UNIT 1 PSYCHOANALYSIS/ PSYCHODYNAMIC COUNSELING

Structure

1.0 INTRODUCTION

Psychodynamic therapy (or Psychoanalytic Psychotherapy as it is sometimes called) 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. Like psychoanalysis, Psychoanalytic Psychotherapy uses the basic assumption that everyone has an unconscious mind (this is sometimes called the subconscious), 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. An example of one of these defenses is called denial, which you may have already come across.

Psychodynamic therapy assumes that these defenses have gone wrong and are causing more harm than good that is why you have needed to seek help. 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.

Psychodynamic psychotherapy takes as its roots the work of Freud (who most people have heard of) and Melanie Klien (who developed the work with children) and Jung (who was a pupil of Freud's yet broke away to develop his own theories).

Psychodynamics takes the approach that our past affects our present. Those who forget history are doomed to repeat it, and this is the same for an individual. Though we may repress very early experiences (thus we do not remember them), the theory is that the "Id" never forgets the experiences. As a child if we had been rewarded with sweets, even today when matured and grown up we reach out for the tub of ice cream whenever we are depressed and we want cheering up.

1.1 OBJECTIVES

On successful completion of this unit, you will be able to:

- Describe the origin and evolution of Psychoanalysis;
- Describe the origin and meaning of Psychoanalysis;
- Define Psychoanalysis/Psychodynamics;
- Define and understand counseling;
- Understand Psychological counseling and its requirement; and
- Explain the use of Psychoanalytic/Psychodynamic counseling.

1.2 PSYCHODYNAMIC / PSYCHOANALYSIS

1.2.1 Freud and Psychoanalysis

Sigmund Freud, a Viennese neurologist (1856-1939), is clearly one of the most influential writers of the twentieth century, admired for his wit, intellect, and willingness to revise and improve his theories as his clinical experience grew. Freud began his practice at a time when there were fewer effective from of treatment in most fields of medicine. Effective treatment generally depends on an understanding of the causes of a disorder, and at that time, although accurate diagnoses could sometimes be made, little was known about the causes of disease, whether physical or mental. A disorder that was particularly common during the late 1800s was hysteria, the presence of physical problems in the absence of any physical causes. Like other well trained neurologists of his time, Freud originally used hypnosis to help his hysterical patients lose their symptoms. Then a friend, Joseph Breuer, told Freud that while under hypnosis one of his patients had recalled and understood the emotional experience that had led to the development of her symptoms, and that her symptos had then disappeared. For a time Freud and Breuer used this method of recapturing memories with some success.

However, because some patients were not easy to hypnotize and sometimes the positive effects did not last long. Freud began to develop his method of psychoanalysis, in which the patient recaptures forgotten memories without the use of hypnosis. Freud's psychoanalytical method made him enormously influential among European clinicians. By the time he visited the United States in 1909, his reputation had already spread across the Atlantic.

1.2.2 Freud's Theory of Personality

Freud's theory of personality may seem complicated because they incorporate many interlocking factors, but two basic assumptions viz., psychic determinism and the conscious unconscious dimension underlie the theory

The principle of psychic determinism states that all behaviour, whether overt (e.g. a muscle movement) or covert (eg., a thought), is caused or determined by prior mental events. The outside world and the private psychic life of the individual combine to determine all aspects of behaviour. As a clinical practitioner, Freud sought to modify unwanted behaviour by identifying and eliminating its psychic determinants.

Freud assumed that mental events such as thoughts and fantasies varied in the ease with which they come to the individual's awareness. For example, aspects of mental life that are currently in awareness are the conscious. Mental contents that are not currently at the level of awareness but can reach that level fairly easily are the preconscious. Mental contents that can be brought to awareness only with great difficulty are the unconscious. Freud was interested mainly in how these unconscious mental contents could influence overt behaviour.

Freud was especially intrigued by thoughts and fantasies that seen to go underground but then reappear at the conscious level. He asserted that the level of intra psychic conflict we a major factor in determining our awareness of particular mental events. According to Freud, the classic example of intra psychic conflict is when a young boy desires to take his father's place in relation to his mother, but at the same time feel love and affection for his father. Freud believed that the greater the degree of intra psychic conflict, the greater the likelihood that the mental events connected with it would remain unconscious. The more massive the unconscious conflict, the greater the person's mental events that may remain in the unconscious. The central hypothesis of Freudian psychoanalysis is that human behavior is determined in large part by unconscious motives (Freud, 1961). Our personality and our actions, argued Freud, were in large part determined by thoughts and feelings contained in the unconscious. Repressed content of the unconscious inadvertently slips through into our words or deeds, resulting in what is commonly called as the 'Freudian slip'. If most activities are governed by the unconscious, the individual may have limited responsibility for his or her actions.

Psychoanalytic / psychodynamic practitioners who use this approach tend to view psychological distress as being related to unconscious mental processes (Jacobs, 1998). Freud's contribution in regard to the mental processes, the unconscious, defense mechanisms etc., have all been developed and expanded by others who were Freud's students or disciples. Some have followed his basic assumptions, and others have developed more independent approaches. The term "psychodynamic" offers a wider perspective, which encompasses the different analytical approaches. As Jacobs (1998) suggested, psychodynamic implies that the psyche (mind/emotions/ spirit/self) is active, not static. These internal mental processes are dynamic forces that influence our relations with others.

The structural concept of Freud's theory of personality consisted of the id, ego, and superego. The id consists of everything present at birth, including instincts. The ego is the executive of the personality, because it controls the gateways to action, selects the features of the environment to which it will respond, and decides which needs will be satisfied and in which order. The superego is the internalised representative of the traditional values, ideals, and moral standards of society and the super ego strives for perfection.

Under the pressure of excessive anxiety, the ego is forced to take extreme measures to relieve the pressure. These measures are called defense mechanisms, because they defend the ego against anxiety. The principal defenses are repression, projection, reaction formation, intellectualisation, denial, rationalisation, displacement, and regression. These defense mechanisms have crept into contemporary therapy as denial and regression. Hence, someone is in denial because they are unable to accept a tragic event as having occurred and keep on stating that it had not occurred. Or to take another example, a child regresses to a previous developmental stage as a way of dealing with a tragic death.

In general, Psychodynamics, also known as dynamic psychology, is the study of interrelationship of various parts of the mind, personality, or psyche as they relate to mental, emotional, or motivational forces especially at the unconscious level. The mental forces involved in Psychodynamics are often divided into two parts

a) *Interaction of emotional forces*: the interaction of the emotional and motivational forces that affect behaviour and mental states, especially on a subconscious level;

b) *Inner forces affecting behaviour*: the study of the emotional and motivational forces that affect behaviour and states of mind;

Freud proposed that psychological energy was constant (hence, emotional changes consisted only in displacements) and that it ended to rest (point attractor) through discharge (catharsis).

In mate selection psychology, psychodynamics is defined as the study of the forces, motives and energy generated by the deepest of human needs.

1.2.3 Origin of Psychodynamics

The original concept of "psychodynamics" was developed by Sigmund Freud. Freud suggested that psychological processes are flows of psychological energy in a complex brain, establishing "psychodynamics" on the basis of psychological energy, which he referred to as the libido.

In general, psychodynamics studies the transformations and exchanges of "psychic energy" within the personality. A focus in psychodynamics is the connection between the energetics of emotional states in the id, ego and superego as they relate to early childhood developments and processes.

At the heart of psychological processes, according to Freud, is the ego, which is envisioned as battling with three forces, viz., the id, the superego and the outside world. Hence, the basic psychodynamic model focuses on the dynamic interactions between the id, ego and superego. Psychodynamics, subsequently, attempts to explain or interpret behaviour or mental states in terms of innate emotional forces or processes.

1.2.4 History of Psychodynamics

Psychodynamics was initially developed by Sigmund Freud, Carl Jung, Alfred Adler and Melanie Klein. By the mid 1940s and into the 1950s, the general application of the "psychodynamics theory" had been well established.

In his 1988 book "Introduction to psychodynamics – a New Synthesis", psychiatrist Mardi J. Horowitz states that his own interest and fascination with psychodynamics began during the 1950s, when he heard Ralph Greenson, a popular local psychoanalyst

who spoke to the public on topics such as "People who hate", and also his speeches on the radio at UCLA. In his radio discussion, according to Horowitz, he 'vividly described neurotic behaviour and unconscious mental processes and linked psychodynamics theory directly to everyday life.

In the 1950s, American psychiatrist Eric Berne built on Freud's psychodynamic model, particularly that of the "ego states", to develop a psychology of human interactions called transactional analysis which, according to physician James R. Allen, is a "Cognitive behavioural approach to treatment and that it is a very effective way of dealing with internal models of self and others as well as other psychodynamic issues." The theory was popularized in the 1964 book "Games people Play".

1.3 MEANING OF PSYCHODYNAMICS

1) Psychodynamics is the systematic study and theory of the psychological forces that underlie human behaviour, emphasising the interplay between unconscious and conscious motivation.
2) The psychology of mental or emotional forces or processes developing especially in early childhood and their effects on behavior and mental states.
3) Explanation or interpretation, as of behaviour or mental states, in terms of mental or emotional forces or processes.
4) Motivational forces acting especially at the unconscious level.

1.3.1 Definition of Psychodynamics

According to the American psychologist Calvin S. Hall, from his 1954 "Primer in Freudian psychology", the definition of psychodynamics is as given below:

"A dynamic psychology is one that studies the transformations and exchanges of energy within the personality."

This was Freud's greatest achievement and as one of the greatest achievements in modern science, it is certainly crucial in the history of psychology.

In 1930s, Freud's daughter Anna Freud began to apply Freud's psychodynamic theories of the "ego" to the study of parent child attachment and especially deprivation and in doing so developed ego psychology.

1.3.2 Freudian Psychodynamics

According to Freud, the ego is seen as battling with three forces, the id, the super ego and the outside world. In his writings about the "engines of human behaviour", Freud used the German word "Id" a word that can be translated into English as either instinct or drive.

1.3.3 Jungian Psychodynamics

A Swiss psychiatrist Carl Jung's in his first book, published in the year 1907, entitled, "Psychology of dementia praecox", upheld the Freudian psychodynamic view point, although with some reservation.

Carl Jung's contribution in psychodynamics psychology includes the following:

1) The psyche tends toward wholeness.
2) The self is composed of the ego, the personal unconscious, the collective unconscious,and the archetypes.

3) Archetypes are composed of dynamic tensions and arise spontaneously in the individual and collective psyche. Archetypes are autonomous energies common to the human species. They give the psyche its dynamic properties and help organise it.

4) The transcendent function: the emergence of the third resolves the split between dynamic polar tensions within the archetypal structure.

5) The recognition of the spiritual dimension of the human psyche.

6) Recognition of the multiplicity of psyche and psychic life.

Psychodynamic therapy 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. Like psychoanalysis, psychodynamic psychotherapy uses the basic assumption that everyone has an unconscious mind, and that feeling held in the unconscious mind are often too painful to be faced. Thus we come up with defenses to protect us from becoming aware of these painful feelings.

Psychodynamic therapy assumes that these defenses have gone wrong and are causing more harm than good that is why you have needed to seek help. 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 feeding will not be as painful.

1.3.4 Meaning of Psychodynamic Counseling

Psychodynamic counseling is based on acceptance, empathy and understanding, with an emphasis on developing a good working alliance that fosters trust. The counselor takes account of the real world of the client, including the impact of trauma, cultural difference, sexual orientation, disability and social context.

Psychodynamic counseling places more emphasis on the influence of past experience on the development of current behaviour, mediated in part through unconscious processes. It is influenced by object relations theory, that is, by the idea that previous relationships leave lasting traces which affect self esteem and may result in maladaptive patterns of behaviour.

Psychodynamic counseling skills and theory can be valuable in many working and social environments. The insight and understanding about human functions gained from psychoanalytic theory can enhance the life of the counselor as well as the client and can be put to a variety of good uses.

1.3.5 Meaning of Psychodynamic Theory

Psychodynamic psychotherapy is derived from psychoanalysis and is based on a number of key analytical concepts. These include Freud's ideas about psychosexual development, defense mechanisms. Free association as the method of recall, and the therapeutic techniques of interpretation, including that of transference, defenses and dreams. Such therapy usually involves once-weekly 50-minute sessions, the length of treatment varying between 3 months and 2 years. The long-term aim of such therapy is twofold: symptom relief and personality change.

Psychodynamic psychotherapy is classically indicated in the treatment of unresolved conflicts in early life, as might be found in non psychotic and personality disorders, but to date there is a lack of convincing evidence concerning its superiority over other forms of treatment.

Psychodynamic theory is based on the premise that human behaviour and relationships are shaped by conscious and unconscious influences.

Psychodynamic therapies, which are sometimes used to treat depressed persons, focus on resolving the patient's conflicted feelings. These therapies are often reserved until the depressive symptoms are significantly improved.

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1.3.6 Psychological Counseling

Counseling is as old as society itself. In every day life, we find, counseling goes on at many levels in a family set up, parents counsel their children, in society doctors counsel patients, lawyers their clients, and teachers their students. There is no limit to the problems on which counseling can be offered nor to the persons who can render this help. Counseling is the core of the guidance program and is considered to be its most intimate and vital part.

1.3.7 Definition of Professional Counseling

What counseling is, especially the Professional counseling, in its present form, which is a recent development. Educational institutions, industries and business establishments are becoming increasingly interpersonal in their relationships. It is believed, where no counsel is, the people fall. But in the multitude of counselors, there is safety. No wonder, counseling is being recognised as an important technique of guidance. Counseling has been understood and defined in a number of ways:

The Webster's dictionary defines counseling as "consultation, mutual interchange of opinions, deliverating together."

Wren says, "Counseling is a dynamic and purposeful relationship between two people who approach a mutually defined problem with mutual consideration of each other to the end that the younger or less mature, or more troubled of the two is aided to a self-determined resolution of his problem."

Pepinsky and Pepinsky feel that, "Counseling relationship refers to the interaction which

i) occurs between two individuals called "the counsellor" and the "client",

ii) takes place within a professional setting, and

iii) is initiated and maintained as a means of facilitating changes in the behaviour of the client.

The counseling relationship develops from the interaction between two individuals, one a professionally trained worker and the other a person who seeks his services."

Hahn and MacLean define counseling as "a process which takes place in a one to one relationship between an individual beset by problems with which he cannot cope alone and a professional worker whose training and experience have qualified him to help others reach solutions to various types of personal difficulties."

An analysis of the above view points will reveal the major elements of counseling:

Counseling involves two individuals, that is, one seeking help and the other, a professional, trained person, who can help the first.

There should be a relationship of mutual respect between the two individuals. The counselor should be friendly and co-operative and the counselee should have trust and confidence in the counselor.

The aim of counseling is to a help a students form a decision, make a choice or find a direction at some important fork in the road such as that of planning a life career, a programme in college or university, or a campaign to obtain employment.

It helps the counselee acquire independence and develop a sense of responsibility. It helps him explore and utilise his potentialities and actualise himself.

It is more than advice giving. The progress comes through the thinking that a person with a problem does for himself rather than through solutions suggested by the counselors.

It involves something more than the solution to an immediate problem. Its function is to produce changes in the individual that will enable him to extricate himself from his immediate difficulties.

It concerns itself with attitudes as well as action.

Emotional rather than purely intellectual attitudes are the raw material of the counseling have their place in the counseling process. But it is the emotionalized feelings which are most important.

1.3.8 Counseling and Psychotherapy

Differences between Psychotherapy and Counseling

Psychotherapy has roots in Freudian psychodynamics, so that a medical aspect to the training was involved in the past, which lends it an air of respectability.

The training period for psychotherapy is long, and involved working with real clients under supervision. The courses in counseling have training shorter and less intensive.

Also psychotherapy requires a long period of self analysis.

Psychotherapy focuses on in-depth consideration of past issues.

As compared to psychotherapy, counseling courses are short, cheaper and more accessible courses and they are very inclusive. Working mothers, part time workers, the unemployed etc can normally find some way to take some form of counseling course.

Psychotherapy involves working in greater depth than counseling, that clients see their therapist more frequently and for a long period of time. By contrast counseling takes place over a shorter period of time.

Counseling is seen to be about short-term help, and psychotherapy about longer term. The focus in psychotherapy is on the past causes of the issues whereas the focus of counseling is in regard to the present issues.

Psychotherapy is concerned with some type of deeper personality change; but counseling is concerned with helping individuals develop their full coping potential in regards to some particular issue.

The setting of the treatment in counseling session often takes place in a number of non-medical settings such as an office or small therapy centre, or even in the therapists flat. Where as Psychotherapy is often thought of as taking place in a more medical setting, perhaps a clinic or hospital.

Psychotherapy is better for those who find it difficult to open up,

Counseling, according to Morgan-Ayers, is a process in which the therapist is there as a 'tour guide' for the client, refocusing them in a process that they are otherwise quite good at exploring themselves.

Similarities between Psychotherapy and Counseling

The aims of both are similar.

Both can be seen as an attempt to allow the person to build up resources to live in more healthy, meaningful and satisfying ways, and to develop self awareness.

Also a high degree of respect for the autonomy of the client is a basic principle in both counseling and Psychotherapy.

Both counseling and psychotherapy involve clear contracts between the therapist and the client as to what the aims are and the roles involved.

Both counseling and psychotherapy require the therapist to have highly developed skills.

Counseling and psychotherapy are different. Although the psychotherapist uses counseling as one of the techniques of treatment, psychotherapy is usually concerned with individuals whose behavior is neurotic. While it deals with repressed individuals, counseling is concerned with normal anxieties. Psychotherapy operates in a medical setting, whereas counseling operates in an educational environment. The psychotherapist uses play therapy, psychodrama, and socio-drama as techniques.

In counseling, such techniques are used as can be employed in educational institutions and individual establishments. Psychotherapy is deeper in scope, whereas counseling has wider implications. A counselor cannot be a psychotherapist, but a psychotherapist being better and specially qualified can be a counselor.

1.3.9 Classification of Counseling

Generally, categorisation of counseling is based on the nature and character of situation, age group, community, society, etc.

There are so many classification of counseling like students counseling, educational counseling, interpersonal and intra personal counseling, adolescent counseling, social counseling, marriage counseling, pre-marital counseling, counseling related to any kind of behaviour, habits and attitudes, career counseling, counseling related to social problems, industrial counseling, management counseling, counseling of life threatening factors…etc.

So the subject of counseling is like big ocean. No definite definition and a single tested approach can be applied for all cases. It is heterogeneous in nature. Every case is different, but approach can be common in most of the cases. Reasons are not same for the same cases. Why? Man is a social animal with variable natures, attitudes, aptitudes, aspirations reactions, different responsive nature. It is different from person to person. So no single approach and solutions can be offered. Every case has to be studied separately and to be dealt carefully with deeper and committed insight.

Counseling can thus be classified according to the nature of the problem, the complexity of treatment, and the competence of the counselor. Some writers classify counseling in terms of several factors. Lloyd Jones and Smith, for example, describe various levels of counseling with respect to the depth of the problem, length of contact, degree of need, and the skill of the counselor.

At the surface level is the counseling offered when the student wishes only some item of information. The counseling given may be casual; it is brief, and it may be superficial in that it is not extensive or intensive. The need for help is important even though slight, and the relationship maintained through the brief contact should not be less than that maintained during the long counseling session.

Counseling at the next level requires a more prolonged contact because the counselee needs more of complicated information. He may, for example, wish assistance in planning a programme of study for a two or a four year period. As the problems become complicated and as an intensive study of the case is required, and more specialised help is needed, counseling at deeper levels becomes necessary.

When the student is seriously disturbed, therapeutic counseling may be needed. Williamson feels that counseling is needed not only for helping individuals to gain insight into their emotional conflicts but also for helping them with problems stemming from lack of information, such as information about vocational aptitudes and interests or about work opportunities, so that they may conduct their future adjustments in such a way that a 'minimum of maladaptive repressions' occur.

1.3.10 Goals of Counseling

Counseling goals may be simply classified in terms of counselor goals and the client goals or the immediate intermediate or long range goals of therapy. Regardless of how one chooses to classify the goals, counseling, like all other meaningful activities, must be goal driven, have a purpose, or seek an objective. Broadly speaking counseling goals may be separated into following categories:

Developmental goals wherein client is assisted in meeting his/her anticipated human growth and development.

- Preventive goals
- Enhancement goals
- Remedial goals
- Exploratory goals
- Reinforcement goals
- Cognitive goals
- Psychological goals
- Physiological goals

1.3.11 Principles of Counseling

Relationship between the counselor and counseling is based on prevalent amount of trust, confidence and openness. Here the counselor will be helping the client to find his existent potentialities.

Respect: This is a very important principle of counseling. The counsellor must respect the client and whatever he or she is expressing with concern, respect and understanding.

Transparency and understanding in communication: The Counsellor must be transparent and must not say something while thinking the opposite. Every attempt should be made by the counsellor to understand whatever is being expressed by the client with genuine interest and concern.

Knowing the counsellor understanding him from his situation: This is yet another important principle. In this the counsellor is expected to know the client completely in terms of the facts gathered during interview and also view him and his problems from the situation that the client faces.

Availability: After giving an appointment at a particular time, the counsellor should never miss the appointment. In case there is an emergency and the appointment cannot be kept up, the counsellor must inform the client ahead in advance and apologise for the cancellation.

Privacy: Whatever is being told by the client has to be considered as completely private and at no time these information should be conveyed to anyone without the clear permission from the client.

Positive approach and recognising client's potentiality: The counsellor must have a positive approach towards the client and his or her problems and should recognise the potentialities that the client has.

Focusing on follow up specifications.

Trustworthy and no misrepresentation/ black mail.

Constant /regular consultation is essential.

1.3.12 Steps in Counseling

The action of transition of theories into action is referred to as counseling process. A process usually specified by a sequence of interaction of steps. Hackney and Cormier (1996) identified the stages as follows:

- Relation establishment.
- Problem identification and exploration.
- Planning for problem solving.
- Solution application and termination.

Self Assessment Questions

1) Psychodynamic counseling places more emphasis on _____ on the development of current behaviour.
2) Counselor's goal is to establish a _____ and _____ relationship.
3) Problem identification is main purpose of counseling (True/False).
4) Psychodynamics is a part of psychoanalysis (True/False).

1.4 THE SITUATION IN WHICH COUNSELING IS REQUIRED

The following are some of the situations in which counseling is needed:

1) When the student needs not only reliable information but an interested interpretation of such information as meets his own personal difficulties.

2) When the student needs a wise, sympathetic listener with broader experience than his own, to whom he can recount his difficulties and from whom he may gain suggestions regarding his own proposed plan of action.

3) When the counselor has access to facilities for helping in the solution of a students' problem.

4) When the student is unaware that he has a certain problem but, for his best development, must be aroused to a consciousness of that problem.

5) When the student is aware of a problem and of the strain and difficulty it is causing, but is unable to define and understand it, and is unable to cope with it independently.

The Psychoanalytical context, then, reducing tension becomes a major goal of counseling. Because personality conflict is present all people, nearly everyone can benefit from professional counseling. In as much the Psychoanalytical approach requires insights that in turn rely on openness and self disclosure.

Psychoanalytic theory usually views the client as a person in need of assistance in restructuring his / her personality. The counselor in the role of expert will facilitate or direct this restructuring. The client will be encouraged to talk freely, to disclose unpleasant, difficult, or embarrassing thoughts.

The counselor will provide interpretation as appropriate, attempting to increase client insights. This in turn may lead the client to work through the unconscious and eventually achieve the ability to cope realistically with the demands of the client's world and society as a whole. In this process, among the techniques the psychoanalytic counselor may employ projective tests, play therapy, dream analysis and free association, all of which require special training for the counselor, usually available only at the doctoral level.

1.5 LET US SUM UP

We have discussed the theoretical basis and origin of Psychoanalysis and Psychodynamics and it's uses in counseling role and goals of counseling. The clear meaning and definition of Psychoanalytic/Psychodynamic counseling.

The students may find the theoretical background helpful to get the clear understanding of counseling in Psychoanalytic context.

1.6 UNIT END QUESTIONS

1) When or under what circumstances would you encourage a friend to seek counseling?

2) What are the basic elements of Psychoanalysis?

3) What is the origin of Psychodynamics?

4) What are the goals of a counselor?

5) What is Psychoanalytic counseling?

1.7 SUGGESTED READINGS

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Seligman, L. (2001): *"Systems, Strategies and Skills of Counseling and Psychotherapy"*, N. J. Merrill, Prentice Hall

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UNIT 2 INSIGHT AND SHORT TERM COUNSELING

Structure

2.0 INTRODUCTION

It has already been discussed what are the objectives of counseling in general along with one method of counseling has also been discussed earlier. It should be kept in mind always that there are several methods / modalities in counseling clients. But all may not be applicable for at all the clients at all the times. Hence we discuss other modalities as well, which have usage for specific populations. Short term counseling and insight counseling are our topic of discussion here. Counseling is an attempt to uncover the deep causes of the individual's problem and to help eliminate defense mechanisms

Counseling is the treatment of a personality disorder by attempting to uncover the deep causes of the individual's problem and to help eliminate defense mechanisms

2.1 OBJECTIVES

On successful completion of this unit, you will be able to:

- Define insight as a counseling method;
- Define insight counseling;
- Describe various insight therapies;
- Explain short term counseling;
- Elucidate the characteristics of short term counseling;
- Define brief therapy; and
- Differentiate between short term counseling and other modalities.

