION

Structure

1.0 INTRODUCTION

Most people at some point in their life experience at least some degree of low mood or depression. It is generally felt as sadness that is a normal response to painful circumstances such as financial losses, the break-up of a relationship or losing a job. However, sometimes the depressed mood continues for a prolonged period of weeks or months. At this stage a psychiatrist might diagnose a depressive disorder.

Depression is a term used to describe a mood state in which the main symptoms or features include prolonged feelings of sadness or emptiness and lack of interest

in previously enjoyed activities. This caused depressed people significant distress, since they lose motivation to participate fully in their lives. Depressed people have difficulty spending time with other people and might lose contact with friends and family, which could deprive them of essential support. They might even lose their job because of poor work performance or attendance.

Depression can also result from medical conditions or other psychological disorders. For example, people suffering from adrenal and thyroid dysfunction display depressive symptoms due to their being either very over or underweight. Similarly, agoraphobics might become depressed because their fear of being vulnerable in public places makes it difficult for them to experience taking part in social activities. This prevents them from having essential, healthy contact with other people. In this unit we will be dealing with depression, define and describe the symptoms, discuss the different types of depression, causes of depression and then the treatment of this disorder.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define depression;
- Describe the symptoms of depression;
- Explain the causes of depression;
- Elucidate the different types of depression; and
- Describe the various treatment interventions for Depression.

1.2 DEFINITION AND DESCRIPTION OF DEPRESSION

Although depression is often thought of being in an extreme state of sadness, there is a vast difference between clinical depression and sadness. Sadness is a part of being human, a natural reaction to painful circumstances. All of us will experience sadness at some point in our lives. Depression, however, is a physical illness with many more symptoms than an unhappy mood.

The person with clinical depression finds that there is not always a logical reason for his dark feelings. Exhortations from well meaning friends and family for him to “snap out of it” provide only frustration, for he can no more “snap out of it” than a diabetic can will his pancreas to produce more insulin.

Sadness is a transient feeling that passes as a person comes to term with his troubles. Depression can linger for weeks, months or even years. The sad person feels bad, but continues to cope with living. A person with clinical depression may feel overwhelmed and hopeless.

To clarify the differences between normal sadness and depression, there are specific, defined criteria for the diagnosis of major depression:

A person who suffers from a major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a two week period. This mood must represent a change from the person’s normal mood and impair his functioning in his daily life.

A depressed mood caused by substances such as drugs, alcohol, or medications is not considered a major depressive disorder, nor is one that is caused by a general medical condition.

1.2.1 Signs and Symptoms of Depression – General Terms

- Loss of interest in formerly pleasurable activities
- Dissatisfaction with life
- Withdrawal from social activities
- Loss of energy
- Feeling useless or hopeless
- Irritability
- Great concern with health problems
- Sadness or crying
- Worry and/or self-criticism
- Difficulty concentrating and/or making decisions
- Loss of appetite and weight.

1.2.2 Psychological Symptoms: Feelings, Thoughts and Behaviours

- Feeling sad, blue, depressed, or hopeless most of the day.
- Greatly reduced interest or pleasure in all or almost all activities; inability to think of anything that would be enjoyable to do (health permitting)
- Feelings of excessive guilt or a feeling that one is a worthless person.
- Slowed or agitated movements (not in response to pain or discomfort)
- Recurrent thoughts of dying or of ending one's own life, with or without a specific plan.

1.2.3 Physical or Somatic Symptoms

- Significant, unintentional weight loss and decrease in appetite; or, less commonly, weight gain and increased in appetite.
- Insomnia or excessive sleeping
- Fatigue and loss of energy
- A diminished ability to think, concentrate, or make decisions
- Physical symptoms of anxiety, including dry mouth, cramps, diarrhea, and sweating, ideation, or suicide attempt or plan.

Self Assessment Questions

1) Define and describe depression.

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2) How is normal depression different from pathological depression?

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3) Elucidate the signs and symptoms of depression in general.

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4) What are the psychological symptoms of depression?

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5) Enlist the physical or somatic symptoms of depression.

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1.2.4 Criteria for Formal Diagnosis of Major Depression

The following criteria are taken from the DSM-IV, the Diagnostic and Statistical Manual of Mental Disorders 4th edition, published by the American Psychiatric Association, 1994.

For your convenience, a general listing of signs and symptoms of depression, the translated version, follows the formal diagnostic criteria, for ease in interpreting the symptoms.

For a diagnosis of a major depression:

1) At least 5 of the following symptoms.
2) These symptoms must be present during the same 2 week period.
3) These symptoms must represent a change from a previous level of functioning.

Depressed mood nearly every day during most of the day.

- Marked diminished interest or pleasure in almost all activities.
- Significant weight loss (when not dieting), weight gain, or a change in appetite.
- Insomnia or hypersomnia (excess sleep).
- Psychomotor agitation or psychomotor retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or inappropriate guilt.
- Impaired ability to concentrate or indecisiveness
- Recurrent thoughts of death, recurrent suicidal
- Someone who has major depressive disorder has experienced one or more major depressive episodes without ever experiencing a manic or hypomanic episode.

1) **Major Depressive Episode:** A major depressive episode is marked by either depressed mood or a loss of interest or pleasure in almost all activities and at least four additional symptoms from the following group.

    - Marked weight loss or gain when not dieting, constant sleeping problems, agitated or greatly slowed down behaviour, fatigue, inability to think clearly, feelings of worthlessness, and frequent thoughts about death or suicide. These symptoms must last at least 2 weeks and represent change from the person's usual functioning.

2) **Recurrent Major depressive Disorder:** At least half of the people who experience a major depressive episode will later have a recurrence of major depression. For many people, an initial episode of major depression will develop over time into a recurrent illness.

3) **Major Depressive Episode with psychotic Features:** About 15% of people with a major depression have some psychotic symptoms usually delusions. The delusions typically include guilt ("It is my fault that she is ill"), punishment ("Iam suffering because Iam a terrible person") or poverty ("I will go bankrupt and starve in my old age"). Sometimes, delusions do not have depressive themes.

1.2.5 Criteria for Dysthymic Disorder

a) Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

   In children and adolescents, mood can be irritable and duration must be at least one year.

b) Presence, while depressed, of two (or more) of the following:

    1) Poor appetite or overeating
    2) Insomnia or hypersomnia
    3) Low energy or fatigue
    4) Low self-esteem

5) Poor concentration or difficulty making decisions

6) Feelings of hopelessness

c) During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

d) No *Major Depressive Episode* has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic *Major Depressive Disorder*, or *Major Depressive Disorder, In Partial Remission*.

e) There has never been a *Manic Episode*, a *Mixed Episode*, or a *Hypomanic Episode*, and criteria have never been met for *Cyclothymic Disorder*.

f) The disturbance does not occur exclusively during the course of a chronic *Psychotic Disorder*, such as *Schizophrenia* or *Delusional Disorder*.

g) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

h) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Most people who have a dysthymic disorder would tell that they have felt depressed for many years, or for as long as they remember. Feeling depressed seems normal to them. It has become a way of life. They feel helpless to change their lives.

Dysthymic is defined as a condition characterised by mild and chronic depressive symptoms. Periods of dysthymia have been found to last from 2 to 20 or more years, with a median duration of about 5 years. About 3% of the general population and about 30% of those seen at outpatient clinics can be classified as dysthymic.

Some researchers have criticized the DSM-IV criteria because they believe they do not give enough emphasis to what these researchers consider the most characteristic symptoms of dysthymia: *the cognitive symptoms, including low self-esteem, feelings of guilt or thinking about the past, and subjective feelings of irritability or excessive anger.*

Because the depressed mood is long-lasting, dysthymia has sometimes been considered a personality disorder. However, most researchers include it in the group of mood disorders and believe it is biologically related to depression.

Dysthymia and major depressive disorder have been found to have a high degree of comorbidirty. This means that both types of mood disorders are likely to occur in the same individual.

A person with dysthymic disorder develops symptoms of major depression because the criteria for both diagnoses are met. This dual state occurs quite frequently

Although dysthymia seems to make people more vulnerable to major depression, dysthymia itself is different from major depression in terms of the ages at which

people are most likely to be affected. In major depression, rates increase in certain age groups, but in dysthymia, the rate is stable from about age 18 until at least age 64

Dysthymic disorders tend to be chronic, persisting for long periods. In contrast, periods of intense depression are usually described as time-limited, which means that even without treatment the symptoms naturally tend to lessen over time.

1.2.6 Criteria for Bipolar I Disorder

(Most Recent Episode Unspecified)

a) Criteria, except for duration, are currently (or most recently) met for a *Manic*, a *Hypomanic*, a *Mixed*, or a *Major Depressive Episode*.

b) There has previously been at least one *Manic Episode* or *Mixed Episode*.

c) The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

d) The mood symptoms in Criteria A and B are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia*, *SchizophreniformDisorder, Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

1.2.7 Criteria for Bipolar II Disorder

a) Presence (or history) of one or more *Major Depressive Episodes*.

b) Presence (or history) of at least one *Hypomanic Episode*.

c) There has never been a *Manic Episode* or a *Mixed Episode*.

d) The mood symptoms in Criteria A and B are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia Schizophreniform Disorder, Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The symptoms cause clinically significant distress or impairment in social occupational, or other important areas of functioning.

1.2.8 Criteria for Cyclothymic Disorder

a) For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a *Major Depressive Episode*.

NOTE: In children and adolescents, the duration must be at least 1 year.

b) During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

c) No *Major Depressive Episode,Manic Episode*, or *Mixed Episode* has been present during the first 2 years of the disturbance.

d) The symptoms in Criterion A are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia*, *Schizophreniform Disorder*, *Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

f) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Self Assessment Questions

1) Delineate the criteria for formal diagnosis of major depression.

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2) What criteria to be followed to diagnose dysthymic disorder?

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3) What criteria do we use to diagnose Bipolar I Disorder?

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4) Describe the criteria to be used for Bipolar disorder II.

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5) Explain the criteria for diagnosing cyclothymic disorder.

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1.3 SEASONAL AFFECTIVE DISORDER (SAD)

Sometimes people can experience depression at particular times of the year, especially in northern countries and typically in winter. This seasonal pattern to the depression is called SAD. People with SAD are often treated with light therapy (exposure to artificial lights that imitate daylight) to lift their depressive episode.

1.3.1 Typical Symptoms

The typical emotions experienced during depression include sadness, guilt and despair. It is also common for a depressed person to experience irritability, agitation and anxiety. People suffering from depression can feel less motivated to participate in activities or interests they previously enjoyed. As the depression becomes worse, they might not bother to eat or cook for themselves, stop going to work or taking care of their appearance. Sometimes depression makes people not want to live and they might contemplate, attempt or even commit suicide.

The effects of depression on a person's thinking include indecisiveness, reduced concentration and decreased speed of thought. People experiencing depression often have negative ideas, including self-criticism, they feel that others do not understand them or punishing them and they do not look forward to the future.

Depression can also cause changes in the sufferer's psychomotor activity. The changes can range from inactivity (psychomotor retardation), such as slowed movements or lack of movement to restless activity (psychomotor agitation) such as pacing up and down.

Depression causes a range of changes in physiological or body functioning such as reduced or increased appetite, fatigue or excessive tiredness and loss of sex drive. Sleep disturbance is very common and has been estimated to affect more than 90% of depressed individuals. Depression can also cause shorter periods of sleep and increasingly broken sleep.

DSM IV outlines the criteria for a major depressive episode and also for the presence of a single episode of depression and recurrent episodes. For a major depressive disorder to be considered recurrent, a period of two months must separate each depressive episode.

1.4 DEPRESSIVE DISORDERS (UNIPOLAR DISORDERS)

1.4.1 Dysthymic Disorders

Most people who have a dysthymic disorder would tell that they have felt depressed for many years, or for as long as they remember. Feeling depressed seems normal to them. It has become a way of life. They feel helpless to change their lives.

Dysthymic is defined as a condition characterised by mild and chronic depressive symptoms. Periods of dysthymia have been found to last from 2 to 20 or more years, with a median duration of about 5 years. About 3% of the general population and about 30% of those seen at outpatient clinics can be classified as dysthymic.

Some researchers have criticized the DSM-IV criteria because they believe they do not give enough emphasis to what these researchers consider the most characteristic symptoms of dysthymia: *the cognitive symptoms, including low self-esteem, feelings of guilt or thinking about the past, and subjective feelings of irritability or excessive anger.*

Because the depressed mood is long-lasting, dysthymia has sometimes been considered a personality disorder. However, most researchers include it in the group of mood disorders and believe it is biologically related to depression.

Dysthymia and major depressive disorder have been found to have a high degree of comorbidirty. This means that both types of mood disorders are likely to occur in the same individual.

A person with dysthymic disorder develops symptoms of major depression because the criteria for both diagnoses are met. This dual state occurs quite frequently

Although dysthymia seems to make people more vulnerable to major depression, dysthymia itself is different from major depression in terms of the ages at which people are most likely to be affected. In major depression, rates increase in certain age groups, but in dysthymia, the rate is stable from about age 18 until at least age 64.

Dysthymic disorders tend to be chronic, persisting for long periods. In contrast, periods of intense depression are usually described as time-limited, which means that even without treatment the symptoms naturally tend to lessen over time.

Self Assessment Questions

1) What is meant by seasonal affective disorder?

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2) What are the typical symptoms of SAD?

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3) Discuss the symptoms of unipolar disorder.

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1.5 CAUSES OF DEPRESSION

Interpersonal and social factors that might affect the development of depression include social isolation and either separation from a partner or divorce.

Biological factors that might influence the development of depression include changes in neurotransmitter levels within the brain. Neurotransmitters carry chemical messages between neurons and can influence mood and behaviour. Three types of neurotransmitters – serotonin, dopamine and norepinephrine assist in the regulation of emotions including stress, sleep functions and appetite. All three are often found at lower levels in depressed people than in nonsufferers.

1.5.1 Genetic Factors

Researches indicate that people are between one and a half and three times more likely to develop depression if one of their parents or brothers or sisters has the disorder. Twin studies also have shown that if one identical twin develops depression, the chances of the other twin developing the disorder can be as high as 75%. This provides the evidence of the role of genetics in the development of the disorder.

Researchers also considered the possibility that the combination of genes might be involved in the development of a vulnerability to depression, which increases a person's chances of developing depression. Vulnerability to depression does not mean that they will develop the disorder but it means that they develop depression if other factors or situations also occur. Examples include growing up with parents who are overly critical or rejecting, losing friends or jobs or being placed in stressful or traumatic situations.

1.5.2 Psychological Factors

Factors which influence the possibility of developing depression include medical illnesses, traumatic experiences such as abuse, war or accidents, job stress, substance abuse and the adjustment required following serious injury.

Psychological theories of depression consider these factors as important in the development of the disorder. They focus on sufferer's subjective experiences and how they interpret the vents that occur in their lives. The three main theories are psychoanalytic, interpersonal and cognitive.

1.5.3 Psychoanalytical Theories

Sigmund Freud suggested that depression occurs as a result of anger being turned inward, especially after the loss of a valued family member or friend. This loss can be either real such as after the end of a relationship or imagined, for example, people who feel that they will never be loved again.

Freud stated that this internally directed anger leads to self-criticism and blame and that the aim of this treatment is to release this anger. A consistent feature of major depression can be irritability often directed toward family members or close friends.

The criticism levelled against this view is that depression can affect people who have not suffered the loss of a loved one. Freud's theory that depressed people have internalised anger is also not supported by dream analysis research.

Some of the latest psychoanalytic theories of depression have tried to address these limitations. They proposed that depression develops when people believe they have not reached their true potential such as achieving good grades in school or gaining promotion or a pay raise at work. The effects of recognising and accepting that they have not reached heir expected goals affects their ego. The result is a general feeling of helplessness and low self-esteem that leads to depression.

1.5.4 Interpersonal Theories

Theories suggest that depressed people have poorer social skills than people not experiencing depression. Social skills include the ability to relate to other people by making appropriate eye contact, being able to communicate clearly, being able to show empathy and having a positive regard for others. People experiencing depression have also been observed to have poor problem solving skills and make poor day –day decisions. It is also found that people who experience recurrent depression make poor decisions between depressive episodes.

Depressed people are more likely to be rejected by their friends or peers as they have an aversive interpersonal style.

1.5.5 Cognitive Theories

According to these theories depression is caused by the misinterpretations or errors people make about themselves, their world and the future. These errors are negatively focussed. For example, sufferers might see themselves as useless, the world as uncaring and the future as hopeless despite being successful in their jobs and having devoted families.

Beck's Cognitive Triad

He observed that depressed people tend to make specific errors in their thinking. For example, deciding that they are stupid simply because they make one mistake in a test. He suggested that depressed people develop specific beliefs with strong

negative elements based on these thought errors. A number of factors might lead to the development of these beliefs, including critical parents or rejection by friends.

Cognitive Errors or Biases in Depression

1) **Arbitrary inference** – Drawing a conclusion from an event or situation when there is lack of evidence to support this conclusion.

   Situation: Waiters in a restaurant forget to take your dinner order.

   Thought: They are ignoring me. I am obviously not worth their time.

2) **Black and white thinking** – Taking an extreme view of a situation.

   Situation: Getting a test back and achieving 70%.

   Thought: If I don't get 100%, Iam a total failure."

3) **Magnification/ minimisation** – Exaggerating or ignoring a particular aspect of a situation.

   Situation: A woman finds out she hasn't been invited to a friend's party.

   Thought: They obviously don't like me anymore. I must be a bad person.

4) **Overgeneralisation –** A gross generalisation based on a single event.

   Situation: Being unable to answer a question asked by a teacher.

   Thought: I am going to fail the rest of the year.

1.5.6 Helplessness Theories

These theories explore the specific thoughts of an individual when depressed. The concept of learned helplessness was demonstrated by Seligman. He believed that sufferers believe or find that they have little control over their lives and become passive. Theories also use the concept of attribution. Attribution refers to people's explanation of a particular event and their response to it. For example, depressed people might attribute failure to themselves when faced with a situation they have difficulty controlling such as a difficult science test.

Self Assessment Questions

1) Delineate the causes of depression.

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2) State genetic factors as causing depression.

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3) Elucidate the psychological factors causing depression.

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4) What is psychoanalytical explanation for depression?

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5) How do interpersonal theories explain depression?

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6) Explain cognitive theories for depression.

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7) Elucidate the helplessness theory of depression.

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1.6 TREATMENT OF DEPRESSION

1.6.1 Biologically Based Treatment

This approach includes antidepressant medication and electroconvulsive therapy (ECT). This approach is often successful in lessening depression. ECT is faster – acting than antidepressant medication and is often used if an effective medication cannot be found.

There are many types of treatment for depression and some of the most frequently used include:

- antidepressant tablets
- mood stabilising medications
- support with day-to-day matters while ill or recovering.

Treatments that are used less often, but which can also be helpful especially in severe depression, of a specific type or has proved difficult to treat include:

- electroconvulsive therapy (ECT)
- special types of operation (psychosurgery)
- bright light therapy for seasonal affective disorder (SAD).

Lastly, there are potential treatments that are still either experimental or for which more evidence needs to be found before they can be considered truly effective and safe:

- herbal remedies (e.g. St John's wort)
- trans-cranial magnetic stimulation (TMS), which involves applying brief magnetic pulses to the brain. This is done with the patient awake and sitting in a chair. A doctor holds an electric coil near to the head that emits repeated short magnetic pulses. The procedure is painless. At the present time, TMS is still under investigation as a treatment for depression. However, current evidence suggests that it may be as effective as ECT, but safer.

Broadly speaking, treatments for depression can be broken down into two types:

- Firstly, there are those that aim to correct the chemical and biological abnormalities that occur in the illness. These are: antidepressants, mood stabilising medications, ECT and psychosurgery.
- Secondly, there are the psychological ones, talking treatments. These involve regular appointments to talk to a professional person who is skilled in a particular type of counselling or psychotherapy to help with depression.

The biological and psychological treatments are certainly not mutually exclusive and are often used in combination.

Neither group of treatments or therapies should be considered better than the other.

The treatment (or combination of treatments) used should be the one most likely to help a person when all the different factors that have led to their illness are taken into account.

This is the reason that approaching a professional is so important in deciding how best to cope with and treat depression.

Antidepressant Tablets

There are a number of different groups of these and they include:

- Tricyclic antidepressants (TCAs), e.g. amitriptyline, imipramine, lofepramine.
- Selective serotonin reputake inhibitors (SSRIs), eg fluoxetine, paroxetine, citalopram.
- Monoamine oxidase inhibitors (MAOIs), eg moclobemide, phenelzine, tranylcypromine.
- Other medicines that do not quite fit neatly into these groups, but that have effects similar to one or more of these groups (eg venlafaxine, mirtazapine, reboxetine, trazodone).

The oldest antidepressants are the monoamine-oxidase inhibitors (MAOIs) and tricylic antidepressants (TCAs). The TCAs are still in wide use today and remain effective medicines.

The MAOIs require a special diet to avoid unpleasant and potentially serious side-effects, and they can interact with many other medicines.

They are therefore generally used only for people whose depression has not responded to other treatments.

The SSRIs are a much newer group of antidepressants, but they have been widely and successfully used for about twenty of years.

- All antidepressants work by boosting one or more chemicals (called neurotransmitters) in the nervous system. These chemicals may be present in insufficient amounts in depression, resulting in the symptoms of the illness.
- All antidepressants take a minimum of two weeks (and sometimes up to eight weeks) to start to work, and once they have started working the depression recovers gradually.
- It’s vitally important, therefore, that if a person is given antidepressants they should keep taking them regularly, even if they don’t seem to make much difference to begin with.
- Some antidepressants can cause mild unpleasant effects if they are stopped very suddenly, but even these can normally be avoided if the medicine is tailed off over a period of time.
- A rule of thumb is that antidepressants should be taken for at least six months at the same dose after the person has recovered. This reduces the risk of the depression coming back again.
- A few people whose depression does return every time they come off antidepressants may need to be on treatment on a long-term basis.
- There is no evidence to suggest that any one antidepressant or antidepressant group is better than any other in terms of the number of people who will benefit from it. (Generally around two-thirds of people will find that their symptoms improve on any particular medication).

- But one may be a better choice than another on the grounds of its side effects: for instance a person who finds that their sleep is disturbed may benefit from an antidepressant that is also quite sedative. By contrast someone who is sleeping reasonably and has to be able to listen out for their children would clearly find this effect a problem, and would be better with a non-sedative medication.

- If an antidepressant from one group does not work very well, then there is a good chance that one from another group may work.

Mood Stabilisers

- In depression, these medicines are used to boost the effects of antidepressants.

- The best-known mood stabiliser is lithium. It is also the best-proven one, but one drawback is that regular blood tests are needed to check its level. (Lithium is also used in bipolar affective disorder – 'manic depression'.)

- There are some newer mood stabilisers available now that offer alternatives to lithium, such as sodium valproate (Epilim) or semisodium valproate (Depakote).

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is a treatment that has been used for many decades for depression. But it is controversial.

The facts are:

- it is a very effective treatment for depression, perhaps the single most effective treatment.
- it is especially effective for severe depression and depression that has a lot of physical symptoms, such as changes in appetite, sleep and concentration.
- it is as safe as any minor procedure that needs a general anaesthetic.
- it can be life saving as it can work more quickly than antidepressant medicines.
- there's no good evidence for any permanent damage to the nervous system.

Like all treatments, ECT does have some side effects. These can include:

- headache
- forgetfulness around the time of treatment.

1.6.2 Psychodynamic Approach to Treatment of Depression

According to Freud, depressed person had a strong and punishing conscience and the reason for it was to control anger and aggressive feelings that otherwise come forth to hurt others. Psychoanalytic theorists have suggested that clinical episodes of depression happen because the events that set off the depression revive dimly conscious, threatening views of the self and others that are based on childhood experience. Bowlby also believed that childhood experiences that contribute to these depressed feelings were not single events but developed from long – term patterns of familial reaction.

This approach helps the client to become aware of their beliefs that originated in childhood. The therapist facilitates the process of transference so that the client

exhibits all his reactions that were suppressed. The therapist helps the client to identify his reactions and help him in alter these reactions.

1.6.3 Interpersonal Psychotherapy

It focuses on teaching people to be more socially effective as a way to improve their relationships with their significant others. It integrates the psychodynamic perspective which emphasises early childhood experiences with the cognitive behavioural perspective which emphasises current psychosocial stressors such as chronic marital discord. This therapy works well when paired with the use of antidepressant medications and has been demonstrated to be effective, both in lessening depressive symptoms and in extending the period of remission for individuals who have a history of recurrent depressions.

1.6.4 Behavioural Therapy

As depressed people lack skills necessary to develop satisfying relationships with others, one behavioural approach to this problem is through social skills training. Social skills' training consists of several parts. First clients are taught basic verbal and nonverbal skills. When these are learned, the clients practice gradually putting the basics together. Then clients are given "homework" assignments in which the goal is to adapt the new skill so it is useful in the everyday environment. Clients are also trained to be more perceptive about cues other people in the environment give and they learn how to change their own behaviour in response. Finally, clients learn to adopt realistic criteria for evaluating their performance and are taught how to be self reinforcing.

Role play is necessary so that the client gets the practice needed to use new behaviours in the real – life situations. The practice gained from these assignments is in turn critical for success in learning new habits.

1.6.5 Cognitive Behavioural Therapy

This therapy makes use of both behavioural and cognitive theoretical perspectives based on the client's skills, degree of depression and on the chosen goals of therapy. The main focus of CBT is to help clients think more adaptively and as a result to experience positive changes in mood, motivation and behaviour.

The more severely depressed the client, the more likely the therapist is to use behavioural techniques at the beginning of the treatment process. Clients are taught how to self – monitor their experiences, noting which gave pleasure and feelings of mastery and which lowered their mood. They are also taught to monitor and record their negative thoughts. Special emphasis is put on *automatic thoughts,* recurring thoughts that come into a person's mind almost as if by habit rather than as a specific response to what is currently going on.

Therapists use several techniques to help clients identify these thoughts, including direct questioning, asking the client to use imagery to evoke the thoughts, or eliciting them by means of a role – play situation. The clients are also asked to keep a daily record of their thoughts. The record includes notes on the situation, emotions, automatic thoughts and the outcome. In this way the client learns that a person's view of reality can be quite different from the reality itself. The therapy can help change dysfunctional thinking and thus alleviate the depression by challenging parts of the client's belief system.

Self Assessment Questions

1) Discuss the biologically based treatment for depression.

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2) What is the psychodynamic approach to treatment of depression?

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3) How does interpersonal psychotherapy function as treatment for depression?

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4) Explain behavioural therapy as treatment of depression.

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5) Elucidate cognitive behavioural therapy as treatment for depression.

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1.7 LET US SUM UP

The term depression is commonly used to refer to normal feelings experienced after significant loss such as the breakup of a relationship or the failure to attain a significant goal. These feelings are not classified as a depressive disorder by DSM –IV. Symptoms of grief over the death of a loved one also are not classified as depression unless they continue for an unusually long period.

Depression can refer to a symptom or disorder. The symptom of depressed mood does not necessarily mean a person has a depressive disorder. Some symptoms of depression occur frequently in people who 'have the blues' but are not clinically depressed. But, those who meet DSM – IV criteria experience symptoms that are more severe.

Depressive disorders include dysthymic disorder and major depressive disorder. Depression is the result of an interaction between biological characteristics, psychological vulnerabilities and stressful events or ongoing stressful life situations. Treatment to depression includes biological, psychodynamic, interpersonal, behavioural and cognitive behavioural approaches.

1.8 UNIT END QUESTIONS

1) Discuss the causes for the occurrence of depression.

2) Explain depressive disorders.

3) Explain the significance of different approaches in treating depression.

1.9 GLOSSARY

Dysthymic disorder : It is a stable condition in which a depressed mood is dominant over long periods of time even if is interrupted by short periods of normal mood.

Major depressive disorder : It is diagnosed when a person has experienced one or more major depressive episodes but has never experienced either a manic or hypomanic episode.

Recurrent major depressive disorder : When a person who has experienced one major depressive episode develops the symptoms again at a later time, the diagnosis is known as recurrent major depressive disorder.

Major depressive episode with psychotic features : If someone experiences delusions or other psychotic symptoms during a major depressive episode, it is diagnosed as major depressive episode with psychotic features.

1.10 SUGGESTED READINGS

Carson, R.C. Butcher, J.N. & Mineka, S. (2000). *Abnormal Psychology and Modern Life.* Pearson Education, India.

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UNIT 2 PERSONALITY DISORDER

Structure

2.0 INTRODUCTION

'Personality' is the characteristics or qualities that form an individual's character. For example the way they feel, behave and their pattern of thoughts all make up someone's personality and this is what makes each person the individual they are. Generally speaking someone's personality does not normally change very much, but it can develop as people go through different experiences in life, and as their circumstances change. People are usually flexible enough to learn from past experiences and change their behaviour to cope with life more effectively, but if someone has a personality disorder they are likely to find this more difficult. In this unit we learn about personality disorders. We start with nature of personality

disorders and follow it up with origin of and different types of personality. Under this we discuss different types of personality even in normal persons. Then we discuss the features of personality disorders followed by causes of personality disorders. Then we present the clusters of personality disorders followed by treatment of personality disorders.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define personality and personality disorders;
- Explain Nature of personality disorders;
- Trace the Origin and diagnosis of personality disorders;
- Elucidate the Types of personality disorders; and
- Describe the Treatment for personality disorders.