2.2 INSIGHT AS A COUNSELING METHOD

Having the capacity to step outside of one's immediate experience and to think about oneself from the perspective of an observer is a very useful ingredient for most Psychoanalytic and Psychodynamic interventions. That is what insight is all about.

Insight is a major goal of both Psychoanalysis and Psychodynamic Psychotherapy counseling because of the belief that as people acquire a more realistic view of their motivations and the needs of other people, the likelihood of behavioral change increases.

2.2.1 Definition of Insight

Insight is self knowledge, understanding the significance and purpose of one's motives or behaviour including the ability to recognise the inappropriateness and irrationality.

2.2.2 Definition of Insight Counseling

"Insight is an integral process in both individual and group process where the client makes connection between new information generated in therapy and present circumstances."

2.2.3 Counseling and Insight

Insight recognises that the first step to solving any problem begins with asking the right questions. Psychologists help their clients to become aware of factors affecting their well being and plan out a treatment programme which is the most appropriate for the client's problem. Insight promotes the mental health of the clients by generating an awareness into their own conflicts and problems and how the same was caused and what could be done to overcome the same. Insight can help clients to realise their full potentials.

Insight actually refers to the treatments involving complex conversations between therapists and clients. The treatment helps clients understand the nature of their problems and the meaning of their behaviour, thoughts and feelings. In other words it helps the person become aware of why he behaves as he does.

Thus insight therapy is an umbrella term used to describe a group of different therapy techniques that have some similar characteristics in theory and thought. Insight therapy assumes that a person's behaviour, thoughts, and emotions become disordered

because the individual does not understand what motivates him, especially when a conflict develops between the person's needs and his drives. The theory of insight therapy, therefore, is that a greater awareness of motivation will result in an increase in control and an improvement in thought, emotion, and behaviour. The goal of this therapy is to help an individual discover the reasons and motivation for his behaviour, feelings, and thinking. The different types of insight therapies are described below.

2.2.4 Psychoanalysis

Freud believed that personal development is based on inborn, and particularly sexual, drives that exist in everyone. He also believed that the mind, or the psyche, is divided into three parts, namely the Id, Ego and the Superego. These three parts function together as a whole and these three parts represent specific energies in a person.

Psychoanalytic theory and psychoanalysis are based on Freud's second theory of neurotic anxiety, which is the reaction of the ego when a previously repressed id impulse pushes it to express itself. The unconscious part of the ego, for example, encounters a situation that reminds it of a repressed childhood conflict, often related to a sexual or aggressive impulse, and is overcome by an overwhelming feeling of tension. Psychoanalytic therapy tries to remove the earlier repression and helps the patient resolve the childhood conflict through the use of adult reality. The childhood repression had prevented the ego from growing; as the conflict is faced and resolved, the ego can reenter a healthy growth pattern.

There are certain important psychoanalytic techniques such as free association, dream analysis, transference etc. In free association the client is free to express what ever he or she wants without inhibition. In the process the client brings into the conscious many of the repressed materials which normally he cannot mention without feeling guilty or ashamed. Once these repressed materials come into the conscious, the therapist or the counsellor is able to provide insight to the client regarding these materials and how these in turn are causing the various symptoms and problems. This insight helps the client to face the problem squarely and understand his or her own behaviours in terms of the root causes. Once the cause is known, the client is able to get over the problem. Thus insight development in psychoanalysis through free association is undertaken.

Another technique of psychoanalysis is what we call as the dream analysis. When a person sleeps the repressed materials are allowed to enter the consciousness. However as these repressed thoughts are threatening they cannot be experienced in their actual form. The thoughts are disguised in dreams, which then become symbolic and significant to the client's psychoanalytic work. As the dreams are told and narrated to the counsellor / therapist, the same is analysed and interpreted by the therapist. As the dreams are interpreted the therapist helps the client to develop insight into the causes of his problems as interpreted from the dreams. This insight helps the client to understand why he behaved as he did and thus change the behaviour.

Another technique of psychoanalysis is the transference. Through transference the psychoanalyst gains insight into the childhood origin of repressed conflicts. One focus of psychoanalysis is the analysis of defenses. This can provide the analyst a clear picture of some of the patient's conflict. The counsellor studies the client's defense mechanisms which are the ego's unconscious way of warding off a confrontation with anxiety. The counsellor tries to interpret the client's behaviour, pointing out its defensive nature in order to stimulate the client to realise that she is avoiding the topic. This insight helps the client to understand the underlying conflicts and helps overcome the problems and symptoms.

2.2.5 Humanistic and Existential Approach

These also fall under the category of insight therapies. These therapies are insight focussed and they are based on the assumption that disordered behaviour can be overcome by increasing the awareness of the client of their motivation and needs. Humanistic and existential therapists / counsellors place more emphasis on a person's freedom of choice, and believe that free will is a person's most valuable trait and is considered a gift to be used wisely.

Analytical psychology organises personality types into groups; the familiar terms "extraverted," or acting out, and "introverted," or turning oneself inward, are Jungian terms used to describe personality traits. Developing a purpose, decision making, and setting goals are other components of Jung's theory. Whereas Freud believed that a person's current and future behaviour is based on experiences of the past, Jungian theorists often focus on dreams, fantasies, and other things that come from or involve the unconscious. Jungian therapy, then, focuses on an analysis of the patient's unconscious processes so the patient can ultimately integrate them into conscious thought and deal with them. Much of the Jungian technique is based on bringing the unconscious into the conscious.

In explaining personality, Jung said there are three levels of consciousness: the conscious, the personal unconscious, and the collective unconscious.

2.2.6 Psychodynamic Therapy

In 1946, psychodynamic therapy was developed in part through the work of Franz Gabriel Alexander, M.D., and Thomas Morton French, M.D., who were supporters of a briefer analytic therapy than Freud's psychoanalytic theory, using a present and more future-oriented approach. Influenced by such Freudian concepts as the defense mechanism and unconscious motivation, psychodynamic therapy is more active than Freudian therapy and focuses more on present problems and relationships than on childhood conflicts. Psychodynamic therapy slowly examines the true sources of client's tension and unhappiness by facing repressed feelings and eventually lifting that repression.

The personal unconscious is the landing area of the brain for the thoughts, feelings, experiences, and perceptions that are not picked up by the ego. Repressed personal conflicts or unresolved issues are also stored here. Jung wove this concept into his psychoanalytic theory: often thoughts, memories and other material in the personal unconscious are associated with each other and form an involuntary theme. Jung assigned the term "complex" to describe this theme. These complexes can have an extreme emotional effect on a person.

Jung believed that to fully understand people, one has to appreciate a person's dreams and not just his or her past experiences. Through analytical psychology, the therapist and patient work together to uncover both parts of the person and address conflicts existing in that person.

Self Assessment Questions

1) Define insight.

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2) Define insight counseling.

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3) What is the relationship between insight and counseling?

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4) Describe psychoanalysis as insight therapy.

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5) Elucidate humanistic approach as insight therapy.

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6) Explain psychodynamic approach as insight counseling.

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2.3 ADLERIAN PSYCHOLOGY

Adler's view of personality stressed the importance of the person as a whole but also of the individual's interaction with surrounding society. He also saw the person as a goal directed, creative individual responsible for his own future.

He emphasised in his own theories of working toward superiority, but not in an antisocial sense. Instead, he viewed people as tied to their surroundings; Adler claimed that a person's fulfillment was based on doing things for the "social good." Like Jung, Adler also argued the importance of working toward personal goals in therapy.

The main factor in Adler's work was a focus on individual psychology, or individual phenomenology—working to help patients get over the "illogical expectations" made on themselves and their lives

Crucial to the Adlerian therapy technique is the establishment of a good therapeutic relationship between therapist and patient, particularly one based on respect and mutual trust.

One of the most important goals of Adlerian therapy is the patient's increase in social interests, as well as an increase in self-awareness and self-confidence.

Adlerian therapy is a practical, humanistic therapy method that helps individuals to identify and change the dysfunction in their lives.

2.4 EXISTENTIAL THERAPY

Another insight therapy, existential therapy is based on the philosophical theory of existentialism, which emphasises the importance of existence, including one's responsibility for one's own psychological existence. One important component of this theory is dealing with life themes instead of techniques; more than other therapies, existential therapy looks at a patient's self awareness and his ability to look beyond the immediate problems and events in his or her life and focus instead on problems of human existence.

The first existential therapists were trained in Freud's theories of psychoanalysis, but they disagreed with Freud's stress on the importance of biological drives and unconscious processes in the psyche. Instead, these therapists saw their patients as they were in reality, not as subjects based on theory.

With existential therapy, the focus is not on technique but on existential themes and how they apply to the patient. Through a positive, constructive therapeutic relationship between therapist and patient, existential therapy uncovers common themes occurring in the patient's life. Patients discover that they are not living their lives to the full potential and learn what they must do to realise their full capacity.

The existential therapist must be fully aware of patients and their needs in order to help them attain that position of living to the full of their existence. As patients become more aware of themselves and the results of their actions, they take more responsibility for life and become more "active." In this sense this is a therapy that instills insight about the individual's behaviour to himself or herself.

2.5 PERSON CENTERED THERAPY

Once called nondirective therapy, the client centered therapy, person centered therapy was developed by American psychologist Carl Rogers. Drawing from years of in depth clinical research, Rogers's therapy is based on four stages, viz., (i) the developmental stage, (ii) the nondirective stage, (iii) the client centered stage, and (iv) the person centered stage.

Person centered therapy looks at assumptions made about human nature and how people can try to understand these assumptions. Like other humanistic therapists,

Rogers believed that people should be responsible for themselves, even when they are troubled. Person centered therapy takes a positive view of patients, believing that they tend to move toward being fully functioning instead of wallowing in their problems.

Person centered therapy is based more on a *way of being* rather than a therapy technique. It focusses on understanding and caring instead of diagnosis and advice, Rogers believed that change in the patient could take place if only a few criteria were met, which according to in were:

1) The patient must be anxious or incongruent (lacking harmony) and be in contact with the therapist.
2) The therapist must be genuine; that is, a therapist's words and feelings must agree.
3) The therapist must accept the client and care unconditionally for the client.
4) In addition, the therapist must understand the patient's thoughts and experiences and relay this understanding to the patient.

If the patient is able to perceive these conditions offered by the therapist, then the therapeutic change in the patient will take place and personal growth and higher consciousness can be reached. In this manner the patient develops an insight into his own conditions, the problems that are affecting him and how to handle with his own efforts etc.

2.6 GESTALT THERAPY

Gestalt psychology emerged from the work of Frederich S. Perls, who felt that a focus on perception, and on the development of the whole individual, were important. This was attained by increasing the patient's awareness of unacknowledged feelings and becoming aware of parts of the patient's personality that had been previously denied.

Gestalt therapy has both humanistic and existential aspects. Gestalt theory states that people are basically good and that this goodness should be allowed to show itself. Also, psychological problems originate in frustrations and denials of this innate goodness.

Gestalt therapists focus on the creative aspects of people, instead of their problematic parts. There is a focus on the patient in the therapy room, in the present, instead of a launching into the past; what is most important for the patient is what is happening in that room at that time. If the past enters a session and creates problems for the patient, it is brought into the present and discussed. The question of "why" is discouraged in Gestalt therapy, because trying to find causes in the past is considered an attempt to escape the responsibility for decisions made in the present. The therapist plays a role, too: Patients are sometimes forced or even bullied into an awareness of every minute detail of the present situation.

Gestaltists believed that awareness acted as a curative, so it is an integral part of this therapy process. The goal of Gestalt therapy is to help patients understand and accept their needs and fears as well as increase awareness of how they keep themselves from reaching their goals and taking care of their needs. Also, the Gestalt therapist strives to help the patient encounter the world in a nonjudgmental way. Concentration on the "here and now" and on the patient as responsible for his or her actions and behaviour is an end result.

Self Assessment Questions

1) Describe Adlerian psychology and indicate how it is insight therapy.

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2) Elucidate existential therapy approach as part of insight therapy.

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3) How does person centered approach an insight therapy?

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4) Explain Gestalt approach as an insight therapy.

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2.7 SHORT TERM COUNSELING

There has been a lot of discussion and research into the question of what kind of couple receives the most benefit from the least amount of marriage counseling. In other words, what type of couples can get help the fastest, in the least amount of sessions. Like any type of generalisation, there are absolute exceptions.

However the following will generally receive and also benefit from short term counseling, especially marriage counseling.

- Couples who are still in active love.
- Couples who are open to therapy and change.

However short term marriage counseling will not be of use to the following persons

- Couples who wait too long before seeking help.
- Couples where one is already set on getting a divorce and are closed to suggestions that may save the marriage.

Instead of looking at these items in terms of who benefits the least from short term counseling, one could look at them instead, in terms of what will benefit each the most. That is, there are different set of problems and require different solutions.

Couples who have been waiting for a long time before entering into marriage counseling are couples who have had years to build bad habits and negative responses and behaviours. Habits that took years to form take time to change and it would be not correct to assume otherwise.

Couples who are still in love but need help resolving some marital issues are having a specific problem that can be addressed in specific ways with specific solutions, making this type of relationship perfect for short term counseling.

The Basis of the Short term Model of counseling.

The short term counseling model is based on the following principles:

2.7.1 A Focus on a Specific Solution that the Counselee Wants to Get

Most people want to focus on the problem, which means looking at the negative side of the issue. While problems cannot be ignored, success is better if the major effort is aimed at the solution to the situation. The counselee is the one who selects the focus, or the preferable future. Counseling is about the counselee, not the counselor. This takes the pressure off the counsellor to be the expert, or the one who must figure out what is best for someone else. The counsellor's task is to work with the counselee in moving to a creative solution.

2.7.2 A Willingness to Change

The basis for helping people is anchored in the understanding that people do have the ability to change. Change is inevitable in people's lives. When we recognise that change is always occurring and that people are continuously changing, we are much more likely to look for change in the clients lives. We also realise that people's problems are always changing.

It is easy to slip into the misconception that change always means a radical, 180-degree reversal. At the same time it must be remembered that one does not make change in giant steps. In counseling, change is made in small, seemingly insignificant movements. Change is an action step. If a person takes even a tiny action of change, it means more change is possible.

2.7.3 A Limited Time Frame

With the many time demands on a counsellor, counseling must be kept in balance with other duties. Some people like to talk about their problems but do not really want to change.

One of the hardest aspects of counseling for most counselors is setting the necessary limits on the relationship. Limits are worked out by the counsellor and it should be adhered to by both counselee and the counsellor. In the long term counseling it is never helpful if limits are consistently ignored. Limit setting is, therefore, a part of all responsible counseling.

What is a reasonable limitation? While there are always exceptions, generally four to six sessions should be a reasonable time frame in dealing with a single, focused solution. If more time is needed, a counsellor may consider referring the counselee to someone who may be more qualified.

2.7.4 A Commitment to Spiritual Development

A person's spiritual life is not an appendage tacked on, like buying an option on a new car. Our spiritual life is related to all aspects of our human existence. "The master goal of counseling is the facilitation of psychological growth. This involves helping people to understand their problems and their lives in the light of their relationship to the others in their lives and to the counsellor and then to live more fully in this relationship. The counsellor's ability to help others arises out of their personal commitment to grow in their relationship in their own life too.

As we considered in the previous sections, the major goal of a counselor in a counseling process is to establish comfortable and positive relationship, facilitate communications, identify and verify the client concerns and plan with the client, to obtain assessment data needed to proceed with counseling process. As far as the client is concerned, his or her major goal is to share and amplify reasons for seeking counseling and cooperate in the assessment of both the problem and self.

For both the purposes a related concept that is important to assess early in treatment is patient's ability to have some "insight". Insight is skills in a constructive way to obtain a new understanding of the problems and difficulties that had not been consciously realised before by the client. Sometimes counselors may provide a relatively benign interpretive comment early in treatment to assess the client or patient's readiness, willingness and capacity for insight (Wanier 1998). Although such interventions must be very carefully timed and crafted, they may allow counselors to get a feeling of how likely patients (clients) will engage in obtaining new levels of understanding. In fact it is often the case that simply summarizing for clients what they have said in ways to draw an association between two important ideas will provide an opportunity to assess how insightful they are.

Metallisation and Insight

As described by Fonagy and colleagues (Fonagy & Target, 1996, 1997; Fonaggy, Gergely, Jurist & Target, 2002), mentalisation or reflective capacity, is the ability of patients to conceive of and to understand their mental states and that of others as an understandable causative mechanism of behavior and experience. Mentalisation means to perceive and communicate mental states, such as beliefs, desires, plans, and goals.

Mental states are unobservable constructs that must be inferred by observers rather than perceived directly. Most of us know what an ego is (and we probably have run into one that is "inflated") but no one has ever perceived an ego directly. Even your own ego has to be inferred.

Mentalisation is largely communication outside of language.

Mentalisation draws heavily from context or the implications of an environment. A gun in a display case will have a different implicit sense to it than a gun being held by a police officer or soldier. We need to be able to mentalise in order to get the implicit meaning of things.

Mentalisation is necessary to "get" the meaning behind metaphor. Metaphor accurately depicts the nature of a situation (the objective reality) *and* is designed to convey a mental state.

Infants are born with an imitative brain . In other words, infants are born with an innate desire to imitate a social partner. Imitation is the seed that will eventually (if all goes well) bear mentalising fruit (to use a metaphor).

Empathy is a form of mentalisation. It is difficult to be empathetic (sympathetic maybe) without the ability to mentalise. Researchers, such as Russell Barkley (1997) are looking at a possible connection between certain forms of ADHD and an impaired capacity to mentalise.

The same brain regions are activated during imitation and mentalisation

Mentalisation is a way to find social partners in the world.

Mentalisation is necessary for the development of a fully developed sense of self and acquired in the context of early attachments, specifically primary object relationships. It is typically the case that the more severe a persons' psychopathology, the more poorly developed is his/her reflective capacity (mentalisation). When patients show very little awareness or recognition of their mental states or inner life, this should be a sign to therapists that more expressive interventions may not be appropriate or well received at this time and that supportive interventions are indicated. The range of interventions would involve reflection and attention by the therapist to signs of patients' mental state and their psychological symptoms.

By way of contrast, patients with greater levels of mentalisation are more likely to come in with some ideas about what is going on in their minds or in the behaviours of others that could be contributing to their difficulties. It is not the case that patients have to have highly well-developed mentalisation capacities for psychoanalytic and psychodynamic interventions to be successful, particularly with interventions targeted toward current life situations. However, an indicator of patients' abilities to improve with psychoanalytic or psychodynamic treatment is related to mentalisation.

Therefore to make good decisions about how to proceed with treatment, it is necessary to assess patients psychological well being and ways of functioning. This can be done by evaluating the capacity for insight or reflective functioning.

Psychodynamic psychotherapy is also known as an "insight" approach, because it is the practice of exploring deeply the inner workings of the mind (how the psyche actually works). Old, unresolved conflicts and beliefs drain energy from people.

By using an insight approach, the counsellor intends to understand the places in the psyche where one has got stuck so that the stuckness—the inability to move forward in life—can relax with the awareness of new options. When a person really sees that now, in the current life, he or she has actually fresh possibilities for action, the old painful dilemmas naturally melt away.

To make permanent change in the reoccurrence of depression and anxiety, it is important to combine insight therapy with the skill building of CBT and mindfulness training. This will lead to relatively more permanent change.

Also known as psychodynamic psychotherapy, insight therapy is a technique which assumes that a person's behavior, thoughts, and emotions become disordered as a result of the individual's lack of understanding as to what motivates him or her, such as unresolved old conflicts or beliefs. The idea behind this therapy is that the therapist will help the client become more aware of themselves and therefore the client can go on to live a more full life.

Example: A clinician trained in insight therapy helps his client to realise and break free of undesirable old patterns by examining how the man has reacted to certain situations in the past

2.7.5 Short Term Counseling

Short Term Counseling: A Six Session Model.

Short term counseling in an occupational health setting is an effective means of reaching a population that may otherwise not have considered counseling. However, because of the time limits, the practitioner must be able to make a quick assessment of the kind of help needed. The seven principles of short term treatment are:

1) Mutual goal directedness;
2) Quick problem identification;
3) Reminder of finiteness of sessions;
4) Making an appropriate referral;
5) Confidentiality;
6) Open communication; and
7) Follow up.

In a six session model, sessions 1 and 2 are for assessment.

Sessions 3 and 4 are for development of insights and strategies

Sessions 5 and 6 are for termination.

Occupational health nurses with mental health training are ideal practitioners of short term counseling, because they can recognise many physical symptoms as having a psychological basis.

Researchers report that a brief behavioral treatment appears to alleviate insomnia in older adults for at least six months. The intervention consisted of two in-person sessions and two phone calls.

Even though pharmacologic and behavioural treatments are approximately equally effective, older adults are prescribed hypnotic agents at disproportionate rates and are also more likely than younger patients to experience adverse drug effects.

Daniel J. Buysse, M.D., of the University of Pittsburgh School of Medicine, and colleagues conducted a randomized clinical trial of a brief behavioural treatment involving 79 older adults (average age 71.7) with insomnia.

Thirty-nine received the treatment, consisting of individualised behavioural instruction delivered by a nurse clinician over four sessions, two in person and two by phone.

The other 40 were assigned to an information control group and received only general printed educational material about insomnia and sleep habits.

All participants provided demographic information, completed self report and interviewer administered questionnaires about sleep habits, kept two-week sleep diaries and underwent sleep assessment by actigraphy (using a wrist or ankle monitor) and polysomnography (a more in-depth monitoring procedure) before treatment and four weeks after beginning therapy.

Participants who showed a response to the brief treatment were contacted again after six months and asked to complete questionnaires and sleep diaries.

After four weeks, a larger percentage of those receiving the brief behavioural treatment showed a favorable response to the treatment (67 percent vs. 25 percent) or were classified as no longer having insomnia (55 percent vs. 13 percent).

Recent years have witnessed increased interest in and practice of short term counseling (Brief therapy) in practice, brief therapy is probably as old as therapy itself; however, it has only recently been recognized and written about as a viable approach for the delivery of counseling assistance. Many a studies indicate that short-term therapy is at least as effective as long term, if not more so, produces lasting or durable results; and more frequently responsible to the client's anticipation of treatment line.

2.7.6 Meaning and Definition of Brief Therapy

Brief therapy, short-term therapy, time limited therapy: making time a defining element in the psychotherapy relationship

The meaning of "brief" is relative to what is considered "long" or "typical." A typical course of classical psychoanalysis often involved three to five years of treatment with 2 to 3 sessions a week (4 and 5 sessions a week might occur by were unusual in standard practice; as was once a week treatment).

More than a precise number of sessions or duration of treatment, the critical feature of the "briefer" therapies is that time becomes an explicit defining feature in the therapeutic contract. Implicit in this type of therapy is the clear view of the starting and ending point, and the pathway that will lead from one to the other. Open ended therapy contacts are defined by broad, mutually agreed upon goals but do not specify the rate of change that is the outcome.

2.7.7 Developments that Influenced Brief Therapies

Several developments contributed to the interest in briefer therapies over the past several decades:

- Much of the identifiable change in psychotherapy occurred within the first 10 sessions.
- Increasing interest in how to make psychotherapy available to larger segments of society / meet the need / demand for psychological services.
- Economic incentives favoring briefer therapies.
- Increased interest in so-called "symptomatic treatments" such as behaviour therapy, marital counseling, problem solving strategies which focused on specific treatments goals rather than change of basic personality patterns / traits.
- Continuing developments have bolstered interest in briefer therapies:
- Managed care strongly encouraged briefer treatments.
- Highly structured, especially "manualized" treatments have become a principal focus of psychotherapy outcome research—the brief therapies were easily adaptable to this model of research.
- Empirical evidence supporting the effectiveness of brief therapies accumulated.
- Virtually all therapeutic models and schools have been able to offer brief therapy alternatives such as psychoanalytic/psychodynamic/object relations therapy, solution focused/narrative therapy, cognitive-behavioral therapy etc.

The major of presenting problems can be approached from a brief therapy model:

- most presenting concerns of individuals
- work with adolescents

- couple counseling
- crisis intervention
- group therapy
- parent training
- family therapy

Self Assessment Questions

1) Describe short term counseling.

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2) What are the conditions for success of short term counseling?

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3) What is meant by commitment to spiritual development?

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4) Describe the meaning and definition of brief therapy.

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2.7.8 Common Aspects to Many Brief Therapies

- Problem/solution vs. pathology/understanding focus
- Active/involved vs. passive/reserved therapist
- Active/experimental vs. passive/receptive client
- Sharply focused and delimited therapeutic goals
- Therapeutic emphasis on the power of thought/image and language for change
- Utilisation of life beyond the therapy session in the process of change

'Descriptions of "Short term" seem to vary somewhat, but it seems to be in the range of one to five sessions with the average length of one hour."

The process itself is characterised by -

Specific Population for Whom Short Term Counseling (STC) is Used

Counselors in nearly all settings deal with a variety of individual problems and concerns STC may be used for these special client populations

i) People who Abuse Drugs

ii) People who use tobacco

iii) People who abuse Alcohol

iv) People with disabilities

v) Women

vi) Victims of Abuse

vii) Older Adults

Use of Short Term Counseling for Child Victim of Sexual Abuse (A Case)

Finding key safe persons for the child and building rapport and trust are key elements at the outside of treatment.

The child's safe person can serve as a bridging tool in the following ways:

- Preparing the child for counseling
- Exhibit stability
- Support the child throughout counseling
- Come to the actual counseling sessions with the child
- Help the child express feelings and contents (if needed)
- Protect the child from the abuser family home life

Clients Concerns in STC for whom STC is used

- Inability to trust others
- Removal from home or removal of offender
- Guilt, shame, stigma
- Disclosure
- Loss of family and friends
- Healing from physical and sexual injuries
- Misunderstanding of what is happening to them emotionally
- Damaged goods syndrome
- Helplessness lack of control.

2.8 LET US SUM UP

We have discussed the different counseling modalities i.e. insight counseling and short term counseling. In what conditions they may be used and how they are useful. We have also brought forth the type of client for whom these counseling techniques are more trusted. The characteristics of both modalities have also been explained.

2.9 UNIT END QUESTIONS

1) Discuss the S.T.C. modalities.
2) What are the client concerns in STC?
3) How is insight counseling useful?
4) Is there and specific problem for which these modalities are more appropriate.
5) What are the various developments that influenced brief therapies?
6) Describe the common aspects of all brief therapies
7) When do we use short term counseling?
8) Who are the beneficiaries of short term counslling?

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UNIT 3 INTERPERSONAL COUNSELING

Structure

3.0 INTRODUCTION

An interpersonal relationship is an association between two or more people that may range from fleeting to enduring. A relationship is normally viewed as a connection between two individuals, such as a romantic or intimate relationship, or a parent–child relationship. Individuals can also have relationships with groups of people, such as the relation between a family and relatives, or a mayor and a town. Finally, groups or even nations may have relations with each other, though this is a much broader domain than that covered under the topic of interpersonal relationships.

These intimate relationships are, however, only a small subset of interpersonal relationships. Interpersonal relationships can also include friendships, such as relationships involving individuals providing relational care to marginalised persons.

These relationships usually involve some level of interdependence. People in a relationship tend to influence each other, share their thoughts and feelings, and engage in activities together. Because of this interdependence, most things that change or impact one member of the relationship will have some level of impact on the other member.

Exceptional interpersonal relationship skill is necessary for both personal and professional success; at the very least, relationship skills are for the purpose of making a "connection" with another human being.

In the chapter various aspects of inter personal counseling and its importance for the counselor are covered.

3.1 OBJECTIVES

After going though this unit, you will be able to:

- Explain various concepts and importance of interpersonal counseling and interpersonal therapy;
- Describe the nature of interpersonal perspective;
- Define and state the meaning of Interpersonal counseling;
- Elucidate the goals of Interpersonal counseling (IPC);
- Describe the meaning of Interpersonal therapy and its aim;
- Identify problem areas;
- Analyse the four basic interpersonal problem areas;
- Elucidate the structure of Inter Personal Counseling (IPC);
- Describe the Subtypes of Interpersonal Therapy(IPT); and
- Elucidate the various counseling techniques.

3.2 NATURE OF INTERPERSONAL PERSPECTIVE

Healthy relationships are built on a foundation of secure attachment and are maintained with love and purposeful positive relationship behaviours. Additionally, healthy relationships can be made to "flourish." Positive psychologists are exploring what makes existing relationships flourish and what skills can be taught to people to enhance their existing and future personal relationships. Positive psychologists use

the term "flourishing relationships" to describe interpersonal relationships that are not merely happy, but instead characterised by intimacy, growth, and resilience. Flourishing relationships also allow a dynamic balance between focus on the intimate relationships and focus on other social relationships.

Humans are social beings, and much of what we are a product of our relationship with others. Psychological problems are increasing coming to be viewed as primarily inter personal in nature. However, it is only recently that all approaches have come to place the interpersonal in the forefront. Now in psychodynamic area; object relation theory, attachment theory, and self psychology hold that psychological problems are primarily a matter of disturbed relationship with other people, and therapy is primarily a matter of repairing such relationship. As cognitive therapist e.g. Aaron Beck see personality disorder as dysfunctional interpersonal strategies that have been learn in an interpersonal matrix in the humanistic view, Gestalt theory also emphasises on interpersonal connections. Hence it should not be surprising that many therapists concluded that abnormal behaviour is best understood by analysing our relationship, past and present with other people. So, interpersonal factors refer to social chemistry or dynamic of relationship between the counselor and the clients.

3.3 HISTORICAL BACKGROUND

The roots of interpersonal approach lie in earlier developments in the psychodynamic movement. According to Adler people inherently social beings are motivated primarily by the desire to belong to and participate in a group. Erikson also extended the interpersonal aspect of human being. Sullivan offered a comprehensive and systematic theory of personality that was explicitly interpersonal relation. Interpersonal accommodation is a process in which two people develop pattern of communication and interaction that enables them to attain common goals, meet mutual needs, and built a satisfying relationship.

Interpersonal therapy was first developed as a theoretical placebo for the use in psychotherapy research by Gerald Klerman et al. IPT was, however, found to be quite effective in the treatment of several psychological problems. IPT was later developed in the 70 and 80s as a treatment for adults who were diagnosed with moderate or severe non-delusional clinical depressed and other psychological problems. IPT takes structure from psychodynamic psychotherapy, but also from contemporary cognitive behavioural approaches also because it is time-limited.

3.4 THEORIES AND EMPIRICAL RESEARCH

Researchers are developing an approach to couples therapy that moves partners from patterns of repeated conflict to patterns of more positive, comfortable exchanges. Goals of therapy include development of social and interpersonal skills. Expressing gratitude and sharing appreciation for a partner is the primary means for creating a positive relationship. Positive marital counseling also emphasises mindfulness.

3.4.1 Minding Relationships

The mindfulness theory of relationships shows how closeness in relationships may be enhanced. Minding is the "reciprocal knowing process involving the nonstop, interrelated thoughts, feelings, and behaviours of persons in a relationship. Five components of "minding" include:

- knowing and being known: seeking to understand the partner;
- making relationship-enhancing attributions for behaviours: giving the benefit of the doubt;
- accepting and respecting: empathy and social skills;
- maintaining reciprocity: active participation in relationship enhancement; and
- continuity in minding: persisting in mindfulness.

3.4.2 Love

Love gives depth to human relationships it brings people closer to each other and makes people think expansively about themselves and the world psychologist Robert Sternberg theorizes that love is a mix of three components:

1) Passion, or physical attraction
2) Intimacy or feelings of closeness, and
3) Commitment, involving the decision to initiate and sustain a relationship.

The presence of all three components characterises consummate love, the most durable type of love. In addition, the presence of intimacy and passion in marital relationships predicts marital satisfaction. Also, commitment is the best predictor of relationship satisfaction, especially in long-term relationships. Positive consequences of being in love include increased self-esteem and self-efficacy.

3.4.3 Neurobiology of Interpersonal Connections

There is an emerging body of research across multiple disciplines investigating the neurological basis of attachment and the pro social emotions and behaviours that are the prerequisites for healthy adult relationships. The social environment, mediated by attachment, influences the maturation of structures in a child's brain. This might explain how infant attachment affects adult emotional health.

3.5 INTERPERSONAL COUNSELING (IPC)

Interpersonal counseling derives directly from IPT but is briefer in the number and duration of sessions. It is designed for patients who are in distress and have symptoms due to current stressors in their lives, but who do not have serious concurrent psychiatric disorders or medical conditions that can or should be treated more effectively by medication or other psychosocial treatments. Interpersonal Counseling (IPC) is a derivative form of interpersonal therapy (IPT).

IPT is a brief technique that has antecedents in the work of Harry Stack Sullivan, but has been modified into its own form of therapy since the 1980s. It consists of roughly 12 to 16 sessions, 50-60 minute per sessions and has been suggested for treatment of conditions like depression personality disorder etc. The Interpersonal counseling (IPC) method is a shortened form of interpersonal therapy (IPT) that usually consists of six sessions, and is not more than half an hour.

Within the Interpersonal counseling IPC framework, psychological distress is viewed as having three component processes:

i) Symptom formation – somatic signs and symptoms, e.g. Fatigue, sleep disturbance, headaches
ii) Social and interpersonal relations, and

iii) Personality – enduring traits and behaviours which may contribute to a predisposition to symptom episodes.

3.5.1 Goals of Interpersonal Counseling

The goals of Interpersonal counseling (IPC) are to intervene to:

- reduce psychological symptoms restoring morale and improving self esteem.
- improve the quality of the patient's social adjustment and interpersonal relations.

3.6 INTERPERSONAL THERAPY/ INTERPERSONAL PSYCHOTHERAPY

Interpersonal therapy is a time-limit counseling that focuses on the interpersonal context and on building interpersonal skills. Where Interpersonal Psychotherapy (IPT) is based on the belief that interpersonal factors may contribute heavily to psychological problems. It is commonly distinguished from other forms of therapy in its emphasis on interpersonal processes rather than intra psychic processes.

In interpersonal counseling and therapy, counselor/ therapists work with clients over issues like depression and other disorders in context of the way symptoms have formed and the way they affect social functioning. At the same time, both IPT and IPC evaluate how social functioning is affected by things like arguments, transitions in roles, experience of grief, or by few or poor interpersonal relationships.

Interpersonal therapy focuses on the present; it can also improve the client's future through increased awareness of preventive measures and strengthened coping skills. Interpersonal psychotherapy typically proceeds in several stages. In the initial stages, therapeutic goals typically include diagnosis, completing the requisite inventories, identifying the patient's major problem areas, and creating a treatment contract.

Interpersonal counseling and therapy is a short-term supportive psychotherapy that focuses on the connection between interactions between people and the development of a person's psychiatric symptoms.

3.6.1 Goals of Interpersonal Psychotherapy (IPT)

IPT aims to change the person's interpersonal behaviour by fostering adaptation to current interpersonal roles and situations. IPT emphasises the ways in which a person's current relationships and social context cause or maintain symptoms rather than exploring the deep-seated sources of the symptoms. Its goals are rapid symptom reduction and improved social adjustment. A frequent byproduct of IPT treatment is more satisfying relationships in the present.

Interpersonal therapy was initially developed to treat adult depression. It has since been applied to the treatment of depression in adolescents, the elderly, and people with Human Immunodeficiency Virus (HIV) infection. There is an IPT conjoint (couple) therapy for people whose marital disputes contribute to depressive episodes. IPT has also been modified for the treatment of a number of disorders, including substance abuse; bulimia; depressed pregnant women; and people suffering from protracted bereavement.

3.7 IDENTIFICATION OF PROBLEM AREAS

Although originally developed as an individual therapy for adults, (IPT) Interpersonal therapy has been modified for use with adolescents and older adults.

Interpersonal therapy (IPT) has been adapted for the treatment of depressed adolescents as developmental issues are most common to teenagers such as separation from parents, development of romantic relationships, and initial experience with death of a relative or friend etc. Interpersonal therapy for adolescent help the adolescent identify and develop more adaptive methods for dealing with the interpersonal issues associated with the onset or maintenance of their depression. It is typically a 12-16 week treatment. Although the treatment involves primarily individual sessions with the teenager, parents are asked to participate in a few sessions to receive education about problem, to address any relationship difficulties that may be occurring between the adolescent and his/her parents, and to help support the adolescent's treatment.

The techniques of Interpersonal therapy IPT were developed to manage four basic interpersonal problem areas: unresolved grief, role transitions; interpersonal role disputes (often marital disputes); and interpersonal deficits (deficiencies). In the early sessions, the interpersonal therapist /counselor and the client attempt to determine which of these four problems is most closely associated with the onset of the current depressive episode?

Therapy is then organised to help the client deal with the interpersonal difficulties in the primary problem area. The coping strategies that the client is encouraged to discover and employ in daily life are tailored to his or her individual situation.

3.7.1 Unresolved Grief

In normal bereavement, person experiences symptoms such as sadness, disturbed sleep, and difficulty functioning but these usually resolve in two to four months. Unresolved grief in depressed people is usually either delayed grief, which has been postponed and then experienced long after the loss; or distorted grief, in which there is no felt emotion of sadness but there may be non emotional symptoms, often physical. If unresolved grief is identified as the primary issue, the goals of treatment are to facilitate the mourning process. Successful therapy/counseling will help the client re-establish interests and relationships that can begin to fill the void of what has been lost.

3.7.2 Role Disputes

Interpersonal role disputes occur when the client and at least one other significant person have differing expectations of their relationship. The IPT therapist /counselor focuses on these disputes if they seem stalled or repetitious, or offer little hope of improvement. The treatment goals include helping the client identify the nature of the dispute; decide on a plan of action; and begin to modify unsatisfying patterns, reassess expectations of the relationship, or both. The therapist/counselor does not direct the client to one particular resolution of difficulties and should not attempt to preserve unworkable relationships.

3.7.3 Role Transitions

Depression associated with role transitions occurs when a person has difficulty coping with life changes that require new roles. These may be such transitions as retirement, a career change, moving, or leaving home. People who are clinically depressed are most likely to experience role changes as losses rather than opportunities. The loss may be obvious, as when a marriage ends, or more subtle, as the loss of freedom people experience after the birth of a child. Therapy/counseling is terminated when a client has given up the old role; expressed the accompanying feelings of guilt, anger, and loss; acquired new skills; and developed a new social network around the new role.

3.7.4 Interpersonal Deficits

Interpersonal deficits are the focus of treatment when the client has a history of inadequate or unsupportive interpersonal relationships. The client may never have established lasting or intimate relationships as an adult, and may experience a sense of inadequacy, lack of self-assertion, and guilt about expressing anger. Generally, clients with a history of extreme social isolation come to therapy with more severe emotional disturbances. The goal of treatment is to reduce the client's social isolation. Instead of focusing on current relationships, Therapy/counseling in this area focuses on the client's past relationships; the present relationship with the therapist/counselor; and ways to form new relationships

3.8 STRUCTURE /MODEL OF INTER PERSONAL COUNSELING (IPC)

One of the most influential models of relationship development was proposed by psychologist George Levinger. This model was formulated to describe heterosexual, adult romantic relationships, but it has been applied to other kinds of interpersonal relations as well. According to the model, the natural development of a relationship follows five stages:

1) **Acquaintance:** Becoming acquainted depends on previous relationships, physical proximity, first impressions, and a variety of other factors. If two people begin to like each other, continued interactions may lead to the next stage, but acquaintance can continue indefinitely.

2) **Buildup:** During this stage, people begin to trust and care about each other. The need for intimacy, compatibility and such filtering agents as common background and goals will influence whether or not interaction continues.

3) **Continuation:** This stage follows a mutual way of commitment to a long-term friendship, romantic relationship, or marriage. It is generally a long, relative stable period. Nevertheless, continued growth and development will occur during this time. Mutual trust is important for sustaining the relationship.

4) **Deterioration:** Not all relationships deteriorate, but those that do tend to show signs of trouble. Boredom, resentment, and dissatisfaction may occur, and individuals may communicate less and avoid self-disclosure. Loss of trust and betrayals may take place as the downward spiral continues, eventually ending the relationship. (Alternately, the participants may find some way to resolve the problems and reestablish trust.)

5) **Termination:** The final stage marks the end of the relationship, either by death in the case of a healthy relationship, or by separation.

3.8.1 Factors Affecting Interpersonal Counseling

The structure of interpersonal counseling is based on the various factors of the client/ personality and the focus is on following:

- Clients' emotions
- An exploration of clients' resistance to treatment
- Discussion of patterns in clients' relationships and experiences
- Taking a detailed past history
- An emphasis on clients' current interpersonal experiences
- Exploration of the counselor /client relationship
- Identification of clients' wishes and fantasies.

Theses are the seven types of factors / interventions that are commonly used in inter personal counseling, many of which reflect the influence of psychodynamic psychotherapy.

3.8.2 Important Features for Interpersonal Counseling for Counselor

To begin with inter personal counseling following point should be in mind by the counselor:

- Establish rapport
- Rule out physical illness as a cause for symptoms
- Determine the presence of any specific psychiatric diagnosis
- Introduce IPC and suggest the possible relationship between the patient's symptoms of distress and current life stress
- Explore the patient's current interpersonal and social situation (interpersonal diagnosis)
- Identify with the patient the specific current stress areas that are contributing to the symptoms (interpersonal formulation)
- Help the patient deal more positively with the specific stress area identified
- Homework assignments are used to accelerate the process of change for each area
- Termination of the IPC relationship.

3.8.3 Stages of Interpersonal Counseling (IPC)

The structure of IPC is of a brief treatment of six sessions, each with an explicit focus: assessment, education about the interaction between interpersonal relationships and psychological symptoms, identifying current stress areas and helping the patient deal with these more positively and termination of the IPC relationship.

Interpersonal Counseling can be utilised general practice to reduce psychological symptoms, restore morale, and improve self esteem and the quality of the client s social adjustment and interpersonal relationships for e.g.

Visit 1 – *the treatment contract*

In the first visit – usually the longest session – the counselor determines the client's suitability for IPC. People with major depression, bipolar disorder, or who are psychotic or suicidal are not suitable for IPC as the therapy is provided. In order to establish an interpersonal diagnosis, the counselor asks the client about recent changes in life circumstances, mood and social functioning, and explores how life circumstances relate to the onset of symptoms. By the end of the session the counselor should develop an explicit treatment contract with the client that emphasises:

- the no psychiatric motive of the intervention, i.e. The focus is on understanding how life stresses are contributing to feelings of the clients
- the short term duration of the intervention (up to six sessions of up to 30 minutes each)
- the expected benefits – to reduce symptoms to find better ways of coping, and
- that IPC is in addition to usual medical care.

At the end of the visit, the counselor gives the client homework on life events and ask him/her to bring in back to the next visit.

Visit 2 – *determining the specific problem area(s)*

The counselor must determine the specific problem area(s) which is useful to review the following:

- onset and duration of present symptoms
- current life circumstances
- close interpersonal relationships, and
- any recent changes in any of these.

Overall, the counselor's task is to assist the client to identify the key person(s) with whom he/she is having difficulties, what type of problems are being experienced, and whether there are ways to make the relationship more satisfactory.

Visits 3–5 – *working on specific stress areas*

The counselor works with the client to deal with specific problem areas e.g.

Grief or loss –Help the patient re-establish interests and significant other relationships that can substitute for what is lost Talk of the deceased – the type of person he/she was relationship with them, circumstances of illness and death

- Look over old photographs, see old friends and discuss at subsequent sessions
- Encourage involvement in new social activities. Enable the client to regard the new role in a more changes positive, less restricted manner, or see as an Similar to those for grief – giving up old role – facilitate opportunity for growth evaluation of what has been lost, encourage release of
- Restore self esteem by developing in the client an affect and develop social support system.

Visit 6 – *Termination*

This visit is usually held 2 weeks after visit five, but may be earlier if the client feels they have achieved all they wanted. The counselor should review the previous sessions and the client s current state and discuss the termination of IPC. The counselor should emphasise the progress made, the supports available to the client, and ability to cope with future problems. The counselor should work with the patient to identify

potential sources of stress and ways in which the client could cope with these, especially referring to strategies that the counselor found effective during counseling. Many clients will show concern about termination. In some cases, an additional visit can also be arranged to complete the termination process.

In the end stages of IPT, the therapist works to consolidate the client's gains, discuss areas which still require work, talk about relapse prevention, and process any emotions related to termination of therapy.

3.9 COUNSELING TECHNIQUES

Interpersonal counseling is apart of psychodynamic therapy, and so it is derived from Psychoanalytic theory of Freud, with its emphasis on the unconscious and childhood experiences. Symptoms and personal difficulties are regarded as arising from deep, unresolved personality or character problems. Psychoanalytic counseling is time consuming and is a long-term method of treatment and the results are also very slow therefore now it is not in much use.

3.9.1 Practical Applications

Interpersonal counseling is designed to help the patient master the context and uses the connection between the onset of depressive symptoms and current interpersonal problems as a practical and commonsense treatment focus. Therapy is focused rather than nondirective and deals with current – not past – interpersonal relationships. The focus is interpersonal rather than intra psychic or cognitive/behavioural.

Essentially, the counselor needs to consider three questions:

1) Are the client's problems amenable to, and best treated by, a psychological therapy?
2) Is this client likely to benefit from, ready for, and motivated to use a psychological therapy? and
3) Is IPC the most suitable psychological approach?

A client's motivation and expectations are critical factors for a successful outcome with psychological treatments. Motivation is a dynamic variable that may vary with treatment successes or disappointments. Appropriate realistic expectations of the treatment and the client's ability to be introspective, self reflective and reality oriented will also influence the likelihood of success. The IPC approach depends on the principle that life events and the social environment affect mood and that mood can affect social and interpersonal functioning and one's response to the environment.

Treatment with IPT is based on the premise that depression occurs in a social and interpersonal context that must be understood for improvement to occur. In the first session, the psychiatric history includes a review of the client's current social functioning and current close relationships, their patterns and their mutual expectations. Changes in relationships prior to the onset of symptoms are clarified, such as the death of a loved one, a child leaving home, or worsening marital conflict.

Treatment with IPC, however, is sometime combined with drug therapy, particularly when the client suffers from such mood disorders as depression, dysthymia, or bipolar disorder. Since the interpersonal therapy model was developed for the treatment of depression and then modified for use with other populations and mental disorders, an understanding of IPT's approach to depression is crucial. Interpersonal therapists focus on the functional role of depression rather than on its etiology or cause, and

they look at the ways in which problematic interactions develop when a person becomes depressed.

The IPT framework considers clinical depression as having three components: the development of symptoms, which arise from biological, genetic and/or psychodynamic processes; social interactions with other people, which are learned over the course of one's life; and personality, made up of the more enduring traits and behaviours that may predispose a person to depressive symptoms. IPT intervenes at the levels of symptom formation and social functioning, and does not attempt to alter aspects of the client's personality.

IPT is psycho educational in nature to some degree. It involves teaching the client about the nature of depression and the ways that it manifests in his or her life and relationships. In the initial sessions, depressive symptoms are reviewed in detail, and the accurate naming of the problem is essential. The therapist then explains depression and its treatment and may explain to the client that he or she has adopted the "sick role." The concept of the "sick role" is derived from the work of a sociologist named Talcott Parsons, and is based on the notion that illness is not merely a condition but a social role that affects the attitudes and behaviours of the client and those around him or her. Over time, the client comes to see that the sick role has increasingly come to govern his or her social interactions.

3.9.2 Behavioural Therapy

Behavioural therapy is used to counsel people with depression by focusing on the external behaviour rather than the internal cognitive processes that stimulate the behaviour. The key to this method of counseling lies in the fact that the person is depressed because of one's behaviour, and that changing behaviour will control the feelings associated with depression. Behavioural changes can produce quite significant results in some people, but it still leaves the underlying issues and causes of depression unexplored.

3.9.3 Cognitive Therapy

Cognitive therapy is the opposite of the behavioural technique. This form of counseling seeks to find the solution in patients' thought processes. Cognitive counseling seeks to change negative thoughts such as pessimism, hopelessness, self-criticism and unrealistic outlooks and expectations. The key to successful cognitive therapy is learning to distinguish between the really important issues affecting one's life and the minor or even trivial issues.

3.9.4 Interpersonal Therapy

Interpersonal therapy is a form of counseling that attempts to locate how social interaction affects depression. Interpersonal therapy does not try to place social contexts as a root cause of depression, but understands that the way that people react to others has a profound effect on the development of symptoms. This form of counseling extends beyond actual interpersonal behaviour to take into consideration such things as fantasies, fears, anxieties and wishes as they relate to social interaction.

3.9.5 Psychotherapy

Psychotherapy is the form of counseling that is most often associated with treating mental illness; it is the counseling that brings to mind the Freudian psychologist listening

to a patient lying on a couch. In reality, the therapist may not subscribe to Freudian theory at all. The purpose of psychotherapy is to get to the core of the causes of depression; as a result, every aspect of the patient's life is fair game. The patient who chooses this form of counseling needs to be very comfortable with and confident in the therapist and be unafraid to open up and discuss even the most painful and personal aspects of one's life.

3.9.6 Psychodynamic Counseling

Psychodynamic counseling is the type of therapy associated with Freudian techniques. This form of counseling differs from psychotherapy by placing the entire emphasis on the unconscious and subconscious thought processes. Rather than attempting to locate alternative causes, psychodynamic counseling seeks specifically to uncover unresolved conflicts that developed during childhood. The aim is to resolve these conflicts; if resolution is impossible, then the patient learns how to cope better with the conflicts.