2.2 NATURE OF PERSONALITY DISORDERS

The term "personality disorder" simply refers to a diagnostic category of psychiatric disorders characterised by a chronic, inflexible, and maladaptive pattern of relating to the world. This maladaptive pattern is evident in the way a person thinks, feels, and behaves. The most noticeable and significant feature of these disorders is their negative effect on interpersonal relationships. A person with an untreated personality disorder is rarely able to enjoy sustained, meaningful, and rewarding relationships with others, and any relationships they do form are often fraught with problems and difficulties.

To be diagnosed with a "personality disorder" does not mean that someone's personality is fatally flawed or that they represent some freak of nature. In fact, these disorders are not that uncommon and are deeply troubling and painful to those who are diagnosed with these disorders. Studies on the prevalence of personality disorders performed in different countries and amongst different populations suggest that roughly 10% of adults can be diagnosed with a personality disorder.

Unlike many types of disorders that are indicated by symptoms that are not usually found in the general population (e.g., seizures), personality disorders cannot be understood independently from healthy personalities. Since everyone has a personality (but not everyone has seizures), personality disorders reflect a variant form of normal, healthy personality. Thus, a personality disorder exists as a special case of a normal, healthy personality in much the same way as a square is a special case of the more general construct of a rectangle. Therefore, it is useful for us to begin our discussion of personality disorders by first discussing the broader, more general construct of personality.

The term *'personality disorder'* describes various clusters of symptoms and slots different groups into separate categories of disorder. There are many different types and it is not uncommon for someone with one type of personality disorder to have other types of personality disorder as well.

Personality disorders are long standing, maladaptive, inflexible ways of relating to the environment. Such disorders can usually be noticed in childhood, or at least by early adolescence, and may continue through adult life. They severely limit an individual's approach to stress – producing situations because his characteristic styles of thinking and behaviour allow for only a rigid and narrow range of responses.

They may have great difficulty controlling their impulses and emotions, and often have distorted perceptions of themselves and others. As a result, these individuals may suffer enormous pain and have significant difficulty functioning at home, work, and in relationships.

Families commonly endure episodes of explosive anger and rage, extreme depression (e.g., person rarely gets out of bed), self-mutilation (self-inflicted cuts and burns), and suicide attempts by family members with personality disorders. These individuals are often referred to treatment by loved ones who recognise a troubling pattern, or who have reached their personal limit in trying to cope with them.

Case 1: Sunitha is 37 years old, married, and the mother of two children. She experiences unstable moods, and has repeatedly cut herself, usually when feeling very stressed or abandoned. She often feels empty and bored. She has abused alcohol and drugs in the past. She is extremely sensitive to criticism, and angrily reacts to perceived rebuffs.

Personality Disorders usually become noticeable in adolescence or early adulthood, but sometimes starts in childhood. It can make it hard for people with a personality disorder to start and keep friendships or other relationships and may find it hard to work effectively with other people.

People with mild personality disorders usually manage to live normal lives but in times of increased stress the symptoms of the personality disorder are likely to impact seriously on how they think and feel and they can find it hard to cope.

2.3 ORIGIN AND DIFFERENT TYPES OF PERSONALITY

A personality disorder, as defined in the *Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR),* is an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances. Ten personality disorders, grouped into 3 clusters (ie, A, B, C), are defined in the *DSM-IV-TR.*

Disordered patterns of behaviour characterised by relatively fixed and inflexible lifelong reactions to stress. Individuals may show repetitive, maladaptive, and frequently self-defeating patterns of behaviour, inadequate handling of impulses, or restricted and inappropriate feelings. The individual has a limited variety of responses to stress, and in the face of failure to cope may show anxiety, denial,

or psychotic behaviour. In the absence of environmental frustration, he tends to show little anxiety or mental or emotional symptoms, and the behaviour patterns are said to be "ego syntonic," i.e., they are felt by the person to be "normal" and "right." Thus, such a person rarely seeks help because of his own anxiety and discomfort; more often he is referred by a family or society with whom he is unable to live in harmony. If the patient seeks help, it usually follows environmental frustrations and he shows typical neurotic symptoms and conflicts.

The maladaptive behaviour patterns seen in personality disorders tend to be exaggerations of mechanisms used at times by, most people. Diagnosis of personality disorders is based on behavioural manifestations and patterns and need not reflect a subjective sense of conflict or distress. Frequently, though, one recognises low self-esteem, paucity or relative superficiality of intimate relationships, difficulty in sustaining interests, low frustration tolerance, difficulty in postponing gratification, and inability to learn from experience.

The causes of these disorders are unknown, but constitutional factors may play a role in some instances (schizoid, cyclothymic, antisocial personalities), In general, it is assumed that patterns of response are a result of early experiences and conditioning, and that early interpersonal relationships are important in establishing modes of defense and their rigidity.

2.3.1 Paranoid Personality

These people tend to be hypersensitive, with an underlying suspicion of others and their motivations. They are often rigid and inflexible in behaviour and react poorly to criticism or suggestions for change. They feel isolated and project onto others harmful motives and blame for misfortune. It is assumed that these traits are the person's ways of dealing with feelings about himself which he regards as unacceptable, demeaning, or dangerous. Often the suspicious attitude leads to aggressive feelings and/or behaviour, with resultant further isolation. The individual's sense of self-adequacy and self-esteem seems particularly impaired.

Often the behaviour of these people is designed to, prove their adequacy, while their sense of worthiness becomes exaggerated and is accompanied by belittlement of others. In many spheres: they may be highly efficient and conscientious, though, lacking flexibility. Positions of power and recognition may be achieved, but frequently at the expense of the ability to relax and to maintain a sense of humor. Often their suspiciousness and hostility bring about rejection by others, which seems to justify their original feelings, but they are unable to see their own part in this cycle. They may be litigious, especially when they feel a sense of righteous indignation.

2.3.2 Cyclothymic Personality

Behaviour is frequently characterised by alternating and recurrent states of depression or elation. While elated, these persons feel active and outgoing; are ambitious, optimistic, and enthusiastic; and may show high levels of energy. At such times they are gregarious and capable of attracting friends who may find them fascinating though unpredictable or eccentric. Periods of depression are characterised pessimism, low levels of energy, and a sense of hopelessness and worry. Moods of cheerfulness and sadness are part of normal behaviour and no doubt there is a continuum with cyclothymic personalities. However, with a cyclothymic disorder, the mood swings are precipitated more by internal than

external events, tend to be more intense, and are apt to be cyclic. At times there is not a regular swing from high to low moods but, rather, a more sustained depression or euphoria. It is uncertain whether the cyclothymic personality disorder lies on a continuum with manic-depressive illness or is a different entity.

2.3.3 Schizoid Personality

These persons are oversensitive, withdrawn, seclusive, and shy, and avoid close or prolonged relationships. They may be characterised as eccentric and their thinking as "autistic" (somewhat idiosyncratic but without loss of reality testing). Daydreaming is common, with difficulty in expressing feelings, and detachment. The range of adaptive responses is limited and withdrawal is the main reaction to stress. Often they develop highly stylised and distinct interests which further separate them from their peers, and, in general, their attention is directed to asocial endeavors.

2.3.4 Explosive Personality

This pattern is characterised by sudden, tantrum like outbursts of rage or verbal or physical aggressiveness. Despite guilty and regretful feelings, these individuals are unable to control their outbursts. They are easily excited by environmental frustrations. Recently, questions have been raised as to whether underlying minor organic brain changes predispose to this explosiveness.

2.3.5 Obsessive Compulsive Personality

Patterns of behaviour are characterised by concern for perfection and orderliness, conformity to social norms, and high personal standards of conscience. Persons with this reaction have difficulty dealing with ambiguous situations; need to define, compartmentalise, and conceptualise problems; and also show some rigidity, inhibition, and difficulty in relaxing. There is a drive to control the situation, and to reduce ambiguity. When faced with new, uncertain, and complex situations, they display anxiety. The quality of compulsiveness is in tune with Western cultural standards, and when the disorder is not too marked these people are often capable of high levels of achievement, especially in the sciences and academic fields where order is desirable. On the other hand, they often feel a sense of isolation and difficulty with interpersonal relationships in which one must rely on others and in which one's feelings are less under strict control and events are less predictable.

2.3.6 Hysterical (Histrionic) Personality

This pattern is characterised by dramatic and attention seeking behaviour, excitability, emotional instability and over-reactivity, self-centeredness, and a provocativeness or sexualisation of nonsexual relationships often combined with sexual frigidity or fears. Though superficially self-assured, such people have major doubts as to their identity and goals. Their difficulty in expressing genuine feelings further prevents intimate relationships. Such relationships are affected by the individual's seemingly insatiable need for affection. Behind their sexually seductive behaviour lies a child-like wish for nonsexual affection and protection.

2.3.7 Asthenic Personality

This category is characterised by lack of enthusiasm, low energy and capability, difficulty in developing a broad sense of enjoyment and pleasure, and a poor

response to even small physical or emotional stresses. These persons never seem to mobilise resources to meet distress and, as a result, feel helpless, wishing they could do more but seemingly unable to feel up to doing it.

2.3.8 Antisocial Personality

This pattern, formerly referred to as "sociopathic," includes those whose behaviour is repetitively in conflict with social mores. Delinquent behaviour is not the sole pattern, but is accompanied by impulsiveness, irresponsibility, either a low sense of guilt or guilt that appears only after an event, callousness toward others, and a superficiality of emotional involvement. These people seem to have a keen capacity for rationalising and explaining their behaviour as a consequence of another's. They also show little foresight. Onset is usually before age 12 to 15. Typical childhood symptoms are theft, lack of discipline, and truancy together with habit disturbances such as enuresis, sleepwalking, and nail-biting. As adults they have continued problems with school, poor work records, and unstable marital histories, besides showing belligerency, social isolation, sexual deviations, and frequently excessive alcohol or drug use. They also complain of anxiety and somatic complaints. The disorder is preponderant in males; there is some evidence to believe that there is a "maturing out" of the disorder between ages 30 and 40, followed by a decrease in gross antisocial behaviour.

2.3.9 Passive Aggressive Personality

This group is subdivided into passive, passive-aggressive, and aggressive types. The passive type is characterised by helplessness, indecisiveness, and a clinging dependency even when given support from others. Such passivity may serve to gain attention and affection, to avoid responsibility, and/or to control others covertly. Passive-aggressive behaviour is characterised by obstinacy, inefficiency, procrastination, and sullenness, often disguised under a superficial compliance. Frequently these people agree to perform a task and then proceed to subtly undermine its completion with complaints and passive obstructionism. The aggressive type is characterised by sullenness, tantrum-like behaviour, provocativeness, and argumentativeness, especially with those in authority. Such behaviour usually serves to deny or conceal marked dependency needs. The behaviour is maladaptive in that, ironically, it drives others away and prevents the individual from receiving even a normal amount of support.

2.3.10 Inadequate Personality

The term describes individuals whose response to any form of stress seems ineffectual. Their behaviour shows poor judgment, ineptness, lack of energy, poor long-range planning, and poor performance. Incentive is lacking, especially to achieve culturally desired levels. These people are marginally involved in social relationships, tend to drift, and take non-demanding jobs. There is no evidence for physical or mental defects. However, there does seem to be some social value-judgment essential to this diagnosis, since those diagnosed as inadequate personalities tend to be in the lower socioeconomic level on the other hand, this may reflect early social, cultural, and experiential deprivation which, together with the repeated experience of failure, leads to passive styles of behaviour. Often these people are welfare recipients or reside in institutions.

2.3.11 Sexual Deviations

This category refers to those who repetitively and somewhat compulsively direct their sexual interests toward objects other than the opposite sex, toward sexual acts not associated with intercourse, or toward intercourse only when associated with stylised behaviour (e.g., sexual sadism). The term carries a moral connotation and is somewhat related to cultural norms. However, it is believed that this behaviour reflects at least developmental difficulties, if not psychopathology, and that "deviant" sexual behaviour is an attempt to achieve some sexual gratification while avoiding fears associated with usual adult sexual practices.

Clinicians use different theories to explain the origin and development of each of these disorders. Some argue that personality disorders are inherited while others suggest that the environment in which we grow up is responsible for our personality traits.

Self Assessment Questions

1) Discuss the nature of personality disorders.

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2) What are the different types of personality that we obtain even in normal persons?

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3) Discuss paranoid, cyclothymic, schizoid and explosive personality.

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4) Elucidate the obsessive compulsive personality, hysgterical ersonality and asthetic personality.

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5) Describe antisocial personality, passive aggressive personality and inadequate personality.

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6) What is sexual deviation?

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2.4 DIAGNOSIS

Personality disorders are diagnosed on DSM-IV's Axis II and they are near *permanent disorders*. On the other hand, Axis I disorders are called symptom disorders which may come and go. Symptom disorders may be triggered by events or environmental factors and may disappear when conditions change. People with Axis I disorders often see themselves as having personal problems (symptoms) that are troublesome and require treatment. People with Axis II disorders are far more likely to say that their difficulties are attributable to the environment and that they do not require clinical treatment.

Clinicians also differ on diagnosis. For example, when a highly unpredictable, exuberant patient walks into a psychiatrist's room, one psychiatrist might diagnose him as having antisocial personality disorder and psychopathy, while another might say that he has borderline personality disorder. This is because the diagnostic methods used such as questionnaires are not very reliable. However, better methods are being devised that might show more of a clear pattern for diagnosis – even across different cultures.

2.5 FEATURES OF PERSONALITY DISORDERS

The features of personality disorders are:

- Early onset: This is evident at least since late adolescence.
- Stability: No significant period when not evident.
- Pervasive: This is evident across a wide range of personal, social and occupational situations
- Clinically significant maladaptation resulting in personal distress or impairment in social and occupational functioning.

2.6 CAUSES OF PERSONALITY DISORDERS

There is no single cause of personality disorder. It is thought that a combination of factors may contribute to people being vulnerable to the development of a personality disorder due to genetic factors. However, it may be related more to the fact that people affected have not had the opportunity to learn at an early age how to act or react and manage their feelings.

A personality disorder may also relate to incidents or traumas in childhood like physical or sexual abuse or where there have been difficulties in parenting. Figures show that around 80% of those diagnosed with borderline personality disorder have been diagnosed as having a childhood trauma.

Dissociative Identity Disorder (previously referred to as 'multiple personality disorder') and other dissociative disorders are now understood to be fairly common side effects of severe traumas in childhood.

Personality disorders are more common when stress levels are high. So treatment tends to focus on coping and learning how to relate to others. This is because people diagnosed with personality disorders have often missed the opportunity in childhood to learn how to cope and manage their feelings.