3.10 APPLICATIONS

3.10.1 IPT/IPC in Special Populations

1) **Elderly clients:** In translating the IPT model of depression to work with different populations, the core principles and problem areas remain essentially the same, with some modifications. In working with the elderly, IPT sessions may be shorter to allow for decreased energy levels, and dependency issues may be more prominent. In addition, the therapist may work with an elderly client toward tolerating rather than eliminating long-standing role disputes.

2) **Clients with HIV infection:** In IPT with HIV-positive clients, particular attention is paid to the clients' unique set of psychosocial stressors: the stigma of the disease; the effects of being gay (if applicable); dealing with family members who may isolate themselves; and coping with the medical consequences of the disease.

3) **Adolescents:** In IPT with adolescents, the therapist addresses such common developmental issues as separation from parents; the client's authority in relationship to parents; the development of new interpersonal relationships; first experiences of the death of a relative or friend; peer pressure; and single-parent families. Adolescents are seen weekly for 12 weeks with once-weekly additional phone contact between therapist and client for the first four weeks of treatment. The parents are interviewed in the initial session to get a comprehensive history of the adolescent's symptoms, and to educate the parents as well as the young person about depression and possible treatments, including a discussion of the need for medication. The therapist refrains from giving advice when working with adolescents, and will primarily use supportive listening, while assessing the client for evidence of suicidal thoughts or problems with school attendance. So far, research does not support the efficacy of antidepressant medication in treating adolescents, though most clinicians will give some younger clients a trial of medication if it appears to offer relief.

4) **Interpersonal therapy for adolescents:** IPT for kids is based on the premise that depression occurs in the context of an individual's relationships regardless of its origins in biology or genetics. More specifically, depression affects people's relationships and these relationships further affect our mood. The IPT model

identifies four general areas in which a person may be having relationship difficulties: 1) grief after the loss of a loved one; 2) conflict in significant relationships; 3) difficulties adapting to changes in relationships or life circumstances; and 4) difficulties stemming from social isolation. The IPT therapist helps identify areas in need of skill-building to improve the client's relationships and decrease the depressive symptoms. Over time, the client learns to link changes in mood to events occurring in his/her relationships, communicate feelings and expectations for the relationships, and problem-solve solutions to difficulties in the relationships.

5) **Clients with substance abuse disorders:** While IPT has not yet demonstrated its efficacy in the field of substance abuse recovery, a version of IPT has been developed for use with substance abusers. The two goals are to help the client stop or cut down on drug use; and to help the client develop better strategies for dealing with the social and interpersonal consequences of drug use. To meet these goals, the client must accept the need to stop; take steps to manage impulsiveness; and recognise the social contexts of drug purchase and use. Relapse is viewed as the rule rather than the exception in treating substance abuse disorders, and the therapist avoids treating the client in a punitive or disapproving manner when it occurs. Instead, the therapist reminds the client of the fact that staying away from drugs is the client's decision.

6) **Clients with eating disorders:** IPT has been extended to the treatment of eating disorders. The IPT therapist does not focus directly on the symptoms of the disorder, but rather, allows for identification of problem areas that have contributed to the emergence of the disorder over time. IPT appears to be useful in treating clients with bulimia whose symptoms are maintained by interpersonal issues, including social anxiety; sensitivity to conflict and rejection; and difficulty managing negative emotions.

IPT is helpful in bringing the problems underlying the bingeing and purging to the surface, such as conflict avoidance; difficulties with role expectations; confusion regarding needs for closeness and distance; and deficiencies in solving social problems. IPT also helps people with bulimia to regulate the emotional states that maintain the bulimic behaviour.

Anorexia nervosa also appears to be responsive to treatment with IPT. Research indicates that there is a connection between interpersonal and family dysfunction and the development of anorexia nervosa. Therapists disagree as to whether interpersonal dysfunction causes or is caused by anorexia. IPT has been helpful because it is not concerned with the origin but rather seeks to improve the client's interpersonal functioning and thereby decreasing symptoms. IPT's four categories of grief, interpersonal disputes, interpersonal deficits, and role transitions correspond to the core issues of clients with anorexia. Social phobia is another disorder that responds well to IPT therapy.

3.11 SUBTYPES OF INTERPERSONAL THERAPY (IPT)

Interpersonal therapy offers two possible treatment plans for persons with depressive disorders. The first plan treats the acute episode of depression by eliminating the current depressive symptoms. This approach requires intervening while the person is in the midst of a depression. The acute phase of treatment typically lasts two to

four months with weekly sessions. Many clients terminate treatment at that point, after their symptoms have subsided. Maintenance treatment (IPT-M) is the second treatment plan and is much less commonly utilised than acute treatment. IPT-M is a longer-term therapy based on the principles of interpersonal therapy but with the aim of preventing or reducing the frequency of further depressive episodes. Some clients choose IPT-M after the acute treatment phase. IPT-M can extend over a period of two to three years, with therapy sessions once a month.

3.12 INTERPERSONAL THERAPY AS A MAINTENANCE APPROACH (IPT-M)

Interpersonal therapy as a maintenance approach (IPT-M) could be viewed as aftercare for clients suffering from depression. It is designed as a preventive measure by focusing on the period after the acute depression has passed. Typically, once the client is in remission and is symptom-free, he or she takes on more responsibilities and has increased social contact. These changes can lead to increased stress and greater vulnerability to another episode of depression. IPT-M enables clients to reduce the stresses associated with remission and thereby lower the risk of recurrence. The goal of maintenance therapy is to keep the client at his or her current level of functioning. Research has shown that for clients with a history of recurrent depression, total prevention is unlikely, but that maintenance therapy may delay a recurrence.

In general, long-term maintenance psychotherapy by itself is not recommended unless there are such reasons as pregnancy or severe side effects that prevent the client from being treated with medication. IPT-M does; however, seem to be particularly helpful with certain groups of patients, either alone or in combination with medication. Women appear to benefit, due to the importance of social environment and social relations in female gender roles; the effects of the menstrual cycle on symptoms; and complications related to victimisation by rape, incest, or battering. IPT is also useful for elderly clients who can't take antidepressants due to intolerable side effects or such medical conditions as autoimmune disorders, cardiovascular disorders, diabetes, or other general medical conditions.

3.13 INTERPERSONAL RELATIONSHIP SKILL

Like living organisms, relationships have a beginning, a lifespan, and an end. They tend to grow and improve gradually, as people get to know each other and become closer emotionally, or they gradually deteriorate as people drift apart, move on with their lives and form new relationships with others. Healthy interpersonal skills reduce stress, reduce conflict, improve communication, enhance intimacy, increase understanding, and promote joy. Interpersonal skills are all the behaviours and feelings that exist within all of us that influence our interactions with others.

The following are the important point /skills for the counselors by which the clients can be helped:

1) **Communication Skills**

   Communion demands that we listen as well as speak

2) **Assertiveness Skills**

   Expressing our self and our rights without violating the rights of others

3) **Conflict Resolution**

Conflict is natural and inevitable. Conflict Resolution helps us to resolve differences so that we may continue with the relationship in an effective way.

4) **Anger Management**

Knowing how to recognise and express anger appropriately can help us to reach goals, handle emergencies, solve problems and even protect our health.

Because Relationship success requires good relationship skills so counselor can make the client learn to make stronger interpersonal connections by...

- Understand the purpose or motive of our communication (give information, connect with others, resolve conflict).
- Speak graciously, without using offensive words.
- Give the benefit of the doubt...doesn't blame others.
- Help the clients by giving the facts i.e people can listen about four times faster than they speak.

The average listening comprehension speed is about 600 words per minute. The average speaking speed is 150-200 words per minute. What does this bit of truth mean to our interpersonal relationship skills?

More focused energy is required to be a good listener.

Listen more than you speak, after all God gave us 2 ears and 1 mouth.

Remember the 80/20 rule. When someone is speaking to you, you should listen 80% of the time and speak only 20%.

Teach them to be an excellent listener by:

- Caring more about what the speaker is saying than your response.
- Choosing not to argue in your head with the listener.
- Choosing not to formulate your rebuttal while the speaker is talking.
- Instead, tune in completely to what they are saying for the purpose of understanding them.
- Choosing to respond to what they said, rather than what you want to say.

You were made for relationship...therefore; choose to be more committed to making a healthy connection with others by developing your interpersonal relationship skill. Our personal and professional success depends on it.

3.14 LET US SUM UP

Interpersonal counseling is a practical and effective approach for the treatment of common mental health problems that can readily be integrated into general practice. The focus on life events, social, and interpersonal problems is familiar to counselors.

The expected outcomes of interpersonal therapy are a reduction or the elimination of symptoms and improved interpersonal functioning. There will also be a greater understanding of the presenting symptoms and ways to prevent their recurrence. e.g. in the case of depression, a person will have been educated about the nature of depression; what it looks like for him or her; and the interpersonal triggers of a depressive episode. A person will also leave therapy with strategies for minimizing triggers and for resolving future depressive episodes more effectively.

Some researchers criticize positive psychology for studying positive processes in isolation from negative processes. On the contrary, some argue that positive and negative processes in relationships may be better understood as functionally independent, not as opposites of each other.

3.15 UNIT END QUESTIONS

1) What is interpersonal relationship and how counseling is important to develop this relationship?
2) Explain interpersonal counseling (IPC).
3) Explain interpersonal therapy (IPT).
4) Differentiate between interpersonal counseling& interpersonal therapy.
5) What is the structure of (IPC) Inter personal counseling.
6) Adler Erikson Gerald Klerman Sullivan are the key person in the inter personal counseling/therapy explain.
7) Describe role disputes.
8) Explain role transitions.
9) How is unresolved grief can be resolved?
10) Importance of interpersonal deficits.
11) Acquaintance Buildup, Continuation, Deterioration Termination.
12) What are the Three Parts of Effective Counseling?
13) What is the Practical application.
14) Describe the Counseling Techniques used for IPC.
15) What are the Subtypes of Interpersonal therapy IPT.
16) Explain the area Applications of IPC and IPT.
17) Explain Interpersonal therapy as a maintenance approach (IPT-M).
18) What are Interpersonal Relationship Skills?
19) Give the treatment plan of IPC and IPT.

3.16 SUGGESTED READINGS

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UNIT 4 COUNSELING CHILDREN

Structure

4.0 INTRODUCTION

Child's development, its meaning, study, research, and child counseling are some of the interesting and exciting areas in today's world. Researches about development have also been stimulated by the social pressure to better the life of children. While studying child development and counseling, certain questions arise in mind. In what way are children's home, school, and neighbourhood experience the same today as they were in generation past and in what way are they different? What perception children have of the world in general and how is it different today? What is the role of heredity and environment on the development of children?

The above are some of the important and central questions in regard to child development and counseling.

In order to look into and to study child development / and how to counsel children, the following three domains are to be considered, viz., (i) Physical development (ii) Cognitive development and (iii) Environment and social development. Let us deal with each of these in detail.

1) **Physical Development**

This comprises of changes in body size, proportion, and appearance, functioning of body system, brain development, perception, motor capacity and psychical health. Special professional help is provided if there is any delay in any of the areas of physical development or any development which is not in accordance with the normal developmental schedule.

2) **Cognitive Development**

This refers to a wide variety of thought processes and intellectual abilities, including attention, memory, academics and every day knowledge, creativity, imagination, problem solving etc. With the increase in age, the capabilities and capacities in regard to all the above areas also increase. However there are children who do not show any increase but conspicuous stagnation or decrease in a few or many of these areas and these disturbances obviously affect the growth and development of children. In such cases, professional consultation may be needed so as to help these children overcome such problems. Such problems may arise due to social factors or environmental factors or in certain cases it could be due to hereditary factors too. The root cause of the problem is generally identified by the counsellor, and counseling is carried on depending on the causative factors so identified.

3) **Environmental and Social Development**

It is the development of the emotional communication, self understanding, ability to manage one's feelings, knowledge about other people, interpersonal skills, friendship, moral reasoning and behaviour, which all develop as children start growing up from stage to stage. According to Erikson's psycho social theory of development, the various stages of development are classified on the basis of social and social and emotional development. For instance in the 1st year of life the social and emotional development is indicated in the trust v/s mistrust in the child. In the second stage the social and emotional development is indicated in the development of initiative versus guilt, in the third stage, it is characterised by industry versus inferiority and so on and at the final adult stage it is the ego integrity versus despair. At each stage of development the problem and the conflicts that arise are resolved and the individual

moves on to the next stage of development and so on. If at any of the stages of development the problems and conflicts are not resolved, the individual may develop all kinds of complexes, inferiority feelings, insecurities, low self esteem, becomes unsocial, lacks decision making power etc. In all such cases counseling will be required to both understand the causes and treat the same and bring the individual back to normal level. In this unit we will be dealing with all these factors and also many of the childhood disorders which need counseling.

4.1 OBJECTIVES

After reading the following unit you will be able to:

- Define child development;
- Explain the various problems related to different stages of development;
- Describe the psychological issues underlying the problems;
- Elucidate the techniques of counseling children for their betterment in life;
- Explain in detail physical development, cognitive development, and environmental and social development;
- Delineate the meaning, casual factors of learning disability;
- Analyse the nature and characteristics of learning disorders;
- Describe the techniques for helping children suffering from learning disability;
- Elucidate the Attention Deficit Hyperactivity Disorder (ADHD);
- Delineate the types of Anxiety Disorder(AD) and its treatment; and
- Explain the general counseling techniques /counseling strategies.

4.2 CHILDREN AND DISORDERS

According to the recent estimates, 17% to 22 % of the children under age of 18 years meet the diagnostic criteria for one or more mental disorders. Of these ,11 to 14 million children, that is at least half of them may be severely handicapped by this order, and half may have trouble coping with the demands of community, family and school. Some behavioural disorders in childhood have long term effect. Maladaptive behaviour in childhood results from normal variations in rates of development. Early childhood experiences which are negative can also lead to inadequacy and inferiority in adulthood.

Children who are unable to master academic work when their classmates are able to, it would indicate that these children are having some serious problem in learning. So the counselor must keep in mind that if these childhood problems are not solved then there are chances that these children when grow up as adults may suffer from low self esteem, depression, anxiety, inferiority complex, etc. and may also develop some or the other personality disorder in later years of life. Many of the untreated children are likely to progress into severely mentally ill adults. According to Jensen (1990) the factors include prenatal psycho pathology, family discord, divorce, low social economic status, child abuse, temperamental characteristics and stressful experiences. Egland et al (1993) stated that abused children have very high rate of psychological problems and these children require counseling as through counseling many of these problems could be sorted out and thus when they grow old and become adults, they will have balanced personality and will be helpful for them selves, family and society.

This chapter will focus on developmental problems of children and how these problems can be handled through various measures /counseling.

The most commonly known developmental problem faced by the children is LD (Learning Disability) , Attention Deficit Hyperactivity Disorder (ADHD), Anxiety Disorder (AD), Disorders such as Enuresis, Encopresis, Sleep Walking, Tics, Autism ,etc.

4.3 LEARNING DISABILITY (LD)

LD is a kind of disorder where inadequate development may be manifested in language, speech, math, or in motor skill area. This may or may not be due to physiological or neurological defect. Most common subtype of learning disability is Dyslexia which is collectively known as reading writing difficulty or vice versa. In LD the children find difficulty in recognising and reading comprehension, often he/she is found markedly deficient in spelling as well as in reading. The learning disability children are generally identified during the early years of childhood, because of the apparent disparity between their expected academic achievement level and their actual academic performance in one or more subjects such as Maths, English, Hindi etc. These children have an average IQ and do not have emotional problems nor do they seem to be lacking in motivation or cooperation.

4.3.1 Casual Factors of Learning Disability

These disorders are a result of some sort of disability, immaturity, or deficiency limited to certain brain functions supportively mediating, as for example dyslexia is associated with failure of brain to develop in normally asymmetrical manner with respect to the right and left hemisphere. The portion of left hemisphere where language functioning is normally mediated, it is under developed in many such cases.

Some researches have also indicated that learning disorder also develops because of genetic transmission. Learning disorder may be due to certain basic psychological processes within the individual. It may also be because of extrinsic factors like sensory impairment, emotional disturbances, cultural differences and lack of educational opportunities etc.

4.3.2 Nature and Characteristic of Learning Disorder

The counselor must remember the following points before diagnosing learning disorder in children

Learning disabled children essentially suffer from serious learning problems for number of reasons.

The problems and disorder are usually manifested by significant difficulties in the acquisition and use of languages (reading, writing, speaking etc), reasoning of social skills, etc.

They may show symptoms of hyper activity, impulsivity and most of them show symptoms of anxiety.

Learning disorder in children is not apparent in the physical appearance.

Learning disorder can occur with normal intelligence.

Learning disorder children show significant educational discrepancy i.e. avoid gap between their learning potential and actual educational achievement and they lack in mastering the academic part.

4.3.3 Techniques for Helping Learning Disability

There are several specialised counseling techniques and approaches that have been involved by the counselors while working with the learning disabled children. Brief introductions of some of them are as follows

i) **Behaviour modification approach:** In this approach the counselor makes attempts to modify the behaviour of LD children. By reconstructing and reorganising the environmental conditions, providing opportunities for modification and change in behaviour, using proper reinforcement they help the LD children acquire desirable learning behaviour.

The other counseling techniques which a counselor uses for treating learning disorder includes token economy, positive reinforcement, timeout procedures and other behaviour modification techniques.

ii) **Psycho analytic approach:** In this approach attempts are made to analyse the behaviour of the disabled child after establishing very good rapport with then child, and find out the root cause of learning disorder. Accordingly, a remedial program is planned and administered to the child to overcome the problem.

iii) **Individualised instructional approach:** This technique of counseling advocates the use of small groups or even individuals for helping them to rectify their learning deficiencies. Peer tutoring has proved to be a successful technique for providing individual assistance to the affected children. The child feels quite safe and secure, and in this atmosphere with the help of the peer, the child is able to come up to a satisfactory learning level.

iv) **Self instructional approach:** In this approach the counselor helps the children by making them realise the concept of self learning and self improvement measures. For this purpose remedial programs are presented in the form of program learning text, computer assisted instructions etc. One can also include self learning questionnaire and instructional module specially prepared for this purpose and put to use by the counselor with the help of the teacher. For better output these programs should be guided by the counselor.

v) **Multisensory approach:** In this type of counseling the counselor help the LD children to use their multiple senses e.g. visual ,touch ,auditory etc depending upon the nature of subject material and its learning objective e.g. to provide wholesome languages experiences, a multisensory approach *VAKT* i.e. Visual Auditory Kinesthetic and Tactile has been devised. While counseling, the counselor must remember to use step by step method, where the children are first acquainted with the letters of words and then slowly with the word. Once the word is mastered the learner is asked to make use of it in a sentence, then into a story writing, after that they are finally provided reading practices.

vi) **Technological approach:** In this approach the counselor can make use of advanced technology for providing remedial instructional program.

In this type of remedial instruction visual and auditory presentation are made by which the children can watch useful and interesting social and academic presentation on the video disc. At the same time they listen to the narration with useful instructions.

Audio tape recorder: Reading, speaking and conversation skills can be better developed within the child with the help of the tape recorder. The counselor is able to rectify many of languages learning difficulty, specially related to the pronunciation and way of speaking.

Computer Assisted Instructions (CAI): Severe LD cases find it difficult to follow classroom teaching and text book. For them, hyper text technology and hyper media technology are used and provision for using computer and computer technology is given. Additional help to the LD children, particularly in severe cases the counselor can provide the certifications of LD and help them use computer while appearing in examination.

In this way the advanced technology can be utilised for providing useful remedial measures to the learning disabled problems.

Self Assessment Questions

1) Describe some of the important childhood disorders.

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2) What is learning disability?

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3) What causes learning disability?

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4) What kind of counseling will help in LD?

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5) What is self instructional approach?

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6) Describe multi sensory approach.

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7) Elucidate the technology approach in treating LD.

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4.4 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

This is another common problem seen in the childhood, as 5% to 7 % of the school age children suffer from the (ADHD) Goldman et al. (ADHD) often referred to as hyperactivity is characterised by difficulties that interfere with effective task oriented behaviour in the children particularly – impulsivity, excessive, motor activity, and difficulties in sustaining attention.

The prevalence of ADHD is much among the boys than of the girls (6 to 9 times more). ADHD occurs with the greatest frequency before the age of eight or nine.

4.4.1 Symptoms of ADHD

The counselor must see the following symptoms in the client before deciding that the child suffers from ADHD

ADHD hyperactive children show excessive or exaggerated muscular activity; such as aimless or haphazard running or fidgeting.

Difficulty in sustaining attention

Highly distractable and fail to follow instructions.

Do not respond to the demands placed on them.

Impulsive behaviour.

Low frustration tolerance.

Some times low IQ (below average) but not always at times they are socially intrusive.

Have great difficulty in getting along with their parents because they do not obey rules.

Do not appear to be anxious.

Commonly shows specific learning disabilities as they are poor in academics.

Pose behavioural problems in elementary grades/classes.

4.4.2 Casual Factors in ADHD

At present the causes for ADHD are not known but probable causes of ADHD may be environment, biological, genetic or social. Many psychologists consider the biological factor, as the genetic inheritance to be the cause of developing ADHD. Hyper activity in children may be produced by dietary factors such as food colorings,

food addictive, food adulteration, preservatives etc. Due to such foods, hyperactivity increases because of the extra energy consumed by the children in form of chocolate candy, fast food etc.

The psychological causes of hyper activity are based on the temperament and learning factors in addition to family pathogens, prenatal problems leading to hyperactivity in children.

4.4.3 Techniques for Helping the ADHD Children

Most common treatment is the use of drug that stimulates the central nervous system. In ADHD, the counseling techniques used are more or less the same as the ones used in learning disability. In ADHD these counseling techniques are used along with medications. Psycho social approaches of counseling may also be used. The medication is seen effective only when it is combined with behaviour modification, parental training etc. and has been found to be more effective in changing the social behaviour of ADHD (Pelham 1993).

Counseling the parent of child and involving them in the treatment plan and behavioural aspect of the treatment are extremely important. It is the duty of the counselor that after diagnosing the problem correct information about the disorder should be given to parents /caretaker which should include its neutral course, positive cases, prognosis with and without treatment. They should also be given practical suggestions for the daily management of their child e.g. parents must learn the importance of avoiding stressful situation known to cause difficulty and excessive fatigue.

During the parental counseling the parents can be taught the general principle of structuring the child's environment to include regular routine and proper limits set on on the child behaviour. According to the need, and if the counselor feels that family counseling is required then the same should be taken up with the family members. Such family counseling may help because family therapy is an umbrella where whole family is the unit by which ADHD child in the family can be treated. In addition, the counselor must focus on the behaviour therapies / counseling which includes social modeling and imitation, social management, social support, self instructions , self praise and behaviour contract. Apart from this if required integrative counseling technique can be used by the counselor. More over medication and yoga has been demonstrated to be extremely effective in treating ADHD.

Self Assessment Questions

1) Define ADHD

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2) What are the symptoms of ADHD?

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3) What are the causes of ADHD?

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4) What kind of counseling would help in these cases?

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4.5 ANXIETY DISORDER

Most children are vulnerable to fear and uncertainty as a normal part of growing up. It is seen that children with anxiety disorder are more extreme in behaviour than those experiencing normal anxiety. These children show certain characteristics such as shyness, timidity, unrealistic fears, phobia for school, over dependency on others for support and help, sleep disturbances, feeling of inadequately, hypersensitivity etc.

Psychological treatments for child anxiety range from simple self management techniques to therapies that are more complex. Administering medication as a management tool can enhance psychological treatment and can prevent or control severe instances of anxiety. The type of therapy needed largely depends on the intensity and frequency of the child's anxiety

Anxiety disorder is very common in childhood as noticed by Dadds et al (1997). In fact 9.7 % of one community based school clearly met the diagnostic criteria for an anxiety based disorder.

Two additional anxiety based disorders are:

a) **Separation Anxiety:** As the name suggests, it is a disorder in children which is most common in childhood as the prevalence rate is very high. The symptoms seen in the children with separation anxiety disorder are

- Lack of confidence
- Apprehensive in new situation
- Tend to be immature for their age
- Over sensitive
- Nervous
- Easily and frequently moved to tears
- Overly dependent

The essential feature is excessive anxiety about separation from attachment figures such as mother, father, etc. This kind of disorder is common in girls.

Though it is not very stable in children, Recovery is seen faster. Some children go on to exhibits school for refusal problem i.e. Fear of leaving home and parents to attain school and continues to have adjustment difficulty in life, if it is untreated.

b) **Selective Mutism:** This is a kind of anxiety disorder where the child is unable to speak in a specific social situation. Example: in school or in social groups. These children are unable to understand and adjust within their class / society. This disorder can only be diagnosed if the child has the ability to speak and such condition should be persistently seen for one month because in initial days of schooling, many children do show these symptoms.

Mutism is very rarely seen in children. This disorder is common in all social strata and the main symptom is failure to speak in particular social situation, mainly in school.

Causes of Mutism

Amongst the various causes for selective mutism, the following are the main ones.

- Biological/genetic factors and
- Environment setting

The typical symptoms in anxiety disorder which the counselor should know before counseling/ therapy are as follows:

- Easily upset by even small disappointments.
- Manifesting unusual constitutional sensitivity.
- The learning factors which have negative influence on the mind of the children e.g. Illness
- accidents, experiences such as hospitalisation.
- Modeling effect of an over anxious and protective parent can also develop anxiety in
- children
- lack of confidence is obtained amongst these children.

Thus the role of social environmental factors also plays an important role in the onset of anxiety disorder in the children.

Repeated experiences of failure, indifferent or detached parents also foster anxiety in their children. Researchers have also shown the threatening situation which is also a cause of withdrawal.

Early childhood experiences also play an important role in causing anxiety disorder.

4.5.1 Techniques for Helping Children with Anxiety Disorder

The counselor while treating anxiety disorder in children should assess the kind of anxiety which the child is having after which process only the counsellor can provide the best counseling services and will be able to get maximum cooperation from the client and also benefit the client maximally.

A child is never too young or too old for an anxiety diagnosis. If left untreated, the anxiety may worsen and eventually spill over into adulthood resulting in a life with problems. In an attempt to escape the unpleasant feelings, the over anxious child will often turn to experimentation with drugs or alcohol.

Anxiety can be specific such as due to separation from a loved one, or more basic such as the generalised anxiety disorder. Each type of child anxiety requires a distinct

psychological treatment that includes a combination of therapies, medicines, play therapy, psychotherapy, behaviour therapy and so on.

A child that knows how to identify and handle times of stress has a better chance of tackling the anxiety before it gets out of control. Self-management tools teach a child how to recognise anxiety triggers so that the child completes prevention or control without any outside assistance.

Knowing what causes the anxiety is necessary for self-management. If the stressor is unavoidable, the child learns how to adapt and handle his or her reaction to the situation prior to it occurring.

This tool emphasises control and reinforces confidence.

Relaxation Techniques

- Taking deep breaths through the nose has a calming effect on the child.
- Being able to relax and calm down during an anxious situation significantly reduces or eliminates the adverse reaction. The best relaxation techniques focus on breathing.
- Breathing increases the supply of oxygen to the brain and naturally reduces stress.
- Focusing on the breathing creates a distraction for the child that further decreases stress.
- Coaching a child to inflate and deflate the "balloon" in their belly is one way to make deep breathing fun. That is also simple.
- Sending the breath on an elevator ride starting in the nose, traveling through the body and arriving at the toes is an imaginative anxiety relieving exercise.

Cognitive Behavioural Therapy

Cognitive behavioural therapy has the ability to transform an anxious child to a calm one.

Cognitive behavioural therapy focuses on educating the child regarding the inappropriateness of their behaviour. Using a story or role-play to act out the scenario is an ideal example of how to use cognitive behavioural therapy to help children modify their reactions.

Since fear is a large component of anxiety, a lack of education can also be a cause for concern. Little to no information about the topic or situation creates an increased fear and anxiety potential. This naturally decreases if the child possesses a full understanding of the stress learned through therapy methods.

Psychotherapy

Psychotherapy provides opportunity for the successful conquering of anxiety.

Counseling the child regularly is a popular method of dealing with anxiety. Addressing the particular aspect of the anxiety that causes the most stress can help the child overcome it. Encouraging talk reveals underlying causes of stress and anxiety and provides an outlet for the child to release fears.

If there is a specific cause for anxiety, psychotherapy can tackle it through exposure.

Slowly having the child encounter his fear can bring about a dismissal of it.

While it initially may seem to aggravate it, in the end the anxiety can be overcome.

If the fear is intense, therapists may first simulate the cause of the fear using a computer or pictures. Eventually the child will be able to deal with the real thing.

Psychiatric Evaluation

Medication may be necessary if standard psychological treatments are not completely effective.

If psychological treatments for child anxiety do not completely address the problem, medication may be helpful. Depending on the severity and complications caused by the child's anxiety, medication may or may not be necessary. The psychologist can refer the child to a psychiatrist who specialises in the specific type of anxiety. While a psychologist can identify the possible need for medication, only a licensed psychiatrist can evaluate the situation and administer the proper drugs.

As affected child have wider interaction in the school so with the help of school counselor peer group activity should be taken up by which the children are able to over come their anxiety.

The counselor should also take the help of other teachers who are aware of the need of the anxious children. This would help the counselor to have effective counseling session according to the need of the child concerned.

The most commonly used counseling is based on behaviour modification. Behaviour therapy has many techniques and the most appropriate technique is used by the counselor depending on the need of the child as given below:

4.5.2 To Provide Help with Mastering Essentials Competency

Systematic desensitisation and In vivo desensitisation that is using real life situations graded in terms of anxiety arousing stimuli.

A counselor can also use cognitive behaviour therapy with behaviour therapy, because once the beliefs and thoughts are identified, then it is easier for the counselor to treat the child. While treating the negative thinking of the child, the counselor must identify automatic thoughts of negativity in the child. Then the counselor helps the child not to blame oneself and counseling involves shifting the focus or attention on the thoughts from self to the other aspects in the situation. The counselor helps the child in searching of alternative solutions to the problem where he or she can take the help of teacher, parents, peers etc.

Cognitive rehearsal is also used in this treatment. The child or the client is given practice to visualize and imagine each successive step leading to the completion of the task, such as talking to some one, working hard at study etc., so the potential obstacles can be identified, anticipated and changed. Parental counseling and family counseling if required can be provided.

Self Assessment Questions

1) Define anxiety disorders.

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2) What are the symptoms of anxiety disorders?

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3) What are the causes of anxiety disorder?

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4) Describe the techniques used in helping children overcome anxiety disorder.

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4.6 BEHAVIOURAL DISORDERS OF CHILDHOOD AND ADOLESCENCE

4.6.1 Sleep Walk

Sleep walk is also termed as somnambulism. It is a disorder in which the children leave their bed and walk around without being conscious of the experience or remembering it later. Onset of sleep walk is usually between the ages of 6 – 12 years and according to DSM IV its prevalence is between 10% – 30%. In this disorder children go to sleep in a normal manner but during the second or third hour of sleep they may walk in the room or in other rooms or even outside of their house. They can also be engaged in complex activities like eating food, playing with toys but finally return to bed, but in the morning they do not remember anything.

Children while walking during sleep may fully open their eyes during walk or partially open their eyes. This episode lasts for 15-30 minutes. The cause is clearly not known but it takes place during Non Rapid Eye Movement (NREM) sleep. According to the researches, sleep walk is related to some anxiety arousing situations that has just occurred or is expected to occur in the near future.

During counseling, the counselor can use behavioural therapy with the client as explained above. The assessment data of neurological and medical reports should also be considered along with behaviour therapy. The other techniques which the counselor can use for treatment are as given below:

- Telling the parents to wash the face with cold water and make sure that the child is fully awakened.
- Finding out if the child is having dream / nightmare, and if it is nightmare, the type of nightmnare that the child experiences.
- Assertive training including integrative approach of counseling along with interpretation of dream can be useful.

4.6.2 Tics

Tic is a muscular twist or a spasm related to muscle. It can be blinking of eyes, licking the lip, twisting the neck, blowing the nose, clearing the throat, twisting mouth etc. It occurs generally between the ages of 2 – 14 years.

It is more common in boys than in girls. The treatments for such anxiety related issue are behaviour intervention, relaxation technique, awareness technique, cognitive technique. Yoga is also helpful in treating such clients.

4.6.3 Functional Enuresis / Encopresis

It refers to involuntary habitual discharge of urine at night even after age of 5 years. It is also called bed wetting. The counselor must notice that it may be because of the child is under stress or is unduly tired. It can also be a result of various organic conditions such as disturbed cerebral control of bladder, side effect due to medicines or neurological dysfunction. The causes can be personal immaturity, emotional problems, faulty learning, disturbed family interaction, hostility and anxiety.

While counseling conditioning procedures if used by the counselor are most effective. parental counseling , learning based procedures are most effective if required the case can also be referred for medical treatment as well with counseling .

The same kind of treatment may also be used for the children who have not learned appropriate toileting for bowel movement after age of 4 years which is named as functional encopresis.

Self Assessment Questions

1) Elucidate the various behaviour disorders of childhood and adolescence.

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2) Describe somnambulism.

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3) What are the causes of somnambulism?

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4) What is the counseling that we can use to help child overcome this disorder?

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5) Describe the Tic disorder and elucidate the causes.

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6) What treatment intervention can we plan form this disorder?

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7) What is enuresis? Discuss how the same can be overcome.

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4.7 AUTISM SPECTRUM DISORDER (ASD)

Autism is a PDD (Pervasive Development Disorder). These disorders are considered to be the result of some structural differences in the brain that are usually evident at birth or become apparent as the child begins to develop. Autism is a development disorder which involves wide range of problematic behaviour .This includes defect in language, perception, motor development not related to reality and social situations. Sometime intellectual ability is also hindered as there is impairment on memory as well.

4.7.1 Causes of Autism Spectrum Disorder

Scientists are not certain about what causes ASD, but it is likely that both genetics and environment play a role. Researchers have identified a number of genes associated with the disorder. Studies of people with ASD have found irregularities

in several regions of the brain. Other studies suggest that people with ASD have abnormal levels of serotonin or other neurotransmitters in the brain. These abnormalities suggest that ASD could result from the disruption of normal brain development early in fetal development caused by defects in genes that control brain growth and that regulate how brain cells communicate with each other, possibly due to the influence of environmental factors on gene function.

Twin and family studies strongly suggest that some people have a genetic predisposition to autism. Identical twin studies show that if one twin is affected, there is up to a 90 percent chance the other twin will be affected. There are a number of studies in progress to determine the specific genetic factors associated with the development of ASD. In families with one child with ASD, the risk of having a second child with the disorder is approximately 5 percent, or one in 20. This is greater than the risk for the general population. Researchers are looking for clues about which genes contribute to this increased susceptibility.

4.7.2 Techniques for Helping Children with ASD

The counselor can provide following method of counseling:

- Help the client in mastering the fundamentals of social behaviour
- Development of some language skills
- Behavioural counseling
- Parental counseling
- Training children to do their own work
- Engaging the child in various activities
- Behaviour modification techniques etc.

The first dimension of parenting behaviour is the Parental acceptance and warmth which appear to influence the degree to which the children internalise the standard and expectations of their parent (Eccles et al 1997). It should be noted by the counselors that children whose parents do not hold them in high regard they develop low self esteem and low self control and suffer from many anxiety disorders and other emotional and behavioural problems.

The second dimension of parenting behaviour is parental strictness and parental standards. The absence of control is associated with maladjustment and high level of aggression. Where parents are moderately controlling and sets up a high performance standard and expects increasingly mature behaviour from children are bound to have children showing high aggression.

Therefore the counsellor during parental counseling must make it clear to the parent about their parenting style and how it adversely affects the development of child's behaviour. The counseling must focus on helping parents to use permissible parenting style that is, acceptance and low control. They should stay alert for good behaviour and reward it, and reinforce rules consistently.

More over the counselor should make it clear to the teachers/parents/caretakers/ family members etc., that punishment should not damage the child's self esteem. The punishment should be swift and consistent if the child is punished he/she should be explained the reason for punishment. The best strategy is to punish an undesirable response and reward the positive alternative behaviour. For example, many troublesome behaviours in children may take the form of attention seeking.

Punishment of these responses will be more effective if parents and teachers provide the child with more acceptable ways to gain attention.

4.8 GENERAL COUNSELING TECHNIQUES

Children have their own ideas and personalities. Counseling can be as difficult for children as it is in the case of adults. Sometimes even more difficult. No matter what the purpose is, it is important to remember that communication with children is not the same as it is with adults. There are varieties of counseling techniques to use with children.

4.8.1 Defining Their World

Counseling can be difficult for children because of the implicit difficulty, with being a child and relating to an adult, especially an adult that they do not know. It is important to start therapy with a child by understanding his/her view point. Instead of starting a conversation with assumptions, lead by asking a question in their language. As rapport continues to build or as the child becomes more comfortable, he will begin to relate the question to how he feels and offer more of an explanation about his personal situation.

4.8.2 Sharing Their World

Role play is a conventional technique and can be extremely effective and revealing. Depending on the child's age, it may be more conducive to ask him to help you write a play about what it is like at home to better understand him.

Ask the child to play the role of one parent while you play the role of the other. They can help you "write" the script by describing what their mommy or daddy would typically say. Observe any emotion in the delivery of lines in the play.

4.8.3 Showing Their World

Art therapy can be an incredibly effective form of counseling with children. Although it is helpful, one does not have to be a certified art therapist to use art therapy in counseling. Most children are interested to draw or do some work of art and it can be a nice distraction in a situation where they are not comfortable verbally communicating how they feel.

Start by asking the child to draw a picture that shows what his day is like from the time he wakes up to the time he goes to bed. Observe any differences between the time he is at home and the time he is outside of the home or at school. If the child seems resistant, sit down with him and offer to do the same with the promise that you will share your picture, too.

4.8.4 Play Therapy

A play therapist much like any other mental health professional sees patients mostly one-on-one in 30- to 50-minute sessions. The Association for Play Therapy estimates that it takes about 20 sessions to address a child's problems, but some children may require more or fewer sessions. A play therapist spends time with each child and sometimes in sessions with the child's family. He/she uses specific play techniques to help the children address behavioural, learning, emotional and social problems. In some cases, these problems arise from environmental stresses, such as divorce, natural disasters, domestic violence, death or war.

4.9 COUNSELING MIDDLE SCHOOL STUDENTS

Middle school students are prime candidates for understanding their strengths and weaknesses, and their relationship with their learning environment. As such, self directed cognitive strategies can improve academic performance and school attendance, and decrease tardiness.

4.9.1 Adolescent Development

As children move towards independence in adolescence, they demonstrate improved abilities to express themselves, begin to think about their future more, and are able to deal more with abstract thought. Depending on the individual student's development, he or she may engage in more sophisticated information processing strategies, and can reflect on complicated problems.

Middle school students also tend to return to childish behaviours and can exhibit more self doubt and frustration. The strengths of development can be directed to offset the weaknesses, and mentoring, counseling and strong role models are often effectively focused to assist the student with the sometimes confusing and distracting world of middle school.

4.9.2 Counseling Strategies

Counseling options for middle school students can engage all of the cognitive processes: memory, convergence, divergence and evaluation. Students can be prompted to rely more on their memories to define, identify and designate. Convergent thinking asks the student to consider explanations, relationships and comparisons. Divergent thinking predicts, hypothesizes, infers, and reconstructs. Evaluative thinking judges, defends and justifies choices.

Using memory, a counselor can prompt the student to identify classroom expectations and standards, social norms and personal goals. The student uses her convergent skills in explaining why these standards are applicable to her, how her goals are important to her, her family, and peers, and can compare and contrast her feelings and ideas with those of others. The counselor can prompt the student with "If... then..." scenarios, and hypothetical situations to develop divergent thinking skills. Finally, the counselor may ask the student his opinion of another's actions or words, and then his own, then justify behaviour based on opinion and precedent.

The counselor can also consider motivation as a cognitive process. "Motivational Enhancement Therapy" focuses on enhancing adolescents' academic motivation. Counselors meet with students and help them focus and be aware of the motivational issues they face rather than denying them.

Counselors also assist the students to develop lasting strategies to maintain their motivation and achievement. Motivators can include goal achievement, competition, self-esteem and self-efficacy, and positive social standards.

The great strength of adolescence is that it is the door to independent living. Middle school students are developing independent thought processes and can be counseled to use these cognitions to benefit their development and growth. Counselors who successfully use cognitive strategies with their students find the student engaged and often receptive to the increased responsibility.

4.10 OTHER COUNSELING TECHNIQUES

The counselor can also help the children by the following counseling techniques:

- Helping the children to assess their own motives in self improvement
- Helping the children in developing self efficacy
- Assisting them in overcoming self defeating behaviour
- Assisting them in self monitoring

4.10.1 Self Assessment

The counselor helps the clients specially children who are more than age of 7, to assess their own motives. It will reflect on truthful information about themselves and they can self verify where the problem is, and self improvement is seen in the children and they will develop a positive feeling for them selves. The only task of the counselor here is to provoke the client about his/her past immediate experiences.

4.10.2 Self Efficacy

Self efficacy is the people's convictions that they can achieve specific goals. The counselor assesses the client to build up self efficacy which also varies according to the children skills e.g. a child may have high self efficacy when it comes to making friends but low self efficacy when it comes to speaking in front of groups or large audience. So self efficacy is concerned not with skills the child has but with his/her belief about what he can do with the skills, therefore the counselor's attention must be such that making the child believe "I think, I can, I think I can" etc. In this manner the counselor can help client (children in four different ways as stated by (Bandura 2000).

1) **Mastering experiences –** mastering new skill can reduce the problem of the child and encourage the children to learn from their own mistakes. This approach provides children with mastering experiences they need to build self efficacy and approach future challenges with confidence.
2) **Vicarious experiences –** the counselor helps the child to improve self efficacy by watching others perform a skill that he/she wants to learn e.g. choosing a model figure and bringing changes in one self by watching.
3) **Persuasion and encouragement –** if the child is encouraged and rewards are given on the smallest steps that they take towards mastering a skill, then one can see the changes in their behaviour. This will help them to become successful.
4) **Interpretation of emotional arousal –** if the child is suffering from anxiety disorder then there are chances of some symptoms related to physiological changes can also be seen.

So the counselor helps the client to bring alternatives to do well and boost the child in believing that he /she will get success.

4.10.3 Self Defeating Behaviour

Children suffering from anxiety disorder generally show self defeating behaviours which are of three categories as given by Roy Baumeister, 1997. Let us take these one by one.

1) **Deliberate self destruction** – children want to harm them selves
2) **Trade offs** - it is seen in the form overeating stress, emotional distress, shyness etc.
3) **Counter productivity –** children show unproductive behaviour by being attached to one thing only. This type of behaviour is mostly seen in children who have emotional problem.

Therefore, the counselor must help and assist children by using client centered approach where unconditional positive regard is given and importance is given to one self.

4.10.4 Self Monitoring

The counselor holds the client to control the negative attitude / impression the children make on others. Clients who are high self monitors seem to be very sensitive to their impact on others (Mark Snyder 1986, 2000). Low self monitor on the other hand are less concerned about impression management and behaviour, therefore low self monitor sees themselves as having the strong principles and behaving in line with them, where as high self monitors perceive them selves as flexible and pragmatic. So the counselor helps to moderate self monitoring building within the clients by which high adjustment is seen and proper self efficacy is built up.

These techniques can be useful if children are able to recognise their self image by learning, more about themselves, try to set their goals that are reachable, that is the goals should be short term, reachable and the counselor must help the children to recognise their goals, and help the children to emphasise on their strength by which the children will think positively and their emotions will be stable which will enhance their personality.

Self Assessment Questions

1) Describe Autism Spectrum Disorder.

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2) What causes ASD?

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3) Describe the techniques of counseling used to overcome autism.

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4) Describe the various general counseling techniques used for children.

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5) What are the typical problems middle school children and adolescents face?

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6) What strategies do we use to help these children overcome their problems?

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7) Describe other counseling techniques.

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4.11 LET US SUM UP

In this unit we have been dealing with the topic of counseling children. We started with the various disorders children suffer from such as the learning disability, Attention Deficit Hyperactivity Disorder, Anxiety disorder etc. We also delineated the causes of these disorders, nature, course, symptoms and treatment of these disorders. We also discussed the techniques of counseling that are suited to children suffering from the different disorders. We then discussed the Autism Spectrum Disorder, delineated the causes and pointed out the various techniques of counseling that would help in these cases. Then we discussed the general counseling techniques and pointed out the problems faced by children in middle schools and the strategies one should use to help these children. Other techniques discussed included self monitoring, self efficiency and self defeating behaviours.

4.12 UNIT END QUESTIONS

1) Explain causes and symptoms of Learning disability?

2) What are the techniques for helping learning disability?

3) Explain briefly multisensory approach, Behaviour approach, Psycho analytic approach of counseling?

4) What is Individualised instructional approach?
5) How Self instructional approach is used?
6) What is the Technological approach to counseling?
7) What are the casual factors in ADHD and its symptoms?
8) What do you understand by separation anxiety and selectivity mutism?
9) Explain the following –
   - Relaxation Techniques
   - Cognitive Behavioural Therapy
   - Psychotherapy
10) What are symptom disorder and its Treatment?
11) What are General counseling techniques for children?
12) Why Play therapy is important for children?
13) What are Counseling Strategies for middle school students?

4.13 SUGGESTED READINGS

Eric J.Mash and Russel A.Barkley (2007). *Assessment of Childhood Disorders.* The Guilford Press, London.

Philip C. Kendall (2000). *Childhood Disorders.* Psychology Press. Ltd. New York.

UNIT 1 INTRODUCTION TO BEHAVIOUR MODIFICATION AND COGNITIVE APPROACH IN COUNSELING

Structure

1.0 INTRODUCTION

Learning is an integral part of life. We learn and unlearn many things from our day to day experience. Since we learn things, we can also unlearn those things. The behavioural counseling approach is based on this assumption of learning and unlearning different aspects of behaviour. We tend to acquire and continue those behaviours that are approved, reinforced and rewarded; whereas behaviour that is not approved or considered undesirable tend to disappear. Thus the behavioural approach makes use of principles of reward, reinforcement and punishment to bring about desired changes in behaviour. However, this approach was mechanical in nature which assumed that human behaviour is governed by external stimuli only.

Human being is not so mechanical as to be regulated by the S – R (stimulus-response) mechanism. What about the thoughts, perception, feelings and beliefs of the human being? Hence it is not only the mechanical acquisition of physical responses, but the perception of the situation by the child also gets associated with physical responses. This led to the emergence of cognitive behavioural approach (Ellis, 1962; Beck, 1976; Meichenbaum,1977). According to this approach, thoughts, ideas, beliefs form an important part of behaviour which is learned. The behavioural view ignored

the subjective experiences of the individual. The individual was seen as passive human beings having no free will of their own. However, the cognitive behavioural approach considered thoughts, ideas, beliefs as important part of human behaviour.

Thus in this unit we are going to learn about the meaning of behaviour approach as well as cognitive approach to counseling. The procedure for each approach will be described and the different techniques under behavioural modification and cognitive approach will also be discussed. Finally the potentials and limitations of both behavioural and cognitive approaches to counseling will be delineated.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define behaviour modification and cognitive approach in counseling;
- Explain the principles of behaviour modification;
- Describe the procedure of behaviour modification and cognitive therapy;
- Explain the different techniques of behaviour modification and cognitive therapy; and
- Analyse the potentials and limitations of both behaviour and cognitive therapy.

1.2 INTRODUCTION TO BEHAVIOUR MODIFICATION

Behaviour modification or behavioural counseling is a form of psychotherapy that is based on the learning theories of classical conditioning and operant conditioning. It applies these learning principles to bring about positive changes in behaviour and reduce or eliminate undesirable behaviour. Behaviour modification employs empirically tested behaviour change techniques to improve behaviour and/or reduce maladaptive/undesirable behaviour. It refers mainly to techniques for increasing adaptive behaviour through reinforcement and decreasing maladaptive behaviour through extinction or punishment.

The first use of the term behaviour modification appears to have been used by Thorndike in the year 1911. He talked about the Law of Effect where responses followed by satisfying state of affairs were strengthened whereas responses followed by dissatisfying state of affairs were decreased or discontinued. The learning theories of classical conditioning by Pavlov and operant conditioning by Skinner have further contributed to the development of behaviour modification approach to counseling. Classical conditioning proposes that our behaviour /responses are conditioned, i.e., there is an association between the stimulus which elicits the response and our response. When this association becomes strengthened on the basis of reward, conditioning happens and the behaviour is learned. This is the basic conditioning process. Operant conditioning is based on the law of effect. This conditioning consists of behaviour that is followed by consequences that are satisfying to the organism and so will be repeated. Behaviour that is followed by unpleasant consequences will be discouraged. For example, when a child throws temper tantrum, parents give in to his demand. As a result, the child learns that if he throws tantrums, his needs will be satisfied. Here parents attention and giving in to his demand is the reinforcer for the child and thus the child will repeat the same behaviour in the future.

1.2.1 Definition of Behaviour

First let us see what do we mean by behaviour? Behaviour is such a term which we use commonly and yet we may not be aware of its exact meaning. We talk about behaviour using the terms such as hard-working, kind, sociable, ungrateful, independent, selfish etc. However, if we analyse, these terms do not refer to the specific things we note in a person when for instance, we say hard-working or selfish. In general we may understand what selfish behaviour means or nervous behaviour means; but we may not know the person's nervousness refers to his nail-biting, or fidgeting, or pacing in the room? It is very essential that we talk about behaviour very specifically.