Many people do not even know they have a personality disorder. They may just think that they are miserable and that their lives are pointless. Part of the problem is they are not able to think about their feelings, so they may even resort to drugs and alcohol, self harm or even overdoses, which make things worse.

The role of causal factors in personality disorders is not known much as these disorders received attention only since the publication of DSM –III and also because they are less amenable to study. One major problem in studying the causes of personality disorders stems from the high level of co morbidity among them i.e. patients who are qualified for one personality disorder diagnosis also qualified for one or more than one other personality disorders. Another problem is that many people with these disorders are never seen by clinical personnel.

2.6.1 Biological Factors

It has been suggested that infant's constitutional reaction tendencies (high or low vitality, behavioural inhibition) may predispose them to the development of particular personality disorders. As most of the personality traits are found to be moderately heritable, there is increasing evidence for genetic contributions to certain personality disorders like paranoid personality disorder, schizotypal

personality disorder, borderline personality disorder and antisocial personality disorder. Some progress is also made in understanding the psychobiological substrate of at least some of the personality disorders. For example, people with borderline personality disorder appear to be characterised by lowered functioning of the neurotransmitter serotonin due to which they show impulsive aggressive behaviour as in parasuicidal acts such as cutting their arms with a knife. Patients with borderline personality disorder may also show disturbances in the regulation of noradrenergic neurotransmitters that are similar to those seen in chronic stress conditions such as PTSD. Moreover, deficits in the dopamine system may be related to a disposition toward transient psychotic symptoms.

2.6.2 Psychological Factors

Early learning experiences are usually assumed to contribute the most in predisposing a person to develop a personality disorder. Numbers of studies have suggested that abuse and neglect in childhood may be related to the development of certain personality disorders. Patients with borderline personality disorder reported significantly higher rates of abuse than patients with other personality disorders.

Psychodynamic theorists also expressed their views on the causes of personality disorders. For example, with regard to narcissistic personality disorder they believed all children go through a phase of primitive grandiosity during which they think that all events and needs revolve around them. For a normal development to occur beyond this phase, parents must do some mirroring of the infant's grandiosity. This disorder is also likely to develop if parents are neglectful, devaluing or unempathetic to the child.

2.6.3 Socio-Cultural Factors

The role of socio-cultural factors is not clearly found. However, the changing culture, emphasis on impulse gratification, instant solutions and pain free benefits are leading more people to develop the self –centered life – styles that we see in more extreme forms in the personality disorders.

Self Assessment Questions

1) How do you diagnose personality disorders?

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2) Delineate the features of personality disorders.

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3) Discuss the biological causative factors of personality disorder.

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4) Elucidate the psychological causes of personality disorder.

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5) What are the socio-cultural factors contributing to personality disorders?

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2.7 CLUSTERS OF PERSONALITY DISORDERS

There are 10 different types of personality disorder. Each one is linked with a different set of attitudes, emotions and behaviours. These personality disorders are grouped into three clusters – A, B and C.

2.7.1 Cluster A Personality Disorders

Cluster A features *odd or eccentric behaviour*. The personality disorders in this cluster include:

1) **Paranoid Personality Disorder**

People with this disorder can be cold and detached and find it hard to form relationships. They are often suspicious in their surroundings and can act angrily towards other people. This distrust and suspiciousness is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1) Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

2) Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.

3) Reluctant to confide in others because of unwarranted fear that the information will be used against him or her

4) Reads hurtful or threatening meanings into kind remarks or events

5) Unforgiving of insults or injuries

6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily

7) Has recurrent suspicions, without justification, regarding faithfulness of spouse or sexual partner.

2) **Schizoid Personality Disorder**

People diagnosed with this disorder can be cold, distant and reclusive, shying away from closeness or intimacy. They can get caught up in their own thoughts and hold back from getting involved with other people. This pattern is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1) neither desires nor enjoys close relationships, including family relationships

2) often chooses activities that don't involve other people.

3) has little interest in having sexual relations with another person

4) enjoys few activities

5) lacks close friends other than immediate family

6) appears indifferent to praise or criticism

7) shows emotional coldness, detachment, or little emotional expression.

3) **Schizotypal Personality Disorder**

It has the same traits as the schizoid personality disorder. But, in addition to the above they can have chaotic thoughts and views and are poor communicators. This disorder is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) ideas of reference, i.e., believes that casual and external events have a particular and unusual meaning that is specific to him or her

2) odd beliefs or magical thinking that influences behaviour and is inconsistent with cultural norms (e.g., belief in superstitions or clairvoyance, telepathy, or "sixth sense"

3) unusual perceptual experiences (e.g., hears a voice murmuring his or her name; reports bodily illusions)

4) odd thinking and speech (e.g., unusual phrasing, speech which is vague, overly elaborate, and wanders from the main point)

5) excessively suspicious thinking

6) inappropriate or constricted emotions (reduced range and intensity of emotion) behaviour or appearance that is odd or peculiar (e.g., unusual mannerisms, avoids eye contact, wears stained, ill-fitting clothes) lack of close friends or confidants other than immediate family excessive social anxiety that remains despite familiarity with people and social situation. The anxiety relates more to suspiciousness about others' motivations than to negative judgments about self.

2.7.2 Cluster B Personality Disorders

Cluster B features *dramatic, emotional or erratic behaviour*. The personality disorders in this cluster include:

a) **Borderline Personality Disorder**

People with this disorder have a shaky, unsure view of themselves and have problems with relationships. They can be moody and see things in black and white. They feel they lost out on nurturing as children and can become very needy and clingy as adults. When their needs are not met, they feel empty, angry and abandoned and may react in a desperate and impulsive way.

This pattern begins by early adulthood, occurs in various contexts, and is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) frantic efforts (excluding suicidal or self-inflicted cuts or burns) to avoid real or imagined abandonment.
2) a pattern of intense and unstable interpersonal relationships that may quickly alternate between extremes of idealisation (the other person may be "put on a pedestal") and devaluation (the other person's negative qualities are now exaggerated).
3) identity disturbance: sudden and dramatic shifts in self-image in terms of shifting values (e.g., sexual identity, types of friends) and vocational goals.
4) impulsiveness in at least two areas that are potentially harmful (e.g., spending, sex, substance abuse, reckless driving, binge eating, excluding suicidal or self-mutilating behaviour).
5) repeated suicidal behaviour or threats, or self-inflicted cuts or burns (e.g., self-mutilating behaviour).
6) significant, sudden changes in mood and observable emotion (e.g., intense periodic sadness, irritability, or anxiety, usually lasting a few hours and rarely lasting more than a few days; extreme reactivity to interpersonal stresses).
7) chronic feelings of emptiness; also may be easily bored.
8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) temporary, stress-related psychosis (symptoms such as paranoia or grossly distorted body image).

b) **Antisocial Personality Disorder**

People diagnosed with this disorder disregard the feelings, property and authority of others; they often have violent and aggressive behaviours and tend to show a lack of remorse.

Individuals with Antisocial Personality Disorder show a pervasive disregard for, and violation of, the rights of others since age 15 years, as indicated by three (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) repeated acts that are grounds for arrest
2) deceitfulness, i.e., repeated lying, use of aliases, or conning others for personal profit or pleasure
3) impulsiveness or failure to plan ahead
4) irritability and aggressiveness, such as repeated physical fights or assaults
5) reckless disregard for the safety of self or others
6) consistent irresponsibility, i.e., repeated failure to sustain consistent work behaviour or honor financial obligations
7) lack of remorse, as indicated by indifference to, or rationalising having hurt, mistreated, or stolen from another.

To receive this diagnosis, an individual also needs to be at least 18 years old, to show evidence of a conduct disorder (which begins before age 15), and to show antisocial behaviour that does not only occur during a manic episode or the course of schizophrenia.

Case 1: Krishna is 46 years old, divorced, and currently unemployed. He has worked for most of his adult life, and at one time owned a business. He has a history of intense, unstable relationships, and has been violent toward his wives and his children. He experiences periods of rage and frequent fighting. Usually the fights are verbal, but occasionally they are physical. When a neighbor spoke to him rudely, he seriously wounded his neighbour. He is in prison at this time.

c) **People diagnosed with Narcissistic Personality Disorder**

They display an abnormally high opinion of themselves, are oversensitive to criticism and resent those people who do not admire them. This pattern is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) has an inflated sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognised as superior without corresponding achievements)
2) is overly concerned with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4) requires excessive admiration
5) has a sense of entitlement, i.e., unreasonable expectations of very positive treatment or automatic compliance with his or her expectations
6) takes advantage of others to achieve his or her own ends
7) lacks empathy: is unwilling to identify with the feelings and needs of others
8) is often jealous of others or believes that others are jealous of him or her
9) shows arrogant or domineering behaviours or attitudes.

d) People diagnosed with Historic Personality Disorder: are obsessive about their appearance and constantly demand attention. Their behaviour is often seen as over the top and they may be referred to as being 'shallow'. This pattern is suggested by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994)

1) discomfort in situations in which he or she is not the center of attention
2) frequent, inappropriate, seductive or provocative behaviour in interpersonal interactions
3) rapid shifts of emotions, and shallow expression of emotions; emotions often appear to be "turned on and off too quickly" to be deeply felt
4) consistent use of physical appearance to draw attention to self
5) excessively dramatic style of speech that lacks detail; opinions are strongly presented, but underlying reasons may be vague, without supporting facts and details
6) self-dramatic, theatrical, and exaggerated expression of emotion
7) easily influenced by others or circumstances (e.g., fads)
8) views relationships as more intimate than they actually are.

2.7.3 Cluster C Personality Disorders

Cluster C features *anxious or fearful behaviour.* The personality disorders in this cluster include:

a) **Dependant Personality Disorder**

Where people depend on their opinion and judgement. Their insecurity, indecision and lack of self esteem can make it difficult for them to take care of themselves. A person with Dependent Personality Disorder shows an extreme need to be taken care of that leads to fears of separation, and passive and clinging behaviour. This disorder is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) difficulty making daily decisions without an excessive amount of advice and reassurance from others
2) needs others to assume responsibility for most major areas of his or her life
3) difficulty voicing disagreement with others because of fear of loss of support or approval (excluding realistic fears of punishment)
4) difficulty starting projects or doing things on his or her own (because of little self-confidence in judgment or abilities, rather than a lack of motivation or energy)
5) excessively attempts to obtain support from others such that he or she volunteers to do unpleasant tasks
6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7) urgently seeks another relationship as a source of support when a close relationship ends
8) overly worried about being left to take care of himself or herself.

b) **Avoidant Personality Disorder**

This disorder causes people diagnosed to avoid situations which can cause conflict because they cannot face the possibility of being rejected. By doing so, however, they make their own situation worse by isolating themselves and avoid forming any relationships.

An individual with Avoidant Personality Disorder typically is socially inhibited, feels inadequate, and is oversensitive to criticism, as indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) avoids work-related activities that involve much social contact, because of fears of criticism, disapproval, or rejection
2) is unwilling to get involved with people unless certain of being liked
3) fears of shame or ridicule lead to excessive shyness within intimate relationships
4) is overly concerned with criticism and rejection in social situations
5) is inhibited in new social situations because of feelings of inadequacy
6) views self as socially incompetent, personally unappealing, or inferior to others unusually reluctant to take personal risks or do new activities because of fear of embarrassment
7) People diagnosed with Obsessive Compulsive Personality Disorder are so inflexible in their approach to things that they become anxious and indecisive and normally end up not completing any tasks they have started. They like to be in control and have difficulty in sustaining healthy relationships.

This pattern is indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) is overly concerned with details, rules, lists, order, organisation, or schedules such that the major point of the activity is lost
2) is unable to complete a project because his or her own overly strict standards are not met
3) excessive emphasis on work and productivity such that leisure activities and friendships are devalued (not accounted for by obvious economic need)
4) is overly conscientious and inflexible about issues involving morality, ethics, or values (not accounted for by cultural or religious identification)
5) is unable to throw out worn-out or worthless objects despite lack of emotional value
6) is reluctant to delegate tasks or work with others unless they agree to exactly his or her way of doing things
7) adopts a stingy spending style toward both self and others; money is seen as something to be gathered for future catastrophes
8) rigidity and stubbornness

There also is a diagnosis known as “Personality Disorders Not Otherwise Specified”, which is separate from the above three groups of disorders.

This diagnosis would be given for disturbed personality functioning that does not meet criteria for any specific personality disorder, but which leads to distress or harm in one or more important areas of functioning (e.g., social or work-related). The clinician also may give this diagnosis if a specific personality disorder that is not included in the DSM IV Classification seems to apply to an individual (e.g., depressive personality disorder, or passive-aggressive personality disorder; DSM IV, American Psychiatric Association, 1994).

Self Assessment Questions

1) Discuss the cluster A personality disorders.

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2) Elucidate the Cluster B personality disorders.

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3) Explain the cluster C personality disorders.

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2.8 TREATMENT OF PERSONALITY DISORDERS

There are various kinds of help available. Family doctor can be a good start as he/she will be to refer you to someone who knows how to offer the best help. Psychological and drug therapies provide some benefit for people with personality disorders. Counselling and psychotherapy give people the chance to talk about their difficulties. Therapy aims at helping people bring their true feelings to the surface, so that they can experience and understand them better. Other forms of help available include Cognitive Behavioural Therapy (CBT) which is a combination of cognitive therapy and behavioural therapy. It helps to weaken the links between upsetting situations and your normal reaction to them, teaching you how to calm your mind and body and feel good. It also helps you to recognise patterns that make you angry, anxious or depressed.

Medical Treatment and Support Groups are also other forms of help available for people suffering from personality disorders.

Treatment will vary depending on the view the clinician holds regarding the origins of personality disorders and will also depend on services available. In the case of psychopathy, it is thought that because people who have this diagnosis feel no emotion, it is impossible to treat them with any kind of talking therapy. The other disorders are mainly treated with a combination of drug and talking therapies.

Treatment of Borderline personality Disorder includes the following steps:

- *Identify disturbances*, chronic feelings of emptiness or boredom and their intolerance of being alone. These people have a strong need for involvement with others and a reliance on external support for self- definition.
- *Affective disturbances*, reflected in their intense, inappropriate anger, emotional instability and unstable interpersonal relationships.
- *Impulsive disturbances,* reflected in their self-damaging acts and impulsive behaviours.