Essentially, behaviour is anything that a person says or does. Behaviour modifiers generally talk very precisely about the behaviour. This helps in focusing on the particular aspect of behaviour which need to be changed. Behaviour also need to be described either as behavioural deficits or behavioural excesses. Behavioural deficit refers to something lacking, e.g., the child is not able to mix and interact with his classmates; the child has not learned how to eat in a proper manner in a restaurant; the teacher is not able to manage her anger if some child disturbs her class; the manager does not know how to conduct himself in a board meeting. Behavioural excesses refer to behaviour which is out of control, for example, a child showing tantrums; an adult engaged in continuous smoking or drinking; a child eating candies and toffees frequently; or seeing television continuously.

Thus there is a deviation of behaviour, either lack or excess of behaviour, which causes the problem and need to be addressed. Behaviour modification helps in changing these problem behaviours and establishing the appropriate behaviour. However, one thing to be noted here is that identification of behavioural lack or behavioural excess should always consider the context, the culture and the ethics of the persons involved. Although some behaviour like self injurious behaviour is always inappropriate no matter what the context is.

1.2.2 Meaning of Behaviour Modification

Thus Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and eliminate undesired behaviours. The behaviour modification approach involves the development and encouragement of desirable behaviours and removal and reduction of undesirable behaviours by methods based on the learning and reinforcement principles.

In simple terms, behaviour modification assumes that behaviours can be acquired/ learned and can also be unlearned. Hence if the child has learned any negative behaviour, it can also be unlearend and new desirable behaviour can be learned. Thus the relationship between observable stimuli and response is important; and reward and punishmnet can be used to control and regulate this relationship between stimulus and response.

Thus according to Skinner, greater or lesser reinforcement can be used to modify behaviour. For example, Rajan , a 5 year old boy always pushes other children in front of him and has not learned to stand in a line and wait for his turn. Behaviour modification in this case will help the child to change his behaviour by the use of reward and learn to be disciplined while standing in a line.

1.2.3 Principles of Behaviour Modification

Behaviour modification principles and practices are used to assist individuals with developing new, desirable behaviours while eliminating behaviours that are no longer useful. Reinforcement and punishment are the main principles of behaviour modification. Reinforcement strengthens a behaviour, while punishment weakens a behaviour. Both can be either positive or negative.

Positive reinforcement describes desirable behaviour rewarded with a pleasant stimulus, while negative reinforcement describes desirable behaviour rewarded with the removal of a negative stimulus.

Positive punishment occurs when an undesirable behaviour results in the addition of a negative stimulus, while negative punishment occurs when an undesirable behaviour results in the removal of a pleasant stimulus. For example, a rat accustomed to receiving food when pressing the lever, no longer receives food when pressing the lever. The rat has experienced negative punishment. However, positive punishment is not much used, because when misused, more aversive punishment can lead to affective/emotional disorders. The difference between positive and negative reinforcement is that in positive reinforcement, a response/behaviour produces a stimulus (positive reinforcer), whereas in negative reinforcement a response removes the occurrence of a negative stimulus. Examples of positive reinforcers are food, money, recognition; whereas negative reinforcement leads to the learning of avoidance and escape responses. For instance, when we ignore the child when he throws a tantrum, it is a negative reinforcement.

Thus positive reinforcement as well as negative reinforcement both tend to increase or strengthen behaviour. However, negative punishment , decrease or weaken the undesirable behaviour. When the child misbehaves and given time out (removal of the pleasant stimulus, for example, being with friends), it leads to decrease the undesirable behaviour of the child.

The principles of operant conditioning which are used for the behaviour modification also applies a schedule of reinforcement to bring about the desired results. Target behaviours are reinforced as soon as they occur, while negative behaviours are discouraged. Reward and punishment tools are also used to strengthen new behaviours. In effect, these tools work to redirect a person's motivations toward the desired outcome.

Further, a behaviour, or habit, is framed by what happens before and what happens after the behaviour is carried out. The principle of extinction is also made use of which works by removing or changing what happens after the behaviour takes place. In effect, the incentive or reward that motivates a person to carry out a certain behaviour is taken away. When this happens over and over again, the motivation to indulge in a certain behaviour begins to fade. Eventually the behaviour itself becomes extinct for lack of incentive.

Self Assessment Questions

1) Explain the meaning of 'behaviour'.

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2) What do you understand by the term behaviour modification?

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3) Describe the principles of behaviour modification.

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4) Fill in the blanks with the following alternatives:

(Deficits, reinforcement, undesirable, unlearned)

a) Behaviour modification involves the reduction of _____ behaviours.

b) Behaviour modification makes use of the principle of _____to bring desirable changes in behaviour.

c) The basic premise of behaviour modification is that 'if a behaviour is learned, it can be _____.'

d) Behaviour is described in terms of behavioural excesses and behavioural _____.

1.2.4 Steps/Procedure of Behaviour Modification

The goal of behaviour modification is always to bring about a change in the behaviour. The change may be in terms of:

- a newly developed behaviour
- increase or strengthening of a behaviour
- maintaining a behaviour at a particular rate or pattern of occurrence
- decrease or change in a behaviour

Deciding the goal is only one part of the entire procedure for behaviour modification. First of all we need to analyse the problem behaviour through a process of behavioural assessment. Behavioural assessment helps us to understand the problem in its different aspects, in different contexts and across different settings/situations. The problem is studied in detail:

Frequency – how often the behaviour occurs, e.g., how many times the child has used abusive language in a class duration

Duration – how long the problem behaviour lasts, e.g., the child goes on talking abusive language or uses it for a while only

Intensity – how severe is the behaviour, e.g., the child uses extreme abusive language or mild abusive language

Thus baseline data forms an important step in the behaviour modification plan. Specific information about the behaviour is collected . The ABC model of behavioural analysis, also called functional analysis is used. The ABC model refers to

- A antecedent it: describes what happens just before the occurrence of the behaviour
- B behaviour: it describes the client's behaviour
- C consequence: it describes the consequence, i.e. what happens after the behaviour

Antecedents help in understanding the problem in detail, what precipitates the problem, when it occurs, at what setting it occurs, who are present, what type of event/ situation usually leads to the behaviour/ problem in question. Behaviour refers to the behaviour shown or demonstrated. Consequences determine the client's behaviour. Consequences refer to what does the behaviour lead to- how do parents, teachers, peer respond to the child's behaviour – this determines whether the behaviour will continue or be modified or decrease or increase.

In other words, the ABC model can be described as follows: What comes directly before the behaviour?", "What does the behaviour look like?", and "What comes directly after the behaviour?" respectively. Once enough observations are made, the data are analysed and patterns are identified. If there are consistent antecedents and/or consequences, an intervention should target those to increase or decrease the target behaviour. If the behaviour pattern shows a particular antecedent or trigger, then intervention can be to avoid that trigger as far as possible and to learn a new behaviour in the presence of the trigger. If a problem behaviour occurs because it achieves some purpose, then there is a requirement to teach an alternative behaviour which will achieve the same purpose without creating any problem.

The functional assessment helps in understanding the behaviour . This facilitates in planning the appropriate intervention technique. The following steps can be delineated in the behavioural assessment process:

The problem behaviour is described in detail with example of its occurrence.

- All the antecedent factors are also elaborated.
- The consequences are noted down.
- The goals are specified.
- Accordingly the target response is stated in precise terms.
- The particular intervention to be used is finalised and implemented.
- Follow up and evaluation is done. If the intervention did not bring in the desired result, then we again go back to the first step of analysing the problem in detail in terms of the antecedent factors and then deciding on the intervention strategies to be adopted.

For instance, the problem is the aggressive behaviour of the child in the playground. Examples of occurrence of the aggressive behaviour by the child in the playground is cited. When did it occur, how did it start, what was the duration and intensity etc. The consequences: how did the teacher react to the aggressive behaviour of the child, how did other classmates present reacted , and any other consequence, may be punishment by the principal of the school are also noted. Analysis of the antecedent and consequences of the problem then leads to the setting of goals. The goal may be to reduce the aggressive behaviour of the child. To achieve this goal, the target response, i.e. the response which need to be changed are specified. In this case, the target responses may be reduction in hitting behaviour, using abusive language, overcoming getting angry very quick. Thereafter, the appropriate intervention technique to be used are decided and implemented.

1.2.5 Techniques of Behaviour Modification

Behaviour modification uses different techniques to modify a person's behaviour. It's based on the use of a reward system that targets specific behaviours. Rewards are used to reshape a person's motivations so old habits are eliminated and new, more beneficial habits are formed.

Three techniques of behaviour modification are (i) systematic desensitisation, (ii) aversive conditioning and (iii) token economy. Other techniques include (iv) extinction and (v) biofeedback. The three techniques are given in detail in the following paragraphs.

i) Systematic Desensitisation

Systematic desensitisation is a behaviour modification practice used to eliminate fears or undesirable emotions. It is based on the classical conditioning principles of pairing anxiety provoking stimulus/event with a relaxation response. Exposure to the fear-producing stimuli while focusing on relaxation techniques eventually leads to the fear-inducing stimuli resulting in the relaxation response, rather than fear. The assumption here is that relaxation and anxiety cannot go together. If we bring in relaxation, then anxiety has to go. Thus systematic desensitisation uses the principle of counter conditioning, which counters the anxiety connected with a particular behaviour or situation by inducing a relaxed response to it instead. This method is often used in the treatment of people who are afraid of flying. Another example of this practice will be removing the fear of public speaking. This is done by gradually exposing the person to the experience of public speaking. Speaking in front of the family or a small group of friends may be the first step. The person then gradually works up to speaking in front of a larger group of strangers or associates.

Systematic desensitisation involves the following steps:

Step 1: Constructing an anxiety hierarchy

The first and most important requirement is to construct/prepare a list of all the situation/events/objects that evoke fear or anxiety in the client. This has to be arranged in a hierarchical order from lowest anxiety provoking stimulus to the highest anxiety provoking stimulus. The degree to which each item produces anxiety is measured in terms of Subjective Unit of Distress (SUD).There should usually be 5-10 SUD difference between each item in the hierarchy. An example of an anxiety hierarchy in case of a person who has fear of speaking in the public is as follows. Rahul is a newly recruited manager of the company and he has to attend a conference of the managers from the region and represent his company's policies and progresses. But Rahul is very anxious about this . Systematic desensitisation can be used to help Rahul overcome his anxiety. First of all the counselor can help Rahul construct an anxiety hierarchy. The list may be as follows:

Two weeks before the conference, reading the brochure for the conference of the managers

Ten days before the conference, discussing with senior managers about things to be presented in the conference.

Eight days before the conference, discussing with the colleagues about the conference.

Six days before the conference, preparing notes on the things to be presented.

Four days before the conference, rehearsing the things to be presented

One day before the conference, keeping the materials ready that need to be taken to the conference.

The night before the conference day

Morning of the conference, getting ready for the conference

Arriving at the conference venue

Meeting other managers from other companies

Rahul's turn comes to present his company's case

Step 2: Training in relaxation

This consists of helping the client achieve a relaxed state of body and mind. Different kinds of relaxation techniques are available. Jacobson's progressive muscular relaxation is commonly used, though it requires training and takes longer time. Among other relaxation methods are 'Shavasana', meditation, 'pranayama' and so on. The main thing here is that the client should find it comfortable and achieve the desired state, i.e., relaxation. Jacobson's relaxation technique is based on the premise that muscular tension and relaxation are incompatible. It involves creating muscular tension in each part of the body and then relaxing it. This practice of alternatively tensing and the relaxing the group of muscles one by one creates a very relaxed state, e.g., for relaxing hands, make a fist , create the tension , feel it, and the gradually relax them by releasing the hand. When we are in anxious state our muscle groups ate tensed. Hence we need to know how to release that tension and make it relaxed.

Step 3: Presenting anxiety provoking items during relaxation state

The last step is presenting the hierarchy of anxiety provoking items one by one when the client is in a relaxed state. It starts from the lowest anxiety producing stimulus to the highest anxiety producing stimulus. The client relaxes and then presented with the first item in the list, and the the client relaxes again. Then the client is presented the next item in the list. The client visualizes each stimulus/situation for at leas 20-30 seconds. If the client experiences anxiety while visualizing any particular item, he can stop there and relax; and then visualize a new item in between, e.g., in the above instance, if Rahul experiences anxiety at the item – six days before the conference; then a new item can be introduced there – seven days before the conference.

This pairing of anxiety provoking situation with relaxation helps one to be able to face the situation and gradually gain confidence in approaching the real life situation later.

ii) **Aversive Conditioning**

Aversion helps break bad habits through associating aversive stimuli to the undesirable habit. Eventually, the undesirable habit becomes associated with the negative consequence and the behaviour is reduced.. This technique employs the principles of classical conditioning to lessen the appeal of a behaviour that is difficult to change because it is either very habitual or temporarily rewarding. The client is exposed to an unpleasant stimulus while engaged in or thinking about the behaviour in question. Eventually the behaviour itself becomes associated with unpleasant rather than pleasant feelings. One treatment method used with alcoholics is the administration of a nausea-inducing drug together with an alcoholic beverage to produce an aversion to the taste and smell of alcohol by having it become associated with nausea.

iii) **Token Economy**

Human behaviour is routinely motivated and rewarded by positive reinforcement. Token economy is based on systematic positive reinforcement where rules are established that specify particular behaviours that are to be reinforced, and a reward system is set up. A token economy is a highly effective behaviour modification technique, especially with children. In this technique, desired behaviours result in the reward of a token—such as a poker chip or a sticker—and undesirable behaviours result in the removal of a token. When children obtain a certain number of tokens, the children get a meaningful object or privilege in exchange for the tokens. Eventually, the rewarding of tokens decreases and desirable behaviours display independently.

iv) **Extinction**

Eradicating undesirable behaviour by deliberately withholding reinforcement is another popular treatment method called extinction. For example, a child who habitually shouts to attract attention may be ignored unless he or she speaks in a conversational tone. This is based on the principle that if the behaviour is not rewarded or encouraged, it will become extinct.

v) **Biofeedback**

Behaviour modification principles also can be used to treat emotional problems that are triggered by a physical symptom. Biofeedback is a method that provides immediate feedback on a person's physiological state, be it heart rate, breathing rate or blood pressure. Feedback is provided by a mechanical device that lets the person know when a particular symptom is present. By controlling the symptom, the resulting emotional response can be prevented. An example of this would be someone who has problems controlling anger. The increases in breathing rate and heart rate can be monitored and controlled with practice. Once controlled, a person is better able to control an angry outburst.

1.2.6 Potentials and Limitations of Behaviour Modification

The whole point of behaviour modification techniques is to change undesirable or harmful behaviours and replace them with healthier, more desirable ones. There are many advantages of the behavioural approach to counseling.

When applied properly, the technique can be effective in working with children, adults and animals also. In fact it can be used for changing the behaviour of any living beings. Animal trainers frequently turn to behaviour modification techniques to help pet owners turn bad habits into good habits. They also make use of behaviour techniques to train animals the different types of new behaviour as we see in animal and birds shows.

Behavioural modification aims at enabling the clients to take charge of their behaviour. Substance abuse counselors, for example, often encourage clients to take ownership of their behaviours and change them using behaviour modification techniques. The subject/client in the behavioural intervention takes an active role and ownership of the change process.

The basic concepts and methods of behaviour modification are pretty easy to understand and implement.

Behavioural approach focusses on the current behavioural problems in the context of the individual's current environment/situation. It does not analyse the past events/ happenings/situation.

Behavioural intervention spells out achievable behavioural goals in terms that enable you to measure your success. The intervention techniques follow a systemaic step by step procedure. A series of steps are delineated that to bring about change and lead to the desired behaviour.

There are a variety of therapeutic techniques and procedures associated with behaviour modification, so the technique is best used by specially trained, skilled practitioners.

Self Assessment Questions

1) Describe the process of functional analysis of behaviour with example.

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2) Seema has extreme fear for examination. Construct an anxiety hierarchy for her.

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3) Explain the meaning of token economy.

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4) List out the advantages of behavioural approach in counseling.

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5) Fill in the blanks from the following choices:

(Consequence, frequency, present, antecedent)

a) _____ refers to the number of times a behaviour occurs.

b) _____ describes the things that occur before the occurrence of the problem behaviour.

c) In the ABC model of behaviour analysis, C refers to _____.

d) Behavioural approach in counseling focuses on the _____ events.

1.3 INTRODUCTION TO COGNITIVE APPROACH

Cognitive approach in counseling emphasises the role of cognition or thought in influencing our behaviour. As opposed to behavioural changes based on reward or punishment system, the cognitive approach focuses on the role that thinking plays in how do we feel and behave. Transformation of how one thinks becomes critical in producing behavioural changes. Cognitive approach in counseling points out the dynamics of the human being in terms of his thoughts, attitudes, beliefs and values. Hence it is not simply a stimulus – response mechanism; the organism in between plays a vital role with all his thoughts and attitude in bringing about behavioural changes.

The fundamental principle here is that thoughts (cognitions) cause our feelings and behaviours. Thus cognitive therapy is based on the idea that our *thoughts* cause our feelings and behaviours, not external things, like people, situations, and events. Hence we can change the way we think to feel / act better even if the situation does not change. Thus, in cognitive therapies the counselors focus on teaching the clients how to think differently. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. Therapists in the cognitive field work with clients to solve present day problems by helping them to identify distorted thinking that causes emotional discomfort. There's little emphasis on the historical root of a problem. Rather, the focus is on what's wrong with my present thinking that is causing me distress.

Aaron Beck developed cognitive therapy in the 1960s. The treatment is based on the principle that maladaptive behaviour (ineffective, self-defeating behaviour) is triggered by inappropriate or irrational thinking patterns, called automatic thoughts. Instead of reacting to the reality of a situation, an individual automatically reacts to his or her own distorted view of the situation. Cognitive therapy strives to change these thought patterns (also known as cognitive distortions), by examining the rationality and validity of the assumptions behind them. This process is termed cognitive restructuring.

Cognitive therapy is different from behaviour therapy in that it focuses mostly on the thoughts and emotions that lead to certain behaviours.

In other words, behaviour therapy is more action-based and cognitive therapy is the mental or emotional beginnings that drive us to perform those actions. Usually in practice both cognitive and behavioural principles are combined to deal with the problems. Hence it is called cognitive behavioural approach which counselors more frequently use in counseling. Most therapists seem to feel that the best form of psychotherapy is a combination of these two principles. This is what's known as *cognitive behaviour modification*, or cognitive-behavioural therapy,

Cognitive behavioural therapy is based on the idea that our feelings are governed by our thoughts about situations, people, and events in our lives and not those things themselves. Rather than focusing on changing the external forces we see as causing the problems, cognitive behavioural therapy focuses on changing the way we think to help us feel better. By learning to think differently, a person can develop rational self-counseling skills that can be used to deal with life. Thus cognitive behaviour therapy is defined as therapy that is based on the belief that our thoughts are directly connected to how we feel. Cognitive-behavioural therapy attempts to change clients' unhealthy behaviour through cognitive restructuring (examining assumptions behind the thought patterns) and through the use of behaviour therapy techniques. For

instance, in the treatment of eating disorders, therapists can help clients to change attitudes and thoughts about ideal body shape and weight; but also at the same time should focus on changing the client's behaviour of eating unhealthy diet and replace it with normalised eating patterns. Thus both cognitive as well as behaviour therapy are involved.

1.3.1 Steps/Procedure of Cognitive Therapy

The focus in cognitive behaviour intervention is the thinking pattern. Hence the first important step is to identify the faulty/irrational thought patterns. Using the Socratic method is one way to do this. By questioning our thoughts about a situation that creates anxiety and stress in us, we can pinpoint the irrational assumptions through which we view situations. If a person is upset because a friend isn't returning a phone call, he may assume that the friend is angry with him; whereas it may be that his friend might have been busy in some important work. Similarly, when the officer calls his junior repeatedly and the latter does not pick up the phone, the officer thinks that the junior knowingly avoids to do work. However, it may be that the junior could not answer the call because of some problem in the phone. Once a person understands their irrational thought patterns, they can use this information to modify their behaviour as they deal with the situations and events of their life that might be causing them problems

In many instances we jump to immediate conclusion and our behaviour becomes governed by this. However, this may lead to problem behaviour. Immediate emotional reactions to situations are created in an area of the brain known as the limbic system. This area of the brain moves fast and reacts to situations based on instantly made impressions. This is helpful when a speeding car is coming at us and we need to freak out and run, but more complex situations need a reaction based more on knowledge, facts, and experience. In these situations speed is not a virtue. The part of the brain used to process these facts is the prefrontal cortex. Unfortunately, this area of the brain takes longer to react, giving people the opportunity to act impulsively in situations using irrational assumptions. If a person can learn to modify the impulsive behaviour and wait for the prefrontal cortex to kick in (in other words, think things through), they can modify the effect the situation has on their emotional state and, sometimes, the situation itself in a more positive manner. Thus irrational ideas/thoughts need to be identified and questioned in order for the positive change in behaviour to occur.

Corey (2009) proposes the following three stages in cognitive behaviour therapy.

Phase 1: Self-Observation

This phase involves listening closely to your internal dialogue or self-talk and observing your own behaviours. You want to be especially aware of any negative self-statements that are actually contributing to your anxiety and panic symptoms.

Phase 2: Begin New Self-Talk

Once you recognise your negative self-talk, you can begin to change it. As you "catch" yourself in familiar negative thought patterns, you recreate a new and positive internal dialogue. "I can't" becomes "It may be difficult, but I can." These new self-statements now guide new behaviours. Rather than using avoidant behaviours to cope with panic and anxiety, you become willing to experience the anxiety-provoking situations. This leads to better coping skills, and as your small successes build upon one another, you make great gains in your recovery.

Phase 3: Learning New Skills

Each time you are able to identify and restructure your negative thoughts and change your response to panic and anxiety, you are learning new skills. Because you are now acutely aware of your thoughts, you are better able to gauge your anxiety and react in a more useful manner.

When your negative thoughts control you, it becomes difficult to control your behavioural responses to unpleasant situations. But, CBM can give you back some lost control. As your thoughts change from negative to positive, you start to behave differently in many situations. And, you will likely find that others react differently to the new "positive" you as well.

Self Assessment Questions

1) Discuss the meaning of cognitive therapy.

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2) Describe the stages in cognitive therapy.

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3) Fill in the blanks from the following alternatives.

(Restructuring, thoughts, distortions)

a) Cognitive therapy places emphasis on _____.

b) Cognitive therapy achieves its aim through cognitive _____.

c) The irrational thought patterns are also called cognitive _____.

1.3.2 Techniques of Cognitive Therapy

The prominent cognitive therapies are Cognitive Behaviour Therapy by Aaron Beck (1976) and Rational Emotive Behaviour Therapy by Albert Ellis (1960). Eric Berne's (1964) Transactional Analysis is also another cognitive intervention used by the therapists.

1.3.3 Cognitive Behaviour Therapy

The therapy assumes that an individual's emotions and behaviour are the outcome of the way in which he thinks about the world. According to Beck, people experience emotional problems when they engage excessively in fallacious or dysfunctional thinking. These are irrational or faulty thought patterns. Here are the ten most common irrational thought patterns or cognitive distortions (Beck, 1976; Burns, 1992).

All or none thinking

This is thinking in terms of either good or bad, e.g., your friend always needs to be good to you.

This type of distortion is the culprit when people think in extremes, with no gray areas or middle ground. All-or-none thinkers often use words like “always” and “never” when describing things. “I always get stuck in traffic!” “My bosses never listen to me!” This type of thinking can magnify the stressors in your life, making them seem like bigger problems than they may, in reality, be.

Overgeneralisation

It refers to our drawing a conclusion based only on a single incident, e.g., when you asked for some help to your neighbour and did not get it, you conclude that your neighbour is not good. Those prone to overgeneralisation tend to take isolated events and assume that all future events will be the same. For example, an overgeneraliser who faces a rude sales clerk may start believing that all sales clerks are rude and that shopping will always be a stressful experience.

Mental Filter

Those who use mental filtering as their distortion of choice tend to gloss over positive events and hold a magnifying glass to the negative. Ten things can go right, but a person operating under the influence of a mental filter may only notice the one thing that goes wrong. (Add a little overgeneralisation and all-or-nothing thinking to the equation, and you have a recipe for stress.)

Disqualifying the Positive

Similar to mental filtering, those who disqualify the positive tend to treat positive events like flukes, thereby clinging to a more negative world view and set of low expectations for the future. Have you ever tried to help a friend solve a problem, only to have every solution you pose shot down with a “Yeah but...” response? You’ve witnessed this cognitive distortion firsthand.

Jumping to Conclusions

People do this one all the time. Rather than letting the evidence bring them to a logical conclusion, they set their sights on a conclusion (often negative), and then look for evidence to back it up, ignoring evidence to the contrary. The kid who decides that everyone in his new class will hate him, and ‘knows’ that they’re only acting nice to him in order to avoid punishment, is jumping to conclusions. Conclusion-jumpers can often fall prey to mind reading (where they believe that they know the true intentions of others without talking to them) and fortune telling (predicting how things will turn out in the future and believing these predictions to be true).