2.9 LET US SUM UP

Personality disorders appear to be extreme or exaggerated patterns of personality traits that predispose an individual to maladaptive behaviour. A number of personality disorders have been delineated in which there are persistent patterns of perceiving, thinking and relating to the environment. Three general clusters of personality disorders have been described – Cluster A which includes individuals with paranoid, schizoid and schizotypal personality disorders who seem odd or eccentric. Cluster B which includes individuals with histrionic, narcissistic, antisocial and borderline personality disorders who share a common tendency to be dramatic, emotional and erratic and Cluster C which includes individuals with avoidant, dependent and obsessive – compulsive personality disorders who show fearfulness or tension as in anxiety – based disorders. Research indicated that constitutional and genetic factors play a role in borderline, paranoid, schizotypal and antisocial personality disorders. Some evidence suggests that early childhood abuse may play a role in causing borderline personality disorder.

Treatment of the Cluster C disorders which includes dependent and avoidant personality disorder seems most promising, although a new form of cognitive-behaviour therapy for borderline personality disorder (dialectical behaviour therapy) also shows considerable promise in treating this very serious condition. Cluster A disorders such as schizotypal and paranoid are most difficult to treat.

2.10 UNIT END QUESTIONS

1) Define personality disorders. Discuss the origin and diagnosis of personality disorders.
2) What are the various personality do we come across?
3) Explain Cluster A, Cluster B and Cluster C personality disorders.

4) Delineate the causes of personality disorders.

5) Discuss the symptoms of Cluster C personality disorders.

6) Explain the strategies to treat personality disorders.

2.11 GLOSSARY

Personality disorders : Gradual development of inflexible and distorted personality and behavioural pattern that result in persistently maladaptive ways of perceiving, thinking about and relating to the world.

Paranoid personality disorders : Pervasive suspiciousness and distrust of others

Histrionic personality disorders : Excessive attention seeking, emotional instability and self – dramatisation.

Narcissistic personality disorders : Exaggerated sense of self importance, preoccupation with being admired and lack of empathy for the feeling of others.

Antisocial personality disorders : Continual violation and disregard for the rights of others through deceitful, aggressive or antisocial behaviour, typically without remorse or loyalty to anyone.

2.12 SUGGESTED READINGS

Carson, R.C. Butcher, J.N. & Mineka, S. (2000). *Abnormal Psychology and Modern Life*. Pearson Education, India.

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UNIT 3 GENDER IDENTITY DISORDER

Structure

3.0 INTRODUCTION

In this unit we will be dealing with gender identity disorder. We start with Definition and description of Gender Identity Disorder and follow it up with Origin of Gender Identity Disorder and Transgender issues. Then we take up Components of Gender Identity Disorder and elucidate Criteria and Diagnosis of Gender Identity Disorder. Then we enlist the Symptoms of Gender Identity Disorder and present the Causes of Gender Identity Disorder. The finally we take up the Treatment of Gender Identity Disorder and indicate the Action Steps in Treatment for Gender Identity Disorder.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe gender identity disorder;
- Trace the Origin of gender identity disorder;
- Elucidate the Components of gender identity disorder;
- Explain the Criteria for diagnosis;
- Delineate the Symptoms of gender identity disorder;
- Discuss the Causes; and
- Describe the Treatment interventions of gender identity disorder.

3.2 DEFINITION AND DESCRIPTION OF GENDER IDENTITY DISORDER

Gender identity, a basic feature of personality, refers to an individual's feeling of being male or female. Children become aware that they are male or female at an early age and once it is formed, their gender identity is highly resistant to change.

Gender identity disorder (GID), is a condition in which a person has been assigned one gender (usually at birth), but identifies as belonging to another gender, or does not conform with the gender role their respective society prescribes to them. It is a psychiatric term for what is widely known by other terms such as transsexuality, transgender, transvestism or cross-dressing.

This disorder is different from transvestism or transvestic fetishism where cross dressing occurs for sexual pleasure, but the transvestite does not identify with the other sex. Transsexualism should also not be confused with the behaviour of drag queens and drag kings. Also, transvestic fetishism usually has little, if anything, to do with transsexualism. As a general rule, transsexual people tend to dress and behave in a manner consistent with the gender with which they identify.

3.3 ORIGIN OF GENDER IDENTITY DISORDER

During the 1950's and 60's, psychologists began studying gender development in young children, partially in an effort to understand the origins of homosexuality which was viewed as a mental disorder at the time. Psychoanalyst Robert Stoller is credited with introducing the term gender identity and behavioural psychologist John Money was also instrumental in the development of early theories of gender identity. His work popularized an interactionist theory of gender identity, suggesting that, up to a certain age, gender identity is relatively fluid and subject to constant negotiation.

Sigmund Freud also had a unique theory for the development of gender identity. He believed it was developed during the phallic stage of development. During this time, young boys develop an Oedipus complex and young girls an Electra complex. Freud believed that during this time, the child has an unconscious sexual desire for the parent of the opposite sex and jealousy or hatred for the same sex parent. That jealousy eventually turns into emulating and the child wants to be like that parent, eventually identifying with it.

The notion of gender identity appeared in the Diagnostic and Statistical Manual of Mental Disorders in its third edition, DSM-III (1980), in the form of two psychiatric diagnoses of gender dysphoria – gender identity disorder of childhood (GIDC), and transsexualism (for adolescents and adults). The 1987 revision of the manual, the DSM-III-R added a third diagnosis – gender identity disorder of adolescence and adulthood, non transsexual type. This later diagnosis was removed in the subsequent revision, DSM-IV (1994), which also collapsed the GIDC and transsexualism in a new diagnosis of gender identity disorder.

3.3.1 Transgender

There are many political points of view in the literature of transgender, but the generally agreed definition of transgender covers everything that does not fall

into society's narrow terms of "man" and "woman." Some of the people who consider themselves as transgendered would include transsexuals (who mayor may not have had sex reassignment surgery), transvestites (who wear clothing and adopt behaviour of the opposite sex), people with ambiguous genitalia, and people who have chosen to perform either an ambiguous gender role or no gender role at all.

There are four main categories in the study of transgender:

1) **Essentialist or naturalist:** This group believes that there is no difference between sex and gender, that there are only two genders, and these cannot be changed.

2) **Social constructivist:** This group believes sex and gender can only be considered as part of a social interaction. In other words, sex and gender are a "construction" assigned by society.

3) **Performance:** Gender performance theorists believe gender is best understood through performance studies and they look at what is revealed from clues such as body position, gesture, facial expression, proximity, voice modulation, speech pattern, social space, clothing, adornment and cosmetics.

4) **Memory and language generation:** This group looks at the body as the expression of the symbols of words, gestures and a larger cultural language. On a gut level, the body has deeper knowledge that may not be registered by the mind.

While transgender theorists do not always agree on definitions and underlying philosophies, this is an emerging field with many avenues for scholarly and political dialogue. As the study of transgender develops, it will influence many other disciplines such as anthropology, psychology, psychiatry, sociology, women's studies, men's studies, and gender studies.

A gender identity disorder causes the person to experience serious discomfort with his/her own biological sex orientation. The gender identity disorder can also causes problems for the person in school, work or social settings. The need for treatment is emphasised by the high rate of mental health problems, including depression, anxiety, and drug and alcohol addiction, as well as a higher suicide rate among untreated transsexual people than in the general population. Many transgender and transsexual activists, and many caregivers, point out that these problems usually are not related to the gender identity issues themselves, but to problems that arise from dealing with those issues and social problems related to them.

3.4 COMPONENTS OF GENDER IDENTITY DISORDER

People with gender identity disorder frequently report their feelings as "having always been there", and the disorder can be evident in early childhood. Most people know whether they have a gender identity problem by the time they reach adolescence, although in some cases it seems to appear in adulthood.

Gender identity disorder is a diagnosis given to persons who meet a certain number of clinical criteria related to feelings of discontent regarding one's biological

sex, and identification with the opposite biological sex. The individual may identify to the point of believing that they are, in fact, a member of the other sex who is trapped in the wrong body.

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis.

i) There must be evidence of a strong and persistent gross-gender identification, which is the desire to be, or the insistence that one is, of the other sex. This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex.

ii) There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

Gender identity disorder can affect children, adolescents, and adults. Individuals with gender identity disorder have strong cross-gender identification. They believe that they are, or should be, the opposite sex. They are uncomfortable with their sexual role and organs and may express a desire to alter their bodies. While not all persons with gender identity disorder are labelled as transsexuals, there are those who are determined to undergo sex change procedures or have done so, and, therefore, are classified as transsexual.

Adults with gender identity disorder sometimes live their lives as members of the opposite sex. They tend to be uncomfortable living in the world as a member of their own biologic or genetic sex. They often cross-dress and prefer to be seen in public as a member of the other sex. Some people with the disorder request sex change surgery.

Self Assessment Questions

1) Define Gender Identity Disorder.

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2) Describe the features of gender identity disorder.

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3) Trace the origin of gender identity disorder.

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4) What is transgender? Explain

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5) Elucidate the components of Gender Identity disorder.

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3.5 CRITERIA FOR GENDER IDENTITY DISORDER

According to the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) the following criteria must be met before a person can be given the official diagnosis of gender identity disorder:

- There must be evidence of strong and persistent cross-gender identification. This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex.
- There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.
- The individual must not have a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia).
- There must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-IV also provides diagnostic criteria for gender disorders that do not meet the criteria for the general gender identity disorder diagnosis. The following criteria are sufficient for a diagnosis of Gender Identity Disorder in Children as well as for Gender Identity Disorder Not Otherwise Specified (GIDNOS). For

the former diagnosis, criteria must be identified before a person is 18 years of age.

a) **Intersex Conditions**

(e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria

Transient, stress-related cross-dressing behaviour.

Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex, which is known as skoptic syndrome.

Cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1) repeatedly stated desire to be, or insistence that he or she is, the other sex.

2) in boys, preference for cross dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.

3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.

4) intense desire to participate in the stereotypical games and pastimes of the other sex.

5) strong preference for playmates of the other sex.

6) In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

b) **Persistent Discomfort with his or her Sex**

Or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following, as for instance in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough and tumble play and rejection of male stereotypical toys, games, and activities.

In girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

c) **The disturbance is not concurrent with a physical intersex condition.**

d) **The disturbance causes clinically significant distress** or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals):

- Sexually Attracted to Males
- Sexually Attracted to Females
- Sexually Attracted to Both
- Sexually Attracted to Neither

3.6 SYMPTOMS OF GENDER IDENTITY DISORDER

Symptoms

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1) repeatedly stated desire to be, or insistence that he or she is, the other sex
2) in boys, preference for cross dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4) intense desire to participate in the stereotypical games and pastimes of the other sex
5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

The disturbance is not concurrent with a physical intersex condition.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender identity disorder in children is often reported as “having always been present,” and persons with the disorder do not remember a time when they were satisfied with their gender.

Other persons with the disorder report that symptoms began in adolescence or adulthood, and seemed to grow in intensity over time.

There is usually strong and persistent preferences for cross sex roles in make believe play or persistent fantasies of being the other sex, an intense desire to participate in the stereotypical games and pastimes of the other sex, and usually a strong preference for playmates of the other sex.

Issues regarding gender identity can manifest in a variety of ways. For example, some people may cross dress, while others may seek a sex change surgery. Below is a list of other common *"symptoms"* of gender identity disorder.

Children

- Express a desire to be the opposite sex
- Find their genitals or indicators of their gender cross
- Believe that they will grow up to become the opposite sex
- Are often rejected by their peers
- Become isolated and shy
- Develop moderate to severe anxiety
- Present low self-esteem
- Drop out of school
- Develop moderate to severe anxiety.

In adolescents there is a preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex).

Adults

- Desire to live as a person of the opposite sex
- Pursue a sex reassignment operation
- Both dress and act in a way that is indicative of the opposite sex
- Become socially isolated or ostracized
- Develop moderate to severe depression
- Develop moderate to severe anxiety.

Some persons with gender identity disorder have genitalia and secondary sex characteristics in line with their biological sex. Others may have ambiguous genitalia, or are hermaphroditic. Not all transsexual persons (persons who dress or act as persons of the opposite gender) have gender identity disorder. Generally homosexuals do not have gender identity disorder. The majority of homosexuals identify strongly with their biological gender. Homosexuality involves only a sexual attraction to persons of the same gender.

Self Assessment Questions

1) What is intersex condition?

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2) What is meant by cross gender identification?

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3) Describe the symptoms of Gender Identity Disorder.

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4) Describe the GID symptoms of children.

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5) Elucidate the symptoms of GID in adolescents and adults.

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3.7 CAUSES OF GENDER IDENTITY DISORDER

John Money has coined a useful term "gender maps" to describe the phenomenon of gender identity. He defined gender map as the entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny. This map or coding imprint is established very early in life through an interaction of nature and nurture. Because gender map development is highly influenced by hormones emanating from the developing fetus, sex and gender identification are generally closely matched. But like most aspects of being human, there are no guarantees. As a result an individual may, as early as the age of four, find themselves aware of being caught between having the anatomy of one sex but being equipped with a gender map much more typical of an individual of the opposite sex. It is also apparently possible for an individual to have no clear sense of gender whatsoever.

There is no clearly understood cause for Gender Identity Disorder.

The biological theory is based on evidence that high levels of the male hormone testosterone are associated with high levels of aggression in boys and tomboyishness in girls.

Social learning theory proposes that gender typing is the result of a combination of observational learning and differential reinforcement.

Cognitive-Developmental theory, states that gender understanding follows a prescribed time line. The pattern put forth is that children recognise that they are either boys or girls by the age of two or three, followed shortly by recognition that gender is stable over time. By the age of six or seven children understand that gender is also stable across situations.

No matter what theory one adopts, for most children, whose sex and gender map are congruent, this insight typically goes unnoticed. However, if there is sex/gender map incongruence, the child is left perplexed about his or her gender status and begins a lifelong, often compulsive search for resolution of the discrepancy.

All children naturally comply with the demands of their internal sense of gender. Boys generally express male behaviour and girls generally express female behaviour even when raised in closely monitored gender neutral conditions. If there is any confusion in the child, he or she quickly learns from adults and peers that certain gender expression behaviours are inappropriate for that individual. This is true even of gender dysphoric children. Some gender dysphoric children internalise their dilemma and make heroic efforts to display the gender behaviour expected of them, while expressing their internal sense of gender through secret play, cross-dressing, and cross-gender fantasies. Others may continue to struggle by insisting that they be allowed to openly express maleness or femaleness irrespective of their assigned sex. Either way, the problem becomes subsumed into the child's personality.

The arrival of adolescence increases the difficulties for people who are gender dysphonic. Without fail, the subsequent development of secondary sex characteristics counter to the individual's desires increases anxiety. Often, frustration sets in, and determination to finally resolve the problem becomes the individual's driving force in life. This is especially true for gender dysphoric males. Since the obvious first effort is to accept the physical evidence of their genitalia as reality, it is very common to see many of these people push through these early years of adulthood by engaging in stereotypical, even supermale activities. Since outward behaviour has no permanent influence on internal gender understanding, these activities serve only to complicate the individual's social involvement, resulting in anxiety about expressing his true felt gender.

This anxiety state is characterised by feelings of confusion, shame, guilt, and fear. These individuals are confused over an inability to handle their gender identity problem in the same way they readily handle other problems in life. They feel shame over an inability to control what they believe society considers to be sexually perverse activities. Even though cross dressing and cross gender fantasies provide much needed temporary relief, these activities often leave the individual profoundly ashamed of what she or he has done.

Closely associated with shame is guilt over being dishonest by hiding secret needs and desires from family, friends, and society. For example, people commonly get married and have children without telling their spouse of their gender dysphoria before making the commitment. Typically it is kept secret because they have the mistaken conviction that participation in marriage and parenting will in itself erase their gender dysphoria. All of this then leads to fear of being discovered. With some justification, gender dysphoric people fear being called sick, uncaring, selfish and even being left alone by the people they love the most.

The psychological diagnosis of gender identity disorder (GID) is used to describe a male or female who feels a strong identification with the opposite sex and experiences considerable distress because of his or her actual sex.

Thus, Gender identity disorder can affect children, adolescents and adults. Individuals with gender identity disorder have strong cross-gender identification. They believe that they are, or should be, the opposite sex. They are uncomfortable with their sexual role and organs and may express a desire to alter their bodies.

While not all persons with GID are labeled as transsexuals, some are determined to undergo sex change procedures or to pass socially as the opposite sex. Transsexuals alter their physical appearance cosmetically and hormonally, and may eventually undergo a sex change operation.

Children with gender identity disorder refuse to dress and act in sex stereotypical ways. It is important to remember that many emotionally healthy children experience fantasies about being a member of the opposite sex. The distinction between these children and gender identity disordered children is that the latter experience significant interference in functioning because of their cross gender identification. They may become severely depressed, anxious, or socially withdrawn.

Psychologists who work with children and teens on gender identity note that cross gender behaviours generally become less overt with time and by late adolescence, GID is usually no longer present.

Long term studies of children referred to a specialty clinic for GID show that cross gender behaviour is tolerated in girls to a far greater degree than it is in boys. Thus, parents are quicker to bring boys in for evaluation. The clinicians who conducted the study theorized that girls may be under referred for GID because there is more social tolerance of “tomboys” than there is of “sissies.” While much more research is needed, scientists theorize that there are other social factors in play as well.

It is much more common for males to wish to cross to the female gender, but there are exceptions. In Poland, the ratio of women who wish to change gender is five times the rate of men who wish to change. Researchers theorize that Polish women face unfavourable living conditions and gender related economic and occupational hardships to a degree that they seek relief by changing gender.

The biological causes of gender identity disorder are not known. According to one theory, a prenatal hormonal imbalance may predispose individuals to the disorder. Problems in the individual’s family interactions or family dynamics may play a part.

3.8 TREATMENT OF GENDER IDENTITY DISORDER

Treatment for children with gender identity disorder focuses on treating secondary problems such as depression and anxiety, and improving self esteem. Treatment may also work on instilling positive identifications with the child's biological gender. Children typically undergo psychosocial therapy sessions; their parents may also be referred for family or individual therapy.

Children and adolescents with GID have never been systematically counted, but gender identity disorder is generally regarded as a rare phenomenon. In Europe, there are treatment centers in London, England; Utrecht, the Netherlands and in Frankfurt, Germany. In North America, patients may seek treatment at special centers for gender identity disorder in Toronto; in New York City; at the University of California, Los Angeles; at Johns Hopkins University in Baltimore; and at Case Western University in Cleveland. The larger number of GID patients in North America may be related to a less permissive attitude toward gender nonconformity. Traditionally, Europe is more tolerant of gender nonconformity and parents are less likely to see their children's GID symptoms as requiring treatment.

With adolescents, there are many variations in gender role behaviour and experienced gender identity specialists avoid making premature decisions, particularly when sex reassignment surgery is under consideration. One study described in a review in the American Journal of Psychotherapy showed that a large number of children with GID grow up to be homosexual or bisexual. The concept of treatment for GID children and adolescents has become highly politicized, since some groups fear that treatment of GID is actually a thinly veiled attempt to curb or even prevent homosexuality.

Hormone and Surgical Treatments

Transsexual adults often request hormone and surgical treatments to suppress their biological sex characteristics and acquire those of the opposite sex. A team of health professionals, including the treating psychologist or psychiatrist, medical doctors, and several surgical specialists, oversee this transitioning process. Because of the irreversible nature of the surgery, candidates for sex change surgery are evaluated extensively and are often required tospend a period of time integrating themselves into the cross gender role before the procedure begins. Usually sex reassignment surgery is not offered to anyone under 18. Before surgery can be considered, candidates undergo at least a year of psychotherapy. A "real life" test of living for at least a year as a member of the desired gender is recommended.

A male who has been cleared for surgery will have a vagino plasty, the surgical technique for creating a neo vagina. The penis and testes are removed. Surgeons permanently remove male hair growth and perform corrective plastic surgery on the larynx. For the patient to successfully pass as a woman, the growth of facial and body hair must be suppressed, and this can be accomplished with a drug such as cyproterone acetate. The surgery for changing a man into a woman is simpler than the surgery for changing a woman into a man, and many more men than women undergo sex change operations.

A woman who has been cleared for surgery will undergo surgical removal of the breasts, uterus and ovaries. In some cases, a phallo plasty will be performed, creating a neo phallus. Premenopausal women who receive sex change operations are given a drug such as lynestrenol to suppress menstruation. Long-term follow-up studies have shown positive results for many transsexuals who have undergone sex-change surgery. However, significant social, personal, and occupational issues may result from surgical sex changes, and the patient may require psychotherapy or counselling.

In the ongoing debate on gender stereotypes, new areas of inquiry have opened up. Scholars and activists have sought new responses to the questions of gender dysphoria (dissatisfaction or discomfort with one's biological gender). In the literature on issues of transgender, some scholars point out that gender is a performance that everyone learns from birth. Under this theory, by the time people are old enough to recognise that their gender identity is a kind of performance, it is so ingrained that people do not think of their gender identity as a separate entity.

Treatment of psychological disorders in GID

According to the American Psychological Association, the transgendered suffer from a higher than average rate of depression, anxiety, suicide and self-mutilation, yet rarely seek treatment. Untreated gender identity disorders may manifest in associated disorders and emotional distress that can interfere with the individual's ability to function socially at school and work or in relationships. Treatment helps a patient achieve and maintain a healthy and stable life.

For children with GID, individual and family counseling, along with social and physical interventions are recommended. Children with gender identity disorder may develop symptoms of depression, generalised anxiety and separation anxiety disorder. Adolescents may be at risk for depression, suicidal thoughts or suicide attempts. Counseling should focus on improving self-esteem and treating associated complications.

Parents are encouraged to allow their child to explore fantasies about being a member of the opposite gender in a safe and tolerant environment. Additionally, parents are offered suggestions such as using gender-neutral language, making gay-friendly media available, and encouraging the child to participate in any activities she or he is interested in without judgment.

Other Psychological Techniques

Psychological techniques that attempt to alter gender identity to one considered appropriate for the person's assigned sex have typically been shown to be ineffective. However, *psychological therapy* can help alter the course of gender identity disorder problems and can be critical in helping the person adjust. Today, most medical professionals who provide transgender transition services now recognise that when able to live out their daily lives with both a physical embodiment and a social expression that most closely matches their internal sense of self, transgender and transsexual individuals live successful, productive lives virtually indistinguishable from anyone else.

Counselling individuals with gender identity disorder should include an understanding of the differences between true transsexualism and other disorder

issues such as transvestic fetishism, non-conformity to stereotypical sex role behaviours, gender dysphoria, and homosexuality. Patients and their families need to be educated about the complexities of these issues, the enduring nature of these disorders, and the challenges that gender disorders typically present.

Multifaceted Therapeutic Approach

When GID is diagnosed in an adult, a multifaceted therapeutic approach begins. In addition to support groups and counseling (both individual and couples counselling), patients may choose hormone therapy, undertake a Real-Life Experience (living full time in their desired gender for a year or longer) and gender reassignment surgery. Patients desiring gender reassignment surgery undergo extensive evaluation, therapy and a transition period before they can be approved for surgery.

It is generally accepted that a reasonable and effective course of treatment for transsexual people can be sex reassignment therapy. This can include hormonal treatment and surgery. Sex reassignment surgery consists of procedures which transsexual women and men undergo in order to match their anatomical sex to their gender identity. While genital reassignment surgery (GRS) refers only to surgeries that correct genital anatomy, sex reassignment surgery (SRS) may refer to all surgical procedures undergone by transsexual patients.

Hormone therapy may also be helpful. In male to female individuals, original sex characteristics can be suppressed, and breasts, increased body fat, and a more feminine body shape can be promoted. In female-to-male individuals, facial and body hair promotion may be achieved with testosterone.

“Transgender transition services”, the various medical treatments and procedures that alter an individual’s primary and/or secondary sexual characteristics, are now considered medically necessary interventions for many transgender persons. Prior to this kind of surgery, the person usually goes through a long period of hormone therapy which attempts to suppress same sex characteristics and accentuate other sex characteristics. For instance, males that have gender identity disorder will be given the female hormone, estrogen.

The estrogen causes the male breasts to enlarge, testes to become smaller, and body hair to diminish. Females with gender identity disorder will be given the male hormone, testosterone, to help them develop a lower voice and possibly a full beard. Following the hormone treatment, the adult will be asked to live in a cross-gender role before surgery to alter their genitalia or breasts is performed. A team of health professionals, including the treating psychologist or psychiatrist, medical doctors, and several surgical specialists, oversee this transitioning process.

Because of the irreversible nature of the surgery, candidates for sex-change surgery are evaluated extensively and are often required to spend a period of time integrating them into the cross-gender role before the procedure begins. Counselling and peer support are also invaluable to transsexual individuals.

Follow up studies have shown positive results for many transsexuals who have undergone sex-change surgery. However, significant social, personal, and occupational issues may result from surgical sex changes, and the patient may require psychotherapy or counseling.

Speech therapy may help individuals use their voice in a manner more appropriate to their preferred sex.

3.8.1 Action Steps in Treatment for Gender Identity Disorder

Treating gender identity disorder can be a slow and complicated process. With gender identity disorder, better recovery outcomes are associated with early diagnosis and treatment.

Step 1: Identify and Challenge Negative Thoughts about One's Biological Sex

First, identify any negative thoughts that are being had in regards to one's gender. For example, a male suffering from gender identity disorder may say, "Men are pigs. They are crude, crass, and uncaring. Unlike me, men are athletic and sportsmanlike. Men don't enjoy art and fashion."

Look at these negative statements and note if there are any "lies" or half-truths that are being said. For example, many men are not crass, are un-athletic, and enjoy art.

Step 2: Find ways that one can identify with one's Biological Sex

A person with gender identity disorder generally believes they cannot identify with their biological sex.

Assess what things are present in one's lives that do correspond with their biological sex. For example, a woman suffering from gender identity disorder may feel that she does not identify with cosmetics. Note these similarities and continue to identify things that one does have in common with others of the same biological sex.

Step 3: Neutralise Physical Issues

Some persons with gender identity disorder have genitalia and secondary sex characteristics in line with their biological sex (meaning they have physically developed normally). However, others may be experiencing either ambiguous genitalia, or a hermaphroditic physical condition.

If the latter is present, consider that even though one's external appearance is different from the average person of a particular sex; genetically one is always fully male or fully female.

This male or female designation does not occur in one's phenotype (the way their body looks externally), it occurs in their genotype, whether they present XX or XY chromosomes.

Confirming one's gender based on genetics, and considering outward biology as only secondary, may be an effective tool in reframing thoughts about gender identity.

Self Assessment Questions

1) What are the causes of GID?

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2) What theories are associated with GID?

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3) Describe the various treatments available for GID?

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4) What are hormonal and surgical treatments for GID?

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5) Describe the psychological treatments for GID.

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6) What are the Action Steps in the treatment of GID?

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3.9 LET US SUM UP

Gender may well be the most basic thing in the elements that make up human personality. In fact, gender is so basic to our identity, most people mistakenly assume our sense of being male or female is defined with absolute certainty by our anatomical sex. Contrary to popular belief, one's sense of gender and one's anatomical sex are two distinct elements – each developing at different times in different parts of the body.

Gender Identity Disorder is a real and serious problem. Although we don't know all of what may be the cause or causes of the problem that these individuals feel toward their assigned sex, we can be reasonably certain that it is connected with either a congenital irregularity, an irregularity that occurs in the first few years of childhood or some combination of the two.

We also know that every individual's sense of gender, once established, is unchangeable over the individual's life time. If the individual's gender dysphoria is a relatively minor one, cross-gender, lifestyle changes in periodic dressing and behaviours may be all that is necessary to ease the anxiety. However, if the individual's dysphoria is profound, a life style change may be insufficient. In this latter case, gender expression moves from a lifestyle problem to a life-threatening imperative.

3.10 UNIT END QUESTIONS

1) Define and describe Gender Identity disorder.
2) Discuss the origin of gender identity disorder.
3) Describe the component factors in GID
4) Explain the symptoms of gender identity disorder.
5) How would you diagnose the existence of gender identity disorder?
6) Explain the various treatments for gender identity disorder.

3.11 GLOSSARY

Gender Identity Disorder **:** It is defined by strong, persistent feelings of identification with the opposite gender and discomfort with one's own assigned sex.

Gender Dysphoria **:** When the gender identity of a person makes them one gender, but their genitals suggest a different sex, they will likely to experience this.

Gender map **:** It is the entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny.

Sex reassignment surgery **:** It consists of procedures which transsexual women and men undergo in order to match their anatomical sex to their gender identity.

Genital reassignment surgery **:** It refers only to surgeries that correct genital anatomy.

3.12 SUGGESTED READINGS

Boenke, Mary (1999). *Trans Forming Families: Real Stories About Transgendered Loved Ones.* Imperial Beach, CA: Walter Trook Publishing.

Cohen-Kettenis,P.T.& Pfäfflin,F(2003). *Transgenderism and Intersexuality in Childhood and Adolescence.* Sage Publications.

Diagnostic and Statistical Manual of Mental Disorders IV (1994). 4th ed. Washington, D.C. American Psychiatric Association

Money, J (1995). *Gender Maps: Social Constructionism, Feminism, and Sexophical History.* New York, The Continuum Publishing Company.

UNIT 4 EATING DISORDER

Structure

4.0 INTRODUCTION

Eating is one of life's great pleasures. But some people have difficult in controlling their food intake. Eating disorders are relatively recent additions to psychiatric classification systems. The vast majority – more than 90% of those affected with eating disorders are adolescents and young adult women. The reason for women being vulnerable to eating disorders is their tendency to go on strict diets to achieve an "ideal" figure.