Magnification and Minimization

Similar to mental filtering and disqualifying the positive, this cognitive distortion involves placing a stronger emphasis on negative events and downplaying the positive ones. The customer service representative who only notices the complaints of customers and fails to notice positive interactions is a victim of magnification and minimization. Another form of this distortion is known as ‘catastrophizing’, where one imagines and then expects the worst possible scenario. It can lead to a lot of stress.

Emotional Reasoning

This one is a close relative of jumping to conclusions in that it involves ignoring certain facts when drawing conclusions. Emotional reasoners will consider their emotions about a situation as evidence rather than objectively looking at the facts. "I'm feeling completely overwhelmed, therefore my problems must be completely beyond my ability to solve them," or, "I'm angry with you; therefore, you must be in the wrong here," are both examples of faulty emotional reasoning. Acting on these beliefs as fact can, understandably, contribute to even more problems to solve.

'Should', 'must' statements

I must get Grade A, I should obey my parents all the time, I must have this top brand toy set, I should be loved by all – these are the statements which are irrational and illogical and lead to problems. Those who rely on 'should statements' tend to have rigid rules, set by themselves or others, that always need to be followed — at least in their minds. They don't see flexibility in different circumstances, and they put themselves under considerable stress trying to live up to these self-imposed expectations. If your internal dialogue involves a large number of 'shoulds,' you may be under the influence of this cognitive distortion.

Labeling and Mislabeling

Those who label or mislabel will habitually place labels that are often inaccurate or negative on themselves and others. "He's a whiner." "She's lazy." "I'm just a useless worrier." These labels tend to define people and contribute to a one-dimensional view of them, paving the way for overgeneralisations to move in. Labeling cages people into roles that don't always apply and prevents us from seeing people (ourselves included) as we really are.

Personalisation

When you attribute everything to your self – that you are the cause of it – it causes anxiety and distress. Those who personalise their stressors tend to blame themselves or others for things over which they have no control, creating stress where it need not be. Those prone to personalisation tend to blame themselves for the actions of others, or blame others for their own feelings.

Cognitive behaviour therapy aims at identifying our faulty/irrational thought patterns and making them conscious. The patient is then able to recognise when he is about to perform an undesirable behaviour, such as compulsive hand-washing, or when he is engaging in negative thoughts that are not supported by logic or reality. The process then calls for the patient to halt the behaviour or thought, then consciously replace it with a desired thought or behaviour.

1.3.4 Techniques Used by CBT Specialists

Therapists use several different techniques in the course of cognitive-behavioural therapy to help patients examine the dysfunctional thoughts and change to rational thoughts and behaviours. These include:

i) **Reality testing:** The client is asked to put his thought to test in the real situation. Thus the client tests it experimentally.

ii) **Validity testing:** The therapist asks the patient to defend his or her thoughts and beliefs. If the patient cannot produce objective evidence supporting his or her assumptions, the invalidity, or faulty nature, is exposed.

iii) **Guided discovery:** The therapist asks the patient a series of questions designed to guide the patient towards the discovery of his or her cognitive distortions.

iv) **Writing in a journal:** Patients keep a detailed written diary of situations that arise in everyday life, the thoughts and emotions surrounding them, and the behaviours that accompany them. The therapist and patient then review the journal together to discover maladaptive thought patterns and how these thoughts impact behaviour.

v) **Homework:** In order to encourage self-discovery and reinforce insights made in therapy, the therapist may ask the patient to do homework assignments. These may include note-taking during the session, journaling, review of an audiotape of the patient session, or reading books or articles appropriate to the therapy. They may also be more behaviourally focused, applying a newly learned strategy or coping mechanism to a situation, and then recording the results for the next therapy session.

For instance, Sheela felt bad and depressed when her friends did not take her to the market visit. Here the therapist can help Sheela identify the basic assumption she has here which is obviously an irrational thought pattern. Why should Sheela feel that she is bad if her friends did not take her? Does she have all the bad qualities? What are they? Sheela is then helped to analyse the distortions in her thinking that she is the cause, i.e., she is bad, so her friends did not take her.

1.4 RATIONAL EMOTIVE BEHAVIOUR THERAPY

Albert Ellis is the founder of the Rational Emotive Behavioural Therapy. He talks about the irrational beliefs which are responsible for our behavioural and emotional problems/disturbances.

According to Ellis (1962), the eleven common irrational beliefs are:

- It is essential to be loved and approved by every significant person in one's life.
- To be worthwhile, a person must be competent, adequate and achieving in everything attempted.
- Some people are wicked, bad, and villainous and should be blamed or punished.
- It is terrible and disastrous whenever events do not occur as one hopes.
- Unhappiness is the result of outside events and a person has no control over such despair.
- Something potentially dangerous or harmful should be a cause of great concern and should always be kept in mind.
- Running away from difficulties or responsibilities is easier than facing them.
- A person must depend on others and must have someone stronger on whom to rely.
- The past determines one's present behaviour and thus it cannot be changed.
- A person should get upset over the problems and difficulties of others.
- There is always a right answer to every problem, and a failure to find this answer is a disaster.

These beliefs are called irrational because these are rigid, not based on the fact. The REBT help the clients to identify the irrational beliefs and think more rationally. This is done by the ABCD model proposed by Ellis where

A refers to activating events i.e., events/situations causing the distorted thinking

B refers to beliefs, the evaluative beliefs – rational or irrational – which we have about the activating event

C refers to the consequences – the emotional, behavioural and cognitive consequences of the beliefs

D refers to disputing the beliefs on which our irrational thoughts are based

1.4.1 The Sequence in the REBT Model

First, the activating events are identified, then the consequences of this event are identified. Events lead to consequences. However, events as such do not lead to consequences. The consequences or our responses are based on our belief system about the events/situations. When these beliefs are irrational, it results in problems; hence, we need to dispute these. Let us see one example. One evening, Hari was not doing his study and was watching TV; his mother scolded him saying he always sees TV and does not do his studies properly. Hari felt very sad for his mother's scolding. Here the activating event (A) is mother's scolding; consequence (C) is Hari's sadness; this sadness resulted because of Hari's belief (B) system – that my mother always scolds me or nobody loves me - ; this irrational belief then needs to be disputed (D). Disputation is the most important step in the REBT therapy.

Cognitive behavioural approach is widely used for dealing with a range of disorders. Obsessive compulsive disorders, phobias, panic disorder and post-traumatic stress disorder are all conditions that are effectively treated by cognitive behaviour modification. Cognitive-behavioural therapy attempts to change clients' unhealthy behaviour through cognitive restructuring (examining assumptions behind the thought patterns) and through the use of behaviour therapy techniques. Cognitive-behavioural therapy is a treatment option for a number of mental disorders, including depression, dissociative identity disorder, eating disorders, generalised anxiety disorder, hypochondriasis, insomnia and obsessive-compulsive disorder.

1.4.2 Potentials and Limitations of Cognitive Behavioural Approach

Cognitive behavioural approach aims at correcting problematic underlying assumptions, thus leading to long-term results. Thus the cause of the problem is corrected.

The structured nature of therapy sessions ensures bringing about fruitful result/outcome. It very much reduces the possibility that sessions will become "chat sessions" in which not much is accomplished therapeutically.

The course of treatment is shorter than that of conventional talk therapy. This makes the cognitive behaviour modification as a less expensive means of obtaining mental health treatment.

The self-help element of cognitive behaviour therapy enables the clients to on their own to maintain their own treatment even after formal therapy has ended.

Cognitive behaviour modification can be performed individually or in group therapy sessions.

These therapies are best known for treating mild depression, anxiety, and anger problems.

Cognitive-behavioural therapy may not be appropriate for all patients. Patients with significant cognitive impairments (patients with traumatic brain injury or organic brain disease, for example) and individuals who are not willing to take an active role in the treatment process are not usually good candidates. It may not be appropriate for small children also who will not have the language capability to think through their assumptions and thought patterns.

Self Assessment Questions

1) Elucidate with example the various types of cognitive distortions given by Beck.

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2) What do you mean by irrational beliefs? Write down three irrational beliefs with example.

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3) What is the ABCD sequence in Rational Emotive behaviour therapy?

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4) What do you mean by home-work assignment in cognitive behaviour therapy?

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1.5 LET US SUM UP

This unit gives some insight into the behavioural and cognitive approach to counseling. The behavioural approach is based on the two learning theories of classical conditioning by Pavlov and operant conditioning by Skinner. The principles and procedure of behavioural approach are described in detail. We also learned about the different behavioural techniques. One of the important techniques under behavioural counseling is systematic desensitization which aims at shaping the behaviour of the person in a systematic manner. We also came to know about the cognitive behavioural techniques such as cognitive behaviour therapy and rational emotive behaviour therapy which are widely used for dealing with various problem behaviours. The combination of cognitive therapies with behaviour modification has been found to be more effective than either of these approaches alone. They have

been found to be successful in managing many maladaptive behaviours such as phobia, depression, anxiety etc. Finally the merits and limitations of the behavioural and cognitive approach to counseling were also discussed.

1.6 UNIT END QUESTIONS

1) Explain and contrast the behaviour modification and cognitive therapy in counseling.
2) As part of behavioural assessment, what are the different aspects of behaviour that we need to study? Describe with the help of an example.
3) Take a case example. Describe the procedure of systematic desensitization.
4) Give three examples of children's behaviour in classroom learning situations where token economy can be used.
5) Briefly explain Beck's cognitive behaviour therapy,
6) Describe the ABCD model of Rational Emotive Behaviour therapy with an example.
7) List out five problems found among school children and describe the behaviour and cognitive techniques you will use for any three of them.

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UNIT 2 APPLICATION OF COGNITIVE THERAPIES IN COUNSELING

Structure

2.0 INTRODUCTION

Unit 1 has already described the meaning and procedure of behavioural and cognitive approaches to counseling. In this unit we will be discussing the uses and applications of these approaches in different types of counseling situations. These two are important approaches to counseling which find wide applications in a variety of settings because of its ease of use and effectiveness. Counsellors employ the different techniques under these approaches in contexts ranging from educational to as diverse as military and sports counseling. Cognitive therapy focuses on the relationship among cognition, emotion and behaviour in human functioning. The cognitive approach is based on the observation that automatic thoughts that are exaggerated, distorted, mistaken or unrealistic play a major role in psychopathology. These automatic thoughts are shaped by an individual's beliefs, assumptions and schemas. Our perception and interpretation of events greatly depends on these. Irrational thoughts and assumptions shape one's response to experiences and situations, e.g., a child's irrational assumption that "I am no good" will make him shy away from his classmates and in the process he will not be able to make friends. This in turn will reinforce his assumption "I am no good". Hence cognitive therapies focus on changing the irrational assumptions and belief systems of the clients.

In this unit, the cognitive approach which aims to understand why the client is appraising events in particular ways and why he feels the way that he does, etc. will be discussed. For instance, negative thoughts and feelings about one's situation and circumstance lead to depressive feelings, inaction and lack of interest in anything. These depressive feelings and mood in turn give rise to negative thoughts in the individual. Thus it is a vicious cycle of thoughts influencing our feelings and emotions, and again emotions affecting our thought patterns. Sanders & Wills (2005) point out that an external event will have a very different impact on different people because each individual has, first, a different personal domain on which the event impinges. Second, each person has an idiosyncratic way of appraising events because cognitions, perceptions, beliefs and schemas will have been shaped by the individual's unique personal experiences and life history. The aim of cognitive therapy is to understand both the person's personal domain and their idiosyncratic way of appraising events.

2.1 OBJECTIVES

After going through this unit, you will be able to:

- Develop an understanding of the application of cognitive behavioural therapies.
- Appreciate the use of cognitive behaviour therapies in a variety of settings.

2.2 APPLICATION IN DIFFERENT SETTINGS

Cognitive behavioural is a major approach in counseling. The basic premise underlying this approach is the idea that automatic thoughts shape both individual's emotions and their actions in response to events. For example, when the teacher tells the student "meet me after the class", the student starts thinking," Oh, I am gone now, I must have done something serious and something bad will come to me now." Given the presence of this thought in the student's mind, his emotions and behaviour will be shaped accordingly. Cognitive therapy tries to bring client's focus on these irrational thoughts and beliefs, and modify them. In fact, most of us have illogical or irrational thoughts, but when we can not let go of them and they start affecting our actions and behaviours, then it is a problem situation. For example, the thoughts that are problematic for clients who suffer with obsessive compulsive disorders(OCD) are shared by 90 percent of the population (Salkovskis et.al.1995). OCD sufferers however, pay attention to these thoughts in a different way. Non-sufferers can let these thoughts go whereas OCD sufferers cannot. Similarly, those of us who are constant worriers focus more on the worries and cannot let them go. In contrast many of us who are also faced with the same worries do not let these worries control or overpower us. Cognitive therapy aims at making the clients aware about these dysfunctional thoughts and changing them to appropriate rational thoughts.

2.2.1 Educational Setting

Students' behaviour presents a lot of challenge to the present day teacher. In addition to the academic pressure/activities, teachers need to deal with such behaviours of students such as student misconduct, aggression, disobedience or disrespect for authority, hyperactivity, inattention, lack of self-control, teasing, bullying etc. Behavioural excesses and deficits affect negatively the academic performance of the students and hamper positive peer relationships as well as healthy relationship with the teachers.

Application of cognitive behaviour modification in the classroom and school context mainly addresses two aspects, viz., (i) instructional interactions between teachers and learners; and (ii) behavioural interaction between teachers and their learners. Thus it is made use of in a variety of situations such as the following

- increasing academic grades by adopting effective study habits
- increasing one's self confidence to speak in front of a group
- increasing social skills to interact with people in the social gathering
- following a healthy exercise programme
- reducing unhealthy pattern of eating
- decreasing use of abusive language, e.g., using swearing words
- reducing test anxiety

Different strategies are used such as self management, applied behaviour analysis, positive behavioural support, behaviour modification and therapy.

Cognitive Behavioural Interventions (CBI) can be a viable approach for teachers to remediate behavioural deficits and excesses by providing students with the tools necessary to control their own behaviour. CBIs involve teaching the use of inner speech ("self-talk") to modify underlying cognitions that affect overt behaviour (Mahoney, 1974; Meichenbaum, 1977).

Since theorists consider the internalisation of self statements fundamental to developing self control, deficient or maladaptive self statements are viewed as contributing to negative beliefs about oneself, which can contribute significantly to childhood behaviour problems, including aggression. Kendall (1993) noted that cognitive-behavioural techniques for the remediation of social deficits can incorporate cognitive, behavioural, emotive, and developmental strategies, using rewards, modeling, role-plays, and self-evaluation.

CBI incorporates behaviour therapy (e.g., modeling, feedback, reinforcement) and cognitive mediation (e.g., think-aloud) to help clients deal with a variety of problems and situations. For example, not hitting or pushing a peer when teased can be mediated by inner speech such as "That makes me mad, but first I need to calm down and think about this." The fundamental assumption of CBI is that overt behaviour (e.g., hitting or pushing a peer when teased) is mediated by cognitive events (e.g., "I'm going to let him have it") and that individuals can influence cognitive events to change behaviour. Cognitive strategies incorporate a "how-to-think" framework for students to use when modifying behaviour rather than any explicit "what-to-think" instruction from a teacher. Thus, verbal self-regulation, i.e., using self-talk to guide one's behaviour to deal with a problem situation can be effectively used. This is especially relevant to marital problems and family disturbances. Many a times problems arise because the parent reacts impulsively to the child's misbehaviour – 'how can he do like this; how can he not listen to me?'; or the couple gets angry and says harsh words to each other immediately in the event of some misunderstanding – 'he always forgets when he has promised for an evening out; I only end up tidying the house after a party'. In contrast, self talk can be used to deal with such situations in a positive manner, e.g., "Ok, this makes me angry, but first let me think about it." This makes the individual aware of the immediate thought which comes to his mind and gives him time to think about the situation in a clear manner.

Hughes & Hall (1989) points out that cognitive- behavioural approach can be used to help solve a variety of children's learning and adjustment problems, e.g., impulsivity, depression, anxiety, interpersonal problem solving, effects of mild handicaps, problems with arithmetic and reading. For instance, in case of a student exhibiting inattentive, impulsive behaviour – the cognitive behavioural therapy may involve a contingence contract which specifies certain contingencies in response to a targeted behaviour; and also a component o self talk which aims at inhibiting the impulsive behaviour.

Etscheidt (1991) studied the effectiveness of cognitive behaviour therapy in decreasing the aggressive behaviours of students with Emotional and Behaviour Disorder (EBD) as compared to students who did not receive the instruction. Etscheidt's program components were adapted from the Lochman, Nelson, and Sims (1981) Anger Coping Program, which provides students with a way to change aggressive responses into appropriate alternatives by modifying their thinking processes regarding the circumstances surrounding certain situations. The instruction also assists students in

developing, evaluating, and selecting appropriate alternative responses. Etscheidt's goals included increasing self-awareness; identifying a student's reaction to peer influences; providing avenues to identify problem situations; and using problem-solving techniques to identify, evaluate, and select alternative solutions for a specific social situation.

In Etscheidt's program, students used the following sequential strategy when approaching a problem situation:

1) Stop and think before acting. Students are taught to restrain aggressive responses through the use of covert speech.
2) Identify the problem. The students are required to distinguish the specific aspects of a problematic situation that may elicit an aggressive response.
3) Develop alternative solutions. Students generate at least two alternative solutions to a problematic situation, either thinking about something else until able to relax and/or moving to another location in the room to avoid further provocation.
4) Evaluate the consequences of possible solutions. Students assessed the benefits of each possible solution.
5) Select and implement a solution. The students carried out the selected alternative.

Findings showed that the students in the control group exhibited significantly more aggressive behaviours than those who received the training.

Behaviour management will always be a significant part of the teacher's role and responsibility. Hence, cognitive-behavioural interventions comes handy to the teachers to help provide students with methods to successfully control their own behaviour. CBI may offer a viable method for assisting students to manage their thoughts and behaviours, thus creating better learning environments and experiences for them.

Self Assessment Questions

1) How will you use 'self – talk' to overcome problem of shyness in a classroom situation?

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2) Give examples of two problem behaviour in children where cognitive behaviour therapy can be used.

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2.2.2 Clinical Setting

Cognitive therapy has been found to be useful in a variety of clinical disorders such as anxiety, depression, substance abuse, personality disorders, antisocial personality disorder, obsessive-compulsive disorder etc.

Freeman et. al. (2004) has described the application of cognitive behavioural therapies in a wide range of disorders which are described as follows. In treating

schizophrenia and other psychiatric disorders, cognitive therapy is used in combination with pharmacotherapy, not as an alternative to medication.

Cognitive therapy can be used to improve client's compliance with a medication regimen, to help them recognise their symptoms and cope more effectively with them, to improve social problem solving and stress management and to treat comorbid problems such as anxiety and depression. Cognitive behavioural interventions are of great significance because of their potential to reduce the costs associated with in-patient treatment and to improve the client's quality of life.

Further, cognitive therapy when used in combination with medication, emphasises early identification of hypomania and depressive episodes; strategies for dealing with these episodes; regulation of the client's sleeping, eating, and activity levels, reduction of the client's vulnerability and exposure to triggering situations, and enhancement of medication compliance.

Cognitive therapy is also used in case of eating disorders. It focuses on the restructuring of dysfunctional beliefs about food, weight, and one's self (particularly in regard to body image and self worth). Dietary education and monitoring of food intake are emphasised. For instance, in case of the anorexics cognitive behaviour therapy have found much usefulness. The behaviour of the anorexic may be characterised by a pattern of social withdrawal, rigorous exercise, and ritualistic eating habits. The weight loss is very drastic. The emotional profile of the anorexic is marked by a pattern of depression, fear of obesity, and loss of self-confidence. Body-size misperception is a significant feature of the anorexic disorder.

Cognitive Therapy with the anorexic involves challenging the faulty thinking and beliefs of the patient. For example, if the patient expresses apprehension around the issue of losing competence if she gains weight, the therapist can help her develop a working definition of competency that will establish a concept of whether or not it is influenced by weight changes.

She can be asked such questions as, "your friend who is a good singer, weighs more than you; so would you appreciate her less because she is fat?" This type of questions will gradually make her start thinking about her beliefs and assumptions. Questioning the anorexic about what would happen if their worst expectations came to happen may minimize the imagined effects of the event.

The person who wants to be "thin" is obviously anxious when she considers herself "fat." The counselor may inquire, "What's the most horrible thing that could happen if you were to gain weight?"

Cognitive distortions are numerous in the anorexic and must be gently challenged. Distortions such as dichotomous thinking, ("If I gain weight, I'll be considered obese."), overgeneralisations, ("I will never get any better and my eating will never improve."), magnification, ("Gaining any weight will be more than I can take!") must be directly, but gently confronted in counseling.

The individual may be asked to reinterpret what she sees. The anorexic is encouraged to design experiments to test the validity of specific irrational thoughts. For example, the anorexic individual may be encouraged to interview her friends for preferences in physical appearance, checking out how often people select a friend based exclusively on the merit of weight.

Cognitive behaviour intervention also finds application in somatoform disorders. This involves changing beliefs about the nature and consequences of the somatic concerns (Salkovskis, 1989). In addition, coping strategies used for stress management and anxiety reduction are also used.

2.2.3 Personal-Social Situation

Cognitive behavioural therapies have also been found to be beneficial in dealing with personal social related issues. Many a times we are bogged down by our lack of motivation and have doubts with regard to our self efficacy. "I know I'll make a mess of it, It always happens that way only" – such type of thought affects our behaviour accordingly. Cognitive behavioural therapy can prove helpful to the individuals in such type of situations.

Anger has come to be recognised as a significant social problem. In the last two decades, cognitive behavioural therapy has emerged as the most common approach to anger management (Beck & Fernandez, 1998). Beck et. al (1998) have done a meta-analysis of the various researches conducted during the twenty long years and reported the efficacy of cognitive behavioural therapy for anger management.

Cognitive therapy addresses the issue of social anxiety also. Social anxiety is characterised by the following :

a) misperception of themselves in terms of appearance, ability, and self-worth,

b) feelings of guilt, anger and embarrassment arising from past social situations,

c) think that they have to behave perfectly in social situations, and

d) procrastination habits that exist because of social anxiety worries and doubts

The systemaic desensitisation can be used to deal with issues related to social anxiety. The "systematic" part of systematic desensitisation is highly important. In behavioural therapy for social anxiety, the progress must be *systematic, step-by-step, hierarchical, and repetitious*. If it moves too fast, or if it is too much, this therapy will not be helpful. It is very important that any process of desensitisation be gradual and systematic. Self-assertion strategies are taught to the persons with social anxiety. They are also made to realise through the therapy the need to be more realistic and not to expect perfectionism on their part in social situations.

Cognitive behaviour therapy also addresses issues related to how to increase one's self esteem and confidence, how to deal with relationship matters, marital issues, overcoming fears and phobias, and all types of mental disturbances.

Cognitive behavioural therapy has been found to be effective in dealing with stress of our day - to - day living. Cognitive therapy for stress rests on the premise that it's not simply the events in our lives that cause us stress, it's the way we think about them. For example, two people may be caught in traffic. While one person could view this situation as an opportunity to listen to music and get relaxed, another person may focus on the wasted time or the feeling of being trapped, and become distressed.

When something does not turn up the way we had expected, we become upset which affects our other things also. We had planned to go for a concert in the evening, but could not reach home in time because of some overwork at the office. This creates stress in us. There are hundreds of examples of how our thoughts and our negative self talk color our experiences and can lead to a triggered stress response or a calm demeanor. Granath et.al. (2006) in their study on stress management

programme reported both cognitive behaviour therapy and yoga as promising stress management techniques.

Cognitive behaviour therapy suggests that cognitions can influence behaviour and that there is a reciprocal relationship between cognition, behaviour and the environment. The personal-social problems faced by the individuals have often all these dimensions related to the person's behaviour, cognition and the environmental situation. Hence cognitive behavioural therapy attempts to find out these relationships, makes the individual aware about it, and the irrational assumptions or dysfunctional thought patterns underlying it; thereby facilitating the individuals to deal with their problems.

Self Assessment Questions

1) What are the important characteristic features of Cognitive Behaviour Therapy?

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2) Describe the clinical applications of cognitive behavioural therapy.

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3) Explain the use of cognitive behavioural therapy in case of a child with low self confidence.

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4) How do you treat an anorexic with cognitive behaviour therapy?

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2.3 LET US SUM UP

This unit has focused on the application of cognitive behaviour therapy in a wide range of situations. Cognitive therapy is a model of psychological therapy that proposes how we feel, how we think and how we behave are all inter-related, and changes to thoughts and behaviour will influence feelings. It makes use of strategies which try to modify the thinking processes of the client in a systematic way so that it results in a positive change in the client's symptoms/problems.