Eating disorders are sometimes symptoms of a physical ailment, but they might also be external manifestations of mental disorder. The social causes of mental disorder, the interchange between people and society, and the influence that culture has on our perceptions of reality are probably most clearly demonstrated in the mental disorders anorexia nervosa and bulimia nervosa.

Many news papers and magazines feature glamorous celebrities who devised a special diet and shed pounds to become new, healthy, more confident people. Many psychological and social theorists believe that the influx of media images of thin women, many directed at the young, is a prime cause of the massive increase in eating disorders in the western world. In this unit we are going to deal with eating disorders. First we start with definition and description of eating disorders. This is followed by sociocultural comparison of eating disorders within different parts of America and then follow it up with other countries including India. Then we present different types of eating disorders such as anorexia nervosa, bulimia nervosa, binge eating etc. Then we deal with causes of eating disorders in which we present biological, cultural, family and other theories. This is followed by treatment of eating disorders and the different types of treatment.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define eating disorders;
- Describe the prevalence of this disorder;
- Explain the types of eating disorders;
- Elucidate the Causes of eating disorders; and
- Describe the Treatment for eating disorders.

4.2 DEFINITION AND DESCRIPTION OF EATING DISORDERS

"Eating disorder" is when a person eats, or refuses to eat, in order to satisfy a psychic need and not a physical need. The person does not listen to bodily signals or perhaps is not even aware of them. A normal person eats when hungry and stops eating when the body doesn't need more, when he feels the signal of satisfaction.

Eating disorders are usually classified as anorexia nervosa, bulimia nervosa and binge eating disorders, in accordance with the symptoms. However, a person may have an eating disorder without belonging exactly to any of these categories.

Those who lose weight because of illness, e.g., cancer, are not considered to have an eating disorder.

Eating disorders do not seem to manifest as Anorexia Nervosa and Bulimia in non Western cultures like India, but occur infrequently in milder forms with fewer symptoms, In the absence of the major disorders, standard questionnaires such as the Eating Attitudes Test appropriate for detecting severe disorders, may not be useful in identifying low prevalence milder disorders.

Culture has been identified as one of the etiological factors leading to the development of eating disorders. Rates of these disorders appear to vary among different cultures and to change across time as cultures evolve. Additionally, eating disorders appear to be more widespread among contemporary cultural groups than was previously believed. Anorexia nervosa has been recognised as a

medical disorder since the late 19th century, and there is evidence that rates of this disorder have increased significantly over the last few decades. Bulimia nervosa was only first identified in 1979, and there has been some speculation that it may represent a new disorder rather than one that was previously overlooked (Russell, 1997).

However, historical accounts suggest that eating disorders may have existed for centuries, with wide variations in rates. Long before the 19th century, for example, various forms of self starvation have been described (Bemporad, 1996). The exact forms of these disorders and apparent motivations behind the abnormal eating behaviours have varied.

The fact that disordered eating behaviours have been documented throughout most of history calls into question the assertion that eating disorders are a product of current social pressures. Scrutiny of historical patterns has led to the suggestion that these behaviours have flourished during affluent periods in more egalitarian societies (Bemporad, 1997). It seems likely that the sociocultural factors that have occurred across time and across different contemporary societies play a role in the development of these disorders.

4.2.1 Sociocultural Comparisons with America

Several studies have identified sociocultural factors within American society that are associated with the development of eating disorders. Traditionally, eating disorders have been associated with Caucasian upper socioeconomic groups, with a "conspicuous absence of Negro patients" (Bruch, 1966). However, a study by Rowland (1970) found more lower and middle class patients with eating disorders within a sample that consisted primarily of Italians (with a high percentage of Catholics) and Jews. Rowland suggested that Jewish, Catholic and Italian cultural origins may lead to a higher risk of developing an eating disorder due to cultural attitudes about the importance of food.

More recent evidence suggests that the pre-valence of anorexia nervosa among African Americans is higher than previously thought and is rising. A survey of readers of a popular African American fashion magazine (Table) found levels of abnormal eating attitudes and body dissatisfaction that were at least as high as a similar survey of Caucasian women, with a significant negative correlation between body dissatisfaction and a strong black identity (Pumariega et al., 1994).

It has been hypothesized that thinness is gaining more value within the African American culture, just as it has in the Caucasian culture (Hsu, 1987).

Other American ethnic groups also may have higher levels of eating disorders than previously recognised (Pate et al., 1992). A recent study of early adolescent girls found that Hispanic and Asian American girls showed greater body dissatisfaction than white girls (Robinson et al., 1996). Furthermore, another recent study has reported levels of disordered eating attitudes among rural Appalachian adolescents that are comparable to urban rates (Miller et al., in press).

The notion that eating disorders are associated with upper socioeconomic status (SES) also has been challenged. Association between anorexia nervosa and upper SES has been poorly demonstrated, and bulimia nervosa may actually have an

opposite relationship with SES. In fact, several recent studies have shown that bulimia nervosa was more common in lower SES groups. Thus, any association between wealth and eating disorders requires further study (Gard and Freeman, 1996).

4.2.2 Eating Disorders in Other Countries

Outside the United States, eating disorders have been considered to be much rarer. Across cultures, variations occur in the ideals of beauty. In many non Western societies, plumpness is considered attractive and desirable, and may be associated with prosperity, fertility, success and economic security (Nassar, 1988). In such cultures, eating disorders are found much less commonly than in Western nations. However, in recent years, cases have been identified in nonindustrialised or premodern populations (Ritenbaugh et al., 1992).

Cultures in which female social roles are restricted appear to have lower rates of eating disorders, reminiscent of the lower rates observed during historical eras in which women lacked choices. For example, some modern affluent Muslim societies limit the social behaviour of women according to male dictates. In such societies, eating disorders are virtually unknown. This supports the notion that freedom for women, as well as affluence, are sociocultural factors that may predispose to the development of eating disorders

Cross cultural comparisons of eating disorder cases that have been identified have yielded some important findings. In Hong Kong and India, one of the fundamental characteristics of anorexia nervosa is lacking. In these countries, anorexia is not accompanied by a “fear of fatness” or a desire to be thin; instead, anorexic individuals in these countries have been reported to be motivated by the desire to fast for religious purposes or by eccentric nutritional ideas (Castillo, 1997).

Such religious ideation behind anorexic behaviour also was found in the descriptions of saints from the Middle Ages in Western culture, when spiritual purity, rather than thinness, was the ideal (Bemporad, 1996). Thus, the fear of fatness that is required for the diagnosis of anorexia nervosa in the Diagnostic and Statistical Manual, Fourth Edition (American Psychiatric Association) may be a culturally dependent feature (Hsu and Lee, 1993).

Anorexia nervosa has been described as a possible “culture-bound syndrome,” with roots in Western cultural values and conflicts (Prince, 1983). Eating disorders may, in fact, be more prevalent within various cultural groups than previously recognised, as such Western values are becoming more widely accepted. Historical and cross cultural experiences suggest that cultural change, itself, may be associated with increased vulnerability to eating disorders, especially when values about physical aesthetics are involved. Such change may occur across time within a given society, or on an individual level, as when an immigrant moves into a new culture. In addition, cultural factors such as affluence and freedom of choice for women may play a role in the development of these disorders (Bemporad, 1997). Further research of the cultural factors influencing the development of eating disorders is needed.

4.2.3 Eating Disorders in India

Most people in India struggle to get enough to eat and it is estimated that 60% of India's women are clinically malnourished. But psychiatrists in urban areas are reporting cases of anorexia nervosa, the so-called slimming disease that can cause sufferers to starve themselves to death. Most people in India have still not heard of the condition but some psychiatrists are of the view that there is an explosion in anorexia cases over the past few years.

The arrival of cable television and Western fashions and films has given today's teenagers the idea that thin is beautiful. Western fast foods have arrived too but as the young girls at Delhi's pizza and burger bars tuck in, they also say they want to lose weight. The irony is that India's traditional idea of beauty is of healthy, well-fed women with rounded figures.

One report states that there is obsession with physical appearance on rise amongst college going crowd in India. Youngsters in the age group of 12-25 years are using diet pills, fat burners, fasting, resorting to self induced vomiting etc. in order to stay slim and look attractive. They are deeply influenced by modern lifestyles together with ubiquitous show of a perfect 10 figure and airbrushed faces in advertisements & pictures of ramp models, film/sports personalities etc. in newspapers, magazines etc, says ASSOCHAM study.

Kids as young as 12 years old are resorting to severe dieting, consuming fat burners and protein shakes thereby developing serious eating disorders, according to the Chamber study. ASDF team conducted a survey in 10 major cities of Delhi-NCR, Mumbai, Kolkata, Bangalore, Chennai, Hyderabad, Ahmedabad, Chandigarh, Jaipur and Lucknow and interacted with around 2500 young folks (almost equal number of males and females) in the age group of 12-25 years. The study was carried out during October 2010 to March 2011.

According to the ASSOCHAM study, "an interesting aspect that emerged out of the survey was that youngsters in urban India feel the need to diet as they aspire to be thin and beautiful as cine stars, models, celebrities and feel that they will be popular if they are able to attain that 'ideal body image'."

The study stated that today, even the kids are not off limits from the celebrity driven trend of staying slim to look perfect and are dieting and starving themselves to achieve desired results. This trend is equally prevalent both in males and females.

This is likely to have an adverse impact on young people, especially females as they suffer from eating disorder and psychological problems like that of a distorted body image, sense of insecurity and a low self-esteem owing to fear of rejection etc. Parents tend to overlook the strange eating habits of their growing kids without realising that this is robbing them off their childhood.

Youngsters (12-25 years old) in Mumbai topped the chart with around 55 per cent of them admitting to dieting over three days a week and 35 per cent admitting to following a daily diet plan. Youth in Delhi –NCR ranked 2nd with 40 per cent of them admitted to dieting over thrice a week and 30 percent said that they diet daily. Chandigarh ranked third where 25 per cent said that they follow a strict diet regime everyday and 35 per cent said that they diet at least 3 days per week.

Ahmedabad stood on the 4th rung with 30 per cent admitting to dieting over three days a week and 20 per cent said that they diet daily. Figures in Lucknow and Jaipur were almost equal as 25 per cent in said that they diet daily whereas 15 per cent respondents admitted to have been following a daily diet chart.

Majority of respondents agreed to following severe diet regimens but were ignorant about the fact that it was affecting their growth. Besides, ASSOCHAM study has revealed that youngsters obsessed with dieting are becoming anorexic by starving themselves relentlessly and are prone to diseases like depression, anxiety, insomnia etc.

While sharing their views with ASSOCHAM representatives the respondents said that they feel worthless for being over-weight and constantly fear of becoming obese, that's the reason they starve themselves to attain a lean look. Majority of them said admitted that they exercise compulsively, often to the point of exhaustion to compensate for the calorie intake.

Self Assessment Questions

1) Define and describe eating disorders.

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2) Elucidate the prevalence of eating disorders.

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3) Present eating disorders in countries other than USA.

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4) Discuss eating disorders as prevalent in India.

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4.3 TYPES OF EATING DISORDERS

Although there are several different types of eating disorders, psychiatrists and psychologists generally tend to divide them into two broad categories – anorexia nervosa, bulimia nervosa and binge eating.

Anorexia nervosa is a condition characterised by a refusal to maintain a minimal normal body weight, voluntary self starvation and an intense fear of becoming fat. These individuals achieve abnomally low weight by severely dieting fasting and often by exercising compulsively. Most cases are female coming from the upper or middle class.

Bulimia nervosa is characterised by recurrent episodes of binge eating while experiencing a subjective sense of lack of control over the eating, the regular use of extreme weight compensatory methods (for example, self induced vomiting, laxative abuse, diuretic abuse, excessive fasting and compulsive exercise) and dysfunctional beliefs about weight and shape that unduly influence self-evaluation or self worth. 90 per cent of the cases happen to be women. Bulimia nervosa is likely to result from a combination of genetic, familial, psychological, and socio-cultural factors.

Binge eating disorder is characterised by recurrent episodes of binge eating but, unlike bulimia nervosa, no extreme weight control behaviours are present. A decreasing weight goal, increasing criticism of the body, increasing social isolation, disruption of menstruation, reports of purging in the context of dieting are some of the warning signals for parents. Parents are largely responsible for shaping a child's body image and eating lifestyle. It is believed that parents who are themselves preoccupied with body image and weight increase the ranks of childhood anorexics. Parents should communicate with their children and try to maintain a healthy lifestyle at home for the sake of their children.

Depression, stress and genetics are important factors when it comes to eating disorders. It has been observed that those who suffer from anorexia nervosa are usually sensitive, intelligent people who have a tendency to turn into control freaks. On the other hand, Anorexia bulimia is associated with those who are very emotional They then alternate between periods of overeating and then a self-inflicted punishment in the form of starvation.

Since, eating disorders usually begin in teens, parents can play an important role in curbing them. Eating disorders in children can often be a result of unhealthy eating habits at home. Parents should realise that children unconsciously follow most of their dietary habits. For this reason parents have to be careful about their own diet and make sure that they are setting a healthy example for their kids. Second, meal time should be fun. Painful or stressful topics should be kept away from the dinner table. This is not a time to discuss your child's bad performance in exams. Instead, make it a family bonding time. Keep conflicts away from meal time. Parents should also try to make a healthy diet palatable. Incorporate interesting recipes so that eating becomes an enjoyable activity.

A balanced diet consists of adequate amount of carbohydrates, proteins, fats and vitamins. An average Indian meal consisting of chapatis, dal, green vegetables and curd forms an ideal diet. Deviating greatly from this for more than three weeks would be considered as a disorder. There can be several reasons for this.

First, there is tremendous peer pressure on young people to look good. Girls compete with one another to fit into a smaller size as thin is in. The pressure to look attractive is so great that they cut down blindly on the first thing that happens to be in their control, which is their food. In the absence of proper guidance they blindly follow crash diets. Some even deprive themselves of all food. There are others, who only go by calorie count, skip healthy meals and binge on junk foods. In their mind they are not doing anything wrong as long as they do not exceed the calorie count. This lack of information about a balanced diet can lead to severe consequences.

Parents in such a situation should not coerce or nag their children. They, instead have to lead by example. If kids see a healthy and an active lifestyle at home, they will automatically emulate it. Do not sermonise, subtle guidance is the need of the hour.

Sometimes eating disorders are a result of severe emotional stress r depression. Parents have to understand their children and ensure that their emotional needs are being fulfilled. These situations have to be tackled sensitively. In case, you are not able to diagnose the cause, medical help should be considered.

In reality it is difficult to differentiate between the two since there is a lot of overlap in the behavioural characteristics and psychological process of each. Many theorists suggest that people's eating habits and their perception of their own body image lie on a continuum- along a scale that extends from extremely distorted eating habits and an unrealistic body image at one end to no psychological or behavioural distortions at all at the other. Every one stands somewhere within in this range.