The cognitive part of the therapy refers to thinking or learning and is the part of therapy that can be "taught" to the person. The person then needs to take what has been taught, practice it at home, and through means of repetition, get that new "learning" down into the brain over and over again so that is becomes automatic or habitual. This is essentially the same process as school or college learning. You are taught some new information or skills, and then you learn them. When you learn them well enough (through repetition), this affects your memory processes (and physiologically your brain's neural pathways) and allows you to begin thinking, acting, and feeling differently. This takes persistence, practice, and patience, but when a person sticks with this therapy, and does not give up, noticeable progress begins to occur.

Cognitive therapy or cognitive behavioural therapy uses a variety of cognitive and behavioural techniques such as CBT, REBT, behaviour therapy, self management, modeling. In this unit, the application of cognitive behavioural therapies to various situations covering educational, clinical and personal-social is described. Cognitive behavioural therapy addresses the thoughts, behaviour and feelings of the individual/ client. In addition to this focus on the individual's behaviour, cognition and feelings, attention should also be paid to the situation, context and the environment variables. Thus an ecological perspective in cognitive behavioural therapy will be more beneficial and effective.

2.4 UNIT END QUESTIONS

1) List out the different problems and issues related to the teaching-learning in the classroom. In this context, discuss the use of cognitive behavioural therapy.
2) Describe the application of cognitive behavioural therapy with regard to various personal social issues/problems.
3) Cognitive behaviour therapy is the most widely used approach in counseling. Justify.

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UNIT 3 COGNITIVE BEHAVIOUR MODIFICATION

Structure

3.0 INTRODUCTION

Cognitive behaviour modification is a most commonly used intervention in counseling. It focuses on identifying dysfunctional self-talk in order to change unwanted behaviours. In other words, behaviours are viewed as outcomes of our own self-verbalisations. Hence by changing our self talk we can change our behaviour.

Cognitive behaviour modification (CBM) was developed by merging behaviour therapy with cognitive therapy. It is an intervention that combines cognitive and behavioural learning principles to shape and encourage desired behaviours. Although behaviour therapy and cognitive therapy are drawn from different theories, each shares an emphasis on alleviation of symptoms and a focus on the present in developing a course of treatment. In cognitive behaviour modification, the client is trained to recognise destructive or harmful thought patterns or behaviours, then replace them with helpful or constructive thoughts and behaviours.

To be more specific, cognitive behaviour modification refers to theoretical and applied orientations that share three underlying assumptions: (a) an individual's behaviour is mediated by cognitive events; (b) a change in mediating events results in a change in behaviour; and (c) an individual is an active participant in his learning. In short, the cognitive behavioural approach assumes that individuals have both the capacity and preference for monitoring and managing their own behaviour (Heflin & Simpson, 1998). In this unit the different techniques of cognitive behaviour modification will be described.

3.1 OBJECTIVES

After going through this unit, you will be able to:

- Define cognitive behaviour modification
- Describe the meaning of different techniques of behaviour modification
- Explain the different techniques of cognitive behaviour modification
- Analyse the application of behaviour modification techniques in counseling situations

3.2 TECHNIQUES OF COGNITIVE BEHAVIOUR MODIFICATION

In the earlier unit (unit1) cognitive behaviour modification has been described in detail. Here we will focus on the four techniques used by counselors under cognitive behaviour intervention. These are techniques of Stress Inoculation, Self-Instructional, Self-Management and Problem Solving.

3.2.1 Self Instructional Technique

Self instructional training was developed by Donald Meichenbaum (1977) as part of cognitive behaviour therapy. We usually engage in self talk and the nature of our self talk affects our behaviour. Faulty and irrational verbalisations result in anxiety and other emotional and behavioural problems. Hence, in self instructional training the clients are taught to keep track of self statements that are destructive or negative, and are then given training to substitute them with more adaptive ones through homework assignments and practice. Thus healthy self talk replaces the negative self talk or internal statements. Identifying and modifying the negative/destructive/ unhealthy internal statements to positive statements reduces the stress and anxiety.

First, the client is made aware of the negative self talks going on within him. Then, the client is helped to understand/realise how his negative verbalisations lead to the anxiety or fear or other emotions and behaviour of him. Next the client identifies the positive self talk he needs to do in place of the negative ones. He is then given training to make the positive self talk a part of him through practice.

The self instructional training can be used successfully to deal with anxiety, fear, addiction, compulsive behaviours, unhealthy eating habits etc. For example, the child who is obese has unhealthy eating habits. He eats junk food and goes on eating very frequently. He is not able to stop eating and gobbles up more than he should be eating. Self instructional training can help him control his eating habits. The child needs first to identify the kind of internal verbalisations that goes on while succumbing to the temptation of eating. Then he has to practice positive self talk which will be his instruction to the self whenever he engages in unhealthy eating habit.

3.2.2 Stress Inoculation Technique (SIT)

Stress Inoculation Training given by Meichenbaum (1985) is a complete cognitive behavioural intervention package that makes use of cognitive restructuring, self instruction, self-monitoring, problem solving, relaxation training etc.

Stress Inoculation training prepares the individual in advance to handle stressful events successfully. The use of the term “inoculation” is based on the idea that as vaccination inoculates people against diseases; similarly stress inoculation training helps inoculate the person against the stressors in life. In SIT, patients are educated about stressful situations and the general nature of stress, the negative outcomes they may be vulnerable to experiencing when confronted with stress, and steps they can take to avoid those negative outcomes.

Thus stress inoculation is designed to bolster individual’s preparedness and develop a sense of mastery. The treatment goals of SIT are to bolster the clients’ coping repertoire (intra- and interpersonal skills), as well as their confidence in being able to apply their coping skills in a flexible fashion that meets their appraised demands of the stressful situations.

In SIT, the clients become more aware of what things are reminders (also referred to as "cues") for fear and anxiety. They learn how to detect and identify cues as soon as they appear so that they can put the newly learned coping skills into immediate action. In doing so, the patient can tackle the anxiety and stress early on before it gets out of control.

SIT consists of three interlocking and overlapping phases:

Phase 1 Conceptual educational phase

In the initial conceptualisation phase, the client is educated about the nature of stressors and how certain ways of thinking leads to stress and mental disturbances. They are helped to differentiate between aspects of their stressors and their stress-induced reactions that are changeable and aspects that cannot change, so that coping efforts can be adjusted accordingly. Acceptance-based coping is appropriate for aspects of situations that cannot be altered, while more active interventions are appropriate for more changeable stressors.

Phase 2 Skills acquisition and skills consolidation phase

In the next phase of skill acquisition the client is given training on a variety of skills such as emotional self-regulation, relaxation, problem solving, cognitive appraisal, cognitive restructuring, communication and socialisation skills. However, the particular choice of skills taught should be on the basis of the client's unique needs, strengths and vulnerabilities. The skills are then rehearsed so that they become easy to act out.

Phase 3 Application and follow-through phase

In this last phase of application, the client applies the skills learnt in the real life situation. The client is also provided opportunities to practice coping skills in simulated situations using the methods of visualisation, modeling and role playing. After counseling is over, follow up session is organised to find out the effectiveness of the training the client received.

Stress inoculation training aims at building psychological immunities in the individual to deal with stress. It has been helpful in reducing interpersonal and general anxiety. For example, these techniques may be used when a person has an upcoming job interview, speech, or test. Stress inoculation has also been used to treat phobias, fear of heights, and chronic anger problems. It is used as both a treatment as well as a preventive measure. Stress inoculation training is not merely a collection of different coping techniques. It is more than that; it is highly client- sensitive, and involves collaborative mechanism keeping in mind the client's goals and future plans. All these contribute to the comprehensive and robustness of stress inoculation therapy.

Self Assessment Questions

1) Self instructional training involves replacement of negative self talk by healthy self talk. Elaborate with example.

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2) Explain the meaning of "cues" in Stress Inoculation Training.

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3) What do you mean by 'inoculation' in stress inoculation training?

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3.2.3 Self Management Technique

Self management strategies make use of cognitive and behavioural skills by the individuals to maintain self-motivation and achieve personal goals. Most people who decide to use self-control or self management strategies are dissatisfied with a certain aspect of their lives. For example, they may feel they smoke too much, exercise too little, or have difficulty controlling anger. Thus, the goal of self-management strategies is to reduce behavioural deficiencies or behavioural excesses.

Behavioural deficiencies occur when an individual does not engage in a positive, desirable behaviour frequently enough. For example, a student who rarely studies may not graduate. Behavioural excesses occur when an individual engages in negative, undesirable behaviour too often. This results in a negative future consequence. For example, a person who smokes may develop lung cancer. The client is taught to identify, monitor, and bring changes in his behaviour deficit or behavioural excess so that it leads to desired behavioural changes.

There are a variety of self management strategies that make use of stimulus control, reinforcers and punishers to modify the undesirable behaviour. In fact these strategies can be grouped under three broad categories such as (i) Environmental strategies (ii) Behavioural strategies (iii) Cognitive strategies

i) **Environmental Strategies:** Environmental strategies involve changing times, places, or situations where one experiences problematic behaviour. Examples include:

- changing the group of people with whom one socialises
- avoiding situations or settings where an undesirable behaviour is more likely to occur
- changing the time of day for participating in a desirable behaviour to a time when one will be more productive or successful

ii) **Behavioural Strategies:** Behavioural strategies involve changing the antecedents or consequences of a behaviour. Examples include:

- increasing social support by asking others to work towards the same or a similar goal
- placing visual cues or reminders about one's goal in one's daily environment

- developing reinforcers (rewards) for engaging in desirable behaviours or punishers for engaging in undesirable behaviours
- eliminating naturally occurring reinforcers for undesirable behaviour
- engaging in alternative, positive behaviours when one is inclined to engage in an undesirable behaviour
- creating ways to make a desirable behaviour more enjoyable or convenient
- scheduling a specific time to engage in a desirable behaviour
- writing a behavioural contract to hold oneself accountable for carrying out the self-control program

iii) **Cognitive Strategies:** Cognitive strategies involve changing one's thoughts or beliefs about a particular behaviour. Examples include:

- using self-instructions to cue oneself about what to do and how to do it
- using self-praise to commend oneself for engaging in a desirable behaviour
- thinking about the benefits of reaching one's goal
- imagining oneself successfully achieving a goal or using imagery to distract oneself from engaging in an undesirable behaviour
- substituting positive self-statements for unproductive, negative self-statements

Thus self management techniques use self observation, self instruction, self praise, self reward and self punishment to bring about desirable changes in their behaviour.

Self-management strategies are useful for a wide range of concerns, including medical (such as diabetes, chronic pain, asthma, arthritis, incontinence, or obesity), addictions (such as drug and alcohol abuse, smoking, gambling, or eating disorders), occupational (such as study habits, organisational skills, or job productivity), and psychological (such as stress, anxiety, depression, excessive anger, hyperactivity, or shyness). However, if symptoms are severe, self-management strategies should be used in conjunction with other therapies.

3.2.4 Problem Solving Technique

In life we are faced with so many problems related to our school, college, home, work and varied life situations. We need to solve them effectively in order to lead an efficient life. Problem solving comes handy here as a tool, a skill and a process. As a tool it helps you solve a problem or achieve a goal. As a process it involves a number of steps and as a skill, it can be used throughout life to deal with various problems and situations.

Problem-solving has two distinct phases: (i) a problem definition phase and (ii) a problem solution phase.

i) **Problem definition phase:** When defining a problem:

- Be specific
- Be brief
- Express your feelings about the problem
- When solving problems:
- Brainstorm solutions
- Evaluate their costs and benefits

- Decide on the best solution
- Be willing to compromise

ii) **Problem solution phase:** Thus problem solving involves a number of steps such as,

Problem definition – It involves stating the problem in clear terms. What actually is causing the problem? It helps to think in terms of what actually I want. How is the present situation affecting me? How do I want it to change? All these help in specifying the problem.

Problem analysis – After defining the problem, it needs to be analysed or thought of from different angles/perspectives. This enables in further clarification of the problem.

Goal setting – It involves establishing goals what you want to achieve. Based on your analysis of the problem, what is it that you want to change or achieve?

Generation of alternatives – Next step is to generate as many alternatives as possible to achieve the goal. Don't bother about whether they are realistic or will be effective or not? The requirement task is to list down all the possible solutions.

Decision making – This step refers to analysing the solutions/alternatives and deciding on a particular solution. Each alternative is examined, pros and cons are listed out and decision is taken.

Implementation and verification – The last step involves implementing the solution you have chosen and evaluating its effectiveness. It is verified whether the strategies/ techniques adopted led to the solution of the problem.

Problem solving is a cyclical process. If the solution is not found to be effective, again the process starts; and the problem is defined and analysed again, and goals set and solutions found. The client plays an active role in the problem solving process.

Self Assessment Questions

1) Describe the different strategies of self management.

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2) What are the different steps involved in problem solving?

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3) Differentiate the problem definition and problem solution phase.

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3.3 LET US SUM UP

Cognitive behaviour modification is a combination of *behaviour therapy* and *cognitive therapy.* In this intervention technique, you can track from the beginning how your thoughts affect your feelings and then, in turn, your behaviours. If you realise that the originating thought about a situation is irrational, you can realise that the resulting feeling and action are also irrational, and then you can modify your thought. In this unit you learned four techniques of cognitive behaviour modification such as Self Instructional, Stress Inoculation Training, Self Management and Problem Solving. The meaning and procedure for each technique are described. Further, the uses of these techniques are also mentioned. Cognitive behaviour modification (CBM) is at the root of treatment for anorexia nervosa, and other eating disorders. It is also commonly used in the treatment of various anxiety disorders. Since many eating disorder patients experience co-occurring disorders such as anxiety and depression, it makes cognitive behaviour therapy an even more powerful treatment option.

3.4 UNIT END QUESTIONS

1) List out the different situations/problems in the school context in which self instructional training can be used.
2) Explain the different stages of stress inoculation training.
3) 'Stress Inoculation Training helps build up psychological immunities'. Discuss.
4) How will you use self management technique for a child with aggressive behaviour?
5) Evolve a self management strategy to help a child overcome excessive television viewing.
6) Elucidate the problem solving strategy by taking a case example.

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UNIT 4 SOLUTION FOCUSED COUNSELING AND INTEGRATIVE COUNSELING

Structure

4.0 INTRODUCTION

Solution Focused counseling is is a brief therapy which focuses on solution finding rather than looking at the history of the problem etc. It is based on solution focused brief therapy model. Solution focused therapy focuses on people's strength, competence, and possibilities instead of their deficits, weaknesses and limitations (O'Hanlon & Weiner Davis 1989). As such, it represents a dramatic shift in focus from previous approaches that seek to identify and explain problems and their origins. Solution focused therapy is a form of brief therapy. The number of sessions varies, but is usually under ten sessions with an average of four or five. Sometimes just one session is adequate.

Most counseling approaches focus on problems, thus implying that something is wrong with the client. This emphasis on deficits usually leads to an extensive and time consuming exploration of problems, etiology, histories and causes. In contrast, the solution focused counseling takes a positive approach of the client and puts emphasis on the generation of solutions based on the strengths and assets of the client.

In this unit we will discuss the solution focused approach in counseling and describe the solution focused brief therapy. Further we will also discuss about the integrative approach to counseling which emphasises on the integration of different approaches to address the common goal of the client's benefit and betterment.

4.1 OBJECTIVES

After going through this unit, you will be able to:

- Define solution focused counseling;
- Explain the assumptions of solution focused therapy;
- Describe how to carry out the solution focused brief therapy;
- Analyse the pros and cons of solution focused therapy; and
- Explain the concept of integrative counseling.

4.2 MEANING OF SOLUTION FOCUSED COUNSELING

Solution focused counseling focuses on what clients want to achieve through therapy rather than on the problem(s) that made them to seek help. The approach does not focus on the past, but instead, focuses on the present and future. The major emphasis is on the solutions rather than the problem. Brief solution-focused counseling is grounded in four decades of psychotherapy outcome research on the essential ingredients of therapeutic change (Hubble, Duncan, & Miller, 1999). Based on multiple analyses of research in counseling and psychotherapy, Lambert and colleagues (Asay & Lambert, 1999; Lambert & Ogles, 2004) concluded that effective outcomes result primarily from the operation of four "common factors" of change. Common factors are the essential ingredients of change that operate across different clients, problems, settings, and theoretical models. These elements are also referred to as "nonspecific factors" because they operate across all theoretical approaches and are not specific to any one particular model. Successful therapeutic outcomes appear to result primarily from the operation of four interrelated factors. These factors, and their percentage of contribution to successful outcomes, are as follows:

Client factors (accounting for 40% of change): Everything that the client brings to counseling—strengths, interests, perceptions, values, social supports, resilience, and other resources

Relationship factors (accounting for 30% of change): The client's experience of respect, collaboration, acceptance, and validation from the counselor

Hope factors (accounting for 15% of change): The client's positive expectancy and anticipation of change

Model/technique factors (accounting for 15% of change): The counselor's theoretical model and intervention techniques

Thus it can be seen that clients have a major contribution toward the success of counseling. Solution focused counseling believes in the strength of the clients and believes that clients have the capacity to find solutions.

The solution focused brief counseling (SFBC) was developed by Steve deShazer (1985). He discovered that by focusing on solutions rather than problems, clients were getting better faster than with traditional counseling modalities. Thus there is a shift of focus in the SFBC from the traditional problems focus to a solution focus, where exploring the problem was minimized. SFBC outlines an active role of the client, attributing the success of the therapy mostly to the client's efforts.

Implicit in the model is the belief that clients are not always overcome by problems, e.g., depressed clients are not always depressed, there are times when they are not depressed. Thus clients can always identify times and situations when the problem was not there. By rediscovering these resources/ instances, clients are encouraged to analyse them and repeat those successes. Thus SBFC approach emphasises problem solving and client-produced solutions. It does not go for in depth exploration and the causes and origins of the problem; thereby reducing the time required for counseling; hence it is called 'brief'. Moreover, when the focus is on solutions, actions become of primary importance and insight is deemphasised.

4.2.1 Key Assumptions of Solution-Focused Counseling

Murphy (2008) delineated the following assumptions of solution focused counseling:

1) *If it works, do more of it. If it doesn't work, do something different.*

This assumption captures the pragmatic nature of solution-focused counseling. It involves identifying what works and doing more of it; encouraging the clients to build on their strength, success and other resources. If it doesn't work, then try something else. The value of any technique rests on its practical usefulness in promoting change and moving clients closer to their goals.

2) *Every client is unique, resourceful, and capable of changing.*

Adopting a position of curiosity enables us to approach every client from a fresh perspective that honors his or her unique circumstances, goals, and resources. It encourages the clients to recognise and apply their unique strengths and resources toward meaningful goals. Viewing clients as capable and resourceful does not deny the seriousness or pain of a problem. It does, however, create solution opportunities that might otherwise be overlooked.

3) *Cooperative relationships enhance solutions.*

The quality of the client-practitioner alliance is the best predictor of outcomes in counseling (Wampold, 2001). Effective counseling relationships are built on mutual respect and common goals. This includes our accommodation of clients' goals, resources, and feedback, and their trust in our commitment and ability to help them reach their goals.

4) *Client feedback improves outcomes.*

In addition to creating cooperative and accountable relationships, obtaining formal feedback from clients on outcome and alliance has been shown to double the effectiveness of counseling (Lambert et al., 2003).

5) *No problem is constant.*

Regardless of how constant a problem seems, there are always fluctuations in its rate and intensity. Solution-focused counselors seek out these fluctuations or "exceptions" to the problem by directly asking for them (e.g., "Tell me about a recent time when the problem did not occur, or wasn't as bad as usual"), exploring the conditions under which they occur (e.g., "What was different about that time than usual?"), and encouraging students and others to do more of whatever they have done to bring them about (e.g., "What will it take to make that happen more often?"). In addition to providing clues to solutions, discussing exceptions may increase people's hope in the possibility of solutions and in their ability to bring them about.

6) *Big problems do not always require big solutions.*

Solution-focused counseling is based on the practical notion that one small change in any part of the problem system can ripple into larger and more significant changes.

O'Hanlon & Weiner Davis (1989) have provided the following assumptions which act as the foundation of solution-focused therapy:

People 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.

Self Assessment Questions

1) What do you mean by solution focused counseling?

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2) Solution focused counseling puts emphasis on the present and future. Elaborate.

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3) Discuss the importance of bringing about small changes in one's behaviour in the context of solution focused brief therapy.

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4.3 PROCEDURE OF SOLUTION FOCUSED BRIEF THERAPY

Solution focused work can be seen as a way of working that focuses exclusively or predominantly on two things.

a) Supporting people to explore their preferred futures.

b) Exploring when, where, with whom and how pieces of that preferred future are already happening.

Thus solution focused therapy starts with the client envisioning a preferred future, i.e., what does he want, how does he want his future to be. The therapist/counselor uses respectful curiosity to enable the client to envision their preferred future. With the help of the therapist the client starts his journey of achieving his desired goals.

By helping people identify the things that they wish to have changed in their life and also to attend to those things that are currently happening that they wish to continue to have happen, SFBT therapists help their clients to construct a concrete vision of a *preferred future* for themselves. The SFBT therapist then helps the client to identify times in their current life that are closer to this future, and examines what is different on these occasions.

By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, the therapists helps the client move towards the preferred future they have identified. To support this, questions are asked about the client's story, strengths and resources, and about exceptions to the problem.

4.3.1 The Miracle Question

This is a method of questioning that a coach, therapist, or counselor uses to aid the client to envision how the future will be different when the problem is no longer present. Also, this may help to establish goals.

A traditional version of the miracle question would go like this:

"Suppose our meeting is over, you go home, do whatever you planned to do for the rest of the day. And then, some time in the evening, you get tired and go to sleep. And in the middle of the night, when you are fast asleep, a miracle happens and all the problems that brought you here today are solved just like that. But since the miracle happened overnight nobody is telling you that the miracle happened. When you wake up the next morning, how are you going to start discovering that the miracle happened? ... What else are you going to notice? What else?"

In another instance/situation, the counselor may ask,

"If you woke up tomorrow, and a miracle happened so that you no longer easily lost your temper, what would you see differently?" What would the first signs be that the miracle occurred?"

The client (a child) may respond by saying,

"I would not get upset when somebody calls me names."

The counselor wants the client to develop positive goals, or what they will do, rather than what they will not do -to better ensure success. So, the counselor may ask the client, "What will you be doing instead when someone calls you names?"

Thus the counselor enables the client to identify the resources through the use of solution talk, that is focus is on what is right and working for the client rather than what is wrong and problematic. Thus solution talk is practised rather than problem talk.

4.3.2 Exception Seeking

In this, the clients are encouraged to seek out instances of exception when the problem was not present, for instance ; when, where and how these instances occur, are considered and then solutions are developed based on these.

4.3.3 Establishing Positive Goals

In this the clients are encouraged to have positive goals (what they 'can' do) rather than negative goals (i.e., to stop doing something, e.g., fighting, disrupting, playing etc.). The counselor helps clients identify positively worded goals that reflect what they do want to happen which will be a measurable goal.

4.3.4 Resources can be Internal or External

Internal refers to the client's skills, strengths, qualities, beliefs that are useful to them and their capacities. External refers to supportive relationships such as, partners, family, friends, faith or religious groups and also support groups. This helps the client identify new ways of bringing these resources to bear upon the problem.

4.4 POTENTIALS AND LIMITATIONS OF SOLUTION FOCUSED COUNSELING

According to Iveson (2002), "Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. SFBC has wide applications, especially in the school setting. The school counselor has an enormous task of providing counseling to all the students in the school.

Given this the practicing school counselors find it difficult to find the counseling theoretical approaches which can be effectively used for the school setting. Though the counselors need to know all the theoretical approaches including psychodynamic, behavioural, transactional analysis, cognitive behavioural, Adlerian and person-centred, they face a tough task to use the counseling strategies that can actually be applied given the realities of a school setting. In this scenario, the solution focused therapy offers them a great technique which has effective application in the school setting.

SFBC gives rise to immediate observable changes in the behaviour which the clients often want. Clients, parents and teachers or other stakeholders in counseling often want immediate change and solution to the problem. Solution focused therapy helps in bringing about quick changes. This also helps motivate the client.

Some of **the merits** of solution focused counseling can be mentioned as given below:

- SFBC is more action-oriented.
- It is brief as is indicated by its name and less expensive as less number of sessions are required.

- Counselors who use this method make a conscious use of time by engaging the client quickly and keeping the client focused on goals and priorities.
- SFBC is strengths-based. It focuses on the strengths and skills and resources of the client.
- SFBC uses the positive expectations of therapists to affect client success.
- Clear goals are identified early on in the process of solution focused counseling. Because of this, both client and counselor know what success will look like and can more easily identify when therapy is no longer needed.
- SFBC may help in reducing the symptoms of stress, anxiety, and depression and interpersonal relationships may be improved.

Self Assessment Questions

1) What do you mean by the 'miracle question'?

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2) Explain the meaning of positive goals and describe its importance in solution focused