Sometimes, we see people who think they are fat and sometimes starve themselves, or who are on permanent diets. This does not necessarily mean that they have an eating disorder, but it does show how anorexia and bulimia might be extreme versions of common occurrences.

4.3.1 Anorexia Nervosa

Anorexia nervosa literally means *"nervous loss of appetite"* yet people with anorexia do not lose their appetites but are often hungry and preoccupied with food. They want to eat but seem to be starving themselves. Anorexics might even love to cook for others. They might read recipe books, prepare meals, shop for food, and even work in restaurants, but they always avoid eating any caloric rich food themselves. They usually have a distorted body image and think they are fat when, in fact, they are wasting away and many anorexic people try to hide their bodies in oversized clothes.

4.3.2 Diagnosis of Anorexia Nervosa

People are diagnosed as anorexic if they weigh less than 85 per cent of the expected weight for their age and height in the normal circumstances. They might look extremely thin and feeble because of their significant weight loss, and they often have other health problems, including low blood pressure, constipation, dehydration, and low body temperature.

4.3.3 Diagnostic Criteria for Anorexia Nervosa (DSM-IV)

- Refusal to keep body weight or above 85% of the generally recognised normal level for age and height.
- Intense fear of gaining weight or becoming fat, even when underweight.
- Disturbance in experience of body weight or shape, undue influence of these factors on self-esteem or denial of the seriousness of the health risks of the current low body weight.
- If menstruation has begun, the absence of three consecutive menstrual cycles.

Two types of anorexia are recognised:

1) The restricting type in which the main focus is on restricting food intake and
2) The binge – eating/purging type in which there is regular binge eating followed by purging by vomiting, laxatives, etc;

4.3.4 Prevalence of Anorexia Nervosa

Anorexia nervosa occurs mainly in women. For every male sufferer there are 15 females who have the disorder. However, there is evidence that the number of men with eating disorders is rapidly increasing, Anorexia usually starts at between 14 and 16 years, although two researchers from Great Ormond Street children's Hospital in London, England, have reported cases of anorexia in children as young as eight year old. It is estimated that between 5 and 15 percent of people with anorexia die from it or from related disorders.

4.3.5 Bulimia Nervosa

Bulimia nervosa is characterised by sporadic episodes of compulsive binge eating. People with bulimia rapidly eat lots of carbohydrate-rich foods in a seemingly uncontrolled way. They eat more than just a load of cookies – they could eat a whole of pizza, a whole tub of ice-cream, several giant packs of potato chips, a whole creamy desert, a whole quiche, or lots of fizzy or milky drinks. They usually choose foods that are soft and easy to eat. The binge usually ends with stomach pains or some kind of purging-either self-induced vomiting or defecating as a result of taking laxatives.

Some people begin their binges by eating coloured marker food so they will be able to tell when they have thrown up all the food they took in. Although many people describe themselves as binge eaters, it is the severity and frequency of the binge eating in bulimia that makes it such a severe disorder. In mild cases a person might binge two or three times a week. In more extreme cases it might occur 30 times a week.

4.3.6 Diagnostic Criteria for Bulimia Nervosa (DSM IV)

Frequently occurring episodes of binge eating that are characterised by both

a) eating an amount of food that is definitely larger than most people would eat within a specific period of time and in similar circumstances; and
b) a sense of lack of control over eating during the overeating episode.

- Recurrent behaviour to compensate for the overeating and prevent weight gain, including vomiting, laxatives, fasting or excessive exercise.
- The occurrence of both the binge eating and the compensatory behaviours atleast twice a week for at least a 3 – month period.
- Self – evaluation that is over influenced by weight and body shape
- Bulimic behaviour that does not occur only during episodes of anorexia nervosa.

Two types of bulimia nervosa are recognised:

1) the purging type, in which vomiting or doses of laxatives are used during the current episode; and
2) the nonpurging type in which fasting or excessive exercise, but not purging is used to prevent weight again.

4.3.7 Impact of Bulimia

The process of bingeing and purging can have all sorts of side effects on the rest of the body.

Bulimia sufferers often have puffy cheeks, a bit like those of a chipmunk. That is because vomiting swells the parotid glands in the lower jaw.

Their tooth enamel can often decay because of the acid that they bring up when vomiting.

You might also notice little calluses on the back of their hands, caused by the rubbing against the upper teeth while sticking their fingers down their throats to make themselves sick.

Bulimia sufferers also have problems with their digestive tract, dehydration, and nutritional balances, and anxiety, depression, and sleep disturbance.

4.3.8 Binge Eating

It is characterised by episodes of bingeing without the use of compensatory behaviours such as purging that are seen in bulimia nervosa. Two common patterns characterise binge eating – compulsively snacking over long intervals (such as all day at work or all evening in front of the computer or television) or a consumption of large amounts of food at one time beyond the requirements to satisfy normal hunger. Binge eating disorder often leads to problems with weight regulation and sometime obesity. In clinical practice, it is difficult to distinguish between a binge eating disorder and nonpurging bulimia nervosa. Some studies found that binge eating women experienced more negative affect (depression and anxiety). This suggests that treatment approaches should focus on helping binge eaters learn to cope more adaptively with poor mood. In addition to mood, situational and cognitive factors often play important roles in binge eating.

4.3.9 Triggers of Binge Eating

- Particular stressful situations
- Particular upsetting thoughts
- Feeling guilt about something one has done
- Feeling socially isolated or excluded

- Worries about responsibilities, problems or the future
- Boredom

Self Assessment Questions

1) What are the various types of eating disorders? Explain

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2) Discuss Anorexia nervosa in terms of symptoms, diagnosis and its prevalence.

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3) Discuss bulimia nervosa in terms of diagnostic criteria and impact.

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4) What is binge eating? Discuss the triggers nof binge eating.

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4.4 CAUSES OF EATING DISORDERS

There is no single theory that can explain why people experience anorexia and bulimia. There are many biological, psychodynamic, family and socio-cultural theories that, when combined, can provide some understanding of what is happening. The theories can lay the foundation for the types of treatment the person might receive, but as yet there is no scientific explanation of why people suffer from eating disorders.

4.4.1 Biological Theories

Some theories have suggested that anorexia is caused by damage to various parts of the *hypothalamus*, the part of the brain that helps balance, monitors bodily functions and control the endocrine system via the pituitary gland. The endocrine system consists of glands such as the hypothalamus, the pituitary, and the adrenal glands. Glands communicate with each other through chemicals called hormones.

To understand the development and maintenance of eating disorders, researchers have developed the concept of the *"weight set point"*. In experiments with laboratory rats they located two different areas in the hypothalamus that control eating. The *lateral hypothalamus* (LH) produces hunger when it is activated. Even when a laboratory rat has recently been fed, it will still eat if the LH is stimulated. The *ventromedial hypothalamus* (VMH) reduces hunger when it is activated. When the VMH is destroyed, the laboratory rat will not stop eating and grows obese.

The theory proposes that the various parts of the hypothalamus work together to create something like a weight thermostat – a weight set point- that predisposes people to stay at their natural body weight. When the set point falls below a certain level, parts of the hypothalamus would also decrease the metabolic rate if a person is expending too much energy. If people exceed their set point, then another point in the hypothalamus is activated that reduces hunger and therefore reduces eating and restores the weight balance.

The set point is thought to be determined by a person's genetic makeup, early eating practices, and the body's need to maintain equilibrium.

The problem with these biological theories is that it is unclear whether brain dysfunction and changes in the neurotransmitters are causes or effects of the eating disorder.

Some people have wondered whether genetics plays a part in the development of eating disorders. Over the years there have been a series of studies of twins that have tried to determine whether anorexia and bulimia are caused by nature or nurture. But with much debate and controversy regarding the research, the conclusion seems to be that genetic factors play a minimal role.

According to some theorists, the distorted perception that anorexics have of their bodies might be connected to a blood-flow deficiency in the anterior temporal lobes of the brain. The anterior temporal lobes interpret vision; and if there is less blood flowing there, it might explain why anorexics see themselves as a fat when they are thin. However, this alone could not cause anorexia- there must be other triggers that lead to the development of the disorder.

4.4.2 Cultural Theories

Many theorists believe that pressures in western societies are mainly responsible for the origin and maintenance of eating disorders. Between 1995 and 1997 Paul Garfinkel and David Garner examined the look of Miss America contestants and playboy centrefold models over a 27 year period and found that average bust, waist, and hip size of the women featured in the magazine decreased significantly over this period. They also looked at articles in various women's periodicals from 1959 to 1970 and found that in the 1960s there was an average of 16 articles a year on dieting. By the 1970s that figure had increased an average of 23 a year.

Society's emphasis on appearance has historically exerted much greater pressure on women than on men. Some sociological theorists believe that this double standard of attractiveness has made women overly interested in their appearance, dieting, and body image. The idea is supported by trends in advertising that have presented and even to some extent defined a desirable male physical form that has led men to become more concerned than before about their own eating habits. The increasing preoccupation of the media and leisure world with male attractiveness seems to correlate to an increase in the number of men who now appear at clinics with eating disorders.

4.4.3 Family Theories

The family functions like mini society and can often be the starting point for the development of eating disorders. Research shows that about half of the families of people with eating disorders have a history of making big issues of thinness, food, and body image. From early childhood food can be powerful tool for communication between parents and children. Systems theorists are scientists and thinkers who see relationships between all sorts of systems, big or small, physical or abstract, scientific or social. Psychologists who subscribe to systems theory take the view that a family will come to set its own level of homeostasis, or balance. They suggest that the presence of someone with an eating disorder in the family is really only an expression of some pre-existing family disturbance.

The family therapist Salvador Minuchin is a leading systems theorist who has suggested that an enmeshed family pattern often leads to the development of an eating disorder in one of the children. Enmeshment occurs when parent and child are overly involved in each other's lives. On the one hand, enmeshment can create affectionate, close, and loyal relationships. On other hand, it can prevent a child or young adult from growing up and becoming independent.

Adolescence can be a real crisis point for enmeshed parents and children since the young are trying to establish themselves in the grown-up and are searching for identity. It can disrupt the balance of the family. The parents might no longer feel needed, the roles need to change, and as the family seeks to regain its balance, the child is moved to take on a sick role. If the family functions to look after the sick child, the pain of growing up and many other potential conflicts are avoided. In such instances family therapy can be used to help the family face the underlying tensions and shift the eating pattern.

Anorexia is prevalent in the middle-class female children from families with high aspirations whose parents have a professional back ground. It is also more common in those who go on to higher education than in those leave school at the earliest opportunity. Anorexia suffers are often A-grade students who give perfection in all they do – including the way the look. The pressure on these young women to succeed might just to be great, and it sends them into a spiral anorexia or bulimia and anxiety or depression.

4.4.4 Other Possible Causes

Cognitive behavioural and psychodynamic theories are derived from the increasingly popular idea that eating disorders are linked with dieting behaviour. It is akin to a stimulus response mechanism.

Anorexics might be striving for perfection and so go on diets to achieve their ideal weight. When they reach this goal, they might well receive admiration from those around them. And this further reinforces their dieting behaviour and so it goes on in a vicious circle. Reward for not eating might come in the form of attention from family and friends. There might also be approval-the anorexic looks like an athlete or a supermodel and gets admired for it. For bulimia sufferers the reinforcement might come from bingeing and purging, which reduce their anxious thoughts.

Psychiatrist Hilde Bruch was particularly influential in cognitive and psychodynamic understandings of anorexia and bulimia. She argued that disturbed mother-child interactions lead to ego deficiencies in the child (poor sense of autonomy and control), and this causes severe perceptual and other cognitive disturbances. According to the theory, parents fail to respond to their children effectively. For instance, a child cries, and rather than trying to understand what the crying is about- the child might be tired, hungry or scared- the parent will give food for comfort. According to Bruch, children treated this way fail to develop cohesive self. They grow up confused and not sure of when they are hungry or when they are tired. As they grow to adolescents, they need to develop and increased sense of autonomy yet become stuck because they are unable to be independent and judge their own sense of self.

Self Assessment Questions

1) Discuss the biological causes of eating disorders.

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2) What are the cultural theories of eating disorders?

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3) Elucidate the family theories as applicable to eating disorders.

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4) Discuss the other possible causes of eating disorders.

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4.5 TREATMENT OF EATING DISORDERS

A wide variety of treatments have been used with eating disorders. Treatments used range from biologically based approaches involving antidepressants, antianxiety drugs and appetite stimulants to psycho therapy and family therapy based on psychodynamic principles, behavioural and cognitive behavioural therapies and educational therapies such as nutritional education. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy.

4.5.1 The Biological Treatment

The biological treatments show that in 33% cases there is drop out from the treatment. This when compared to the cognitive therapy, which has only a rate of 5% drop out.

4.5.2 Family Treatment

Treatment includes neither biweekly nor monthly family meetings. Sometimes friends of the client and other people can also attend the meetings. The therapist encourages the family to explore its beliefs and behaviours about the disorder and other related family issues.

Therapists work in pairs or teams. The family is encouraged to do homework tasks. The specific nature of intervention is based on the therapist's working hypothesis.

4.5.3 Cognitive Behavioural Treatment

Weekly to biweekly therapy with cognitive therapist. The therapist focuses on interaction between thoughts, feelings and eating behaviours. Behaviours that creat and maintain thinness are negatively reinforced (reduced) by the removal of anxiety. The client and therapist explore society's perception of physical attractiveness. They also examine the client's beliefs about body image. An educational component of the therapy consists of assessing dietary and physical possibilities. The client's monitoring negative automatic thoughts , keeping food diaries and completing rating scales.

4.5.4 Psychoanalytic Treatment

Weekly to 5 times a week individual therapy. The therapy seeks to make the unconscious motivation as conscious motivation of disordered behaviours. It uses the relationship between the therapist and client to explore important relationships in the client's early life, as for example the one that the client had with his or her parents.

4.6 LET US SUM UP

The prevalence of eating disorders appears to have increased over the past 50 years. The major eating disorders are anorexia nervosa, in which the individual seems obsessed with thinness and loses a great deal of weight. Bulimia nervosa, in which excessive quantities of food are eaten followed by purging and binge eating in which large quantities of food are eaten but there is no purging. Personality, family and cultural factors play significant role in causing these disorders. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy.

4.7 UNIT END QUESTIONS

1) What are eating disorders? Explain their nature and symptoms.
2) What is the prevalence of eating disorders? Discuss eating disorders as being obtained in India.
3) What are the various types of eating disorders?
4) Elucidate the causes of eating disorders.
5) Differentiate anorexia nervosa and bulimia nervosa.
6) Discuss the treatment methods used in treating eating disorders.

4.8 SUGGESTED READINGS

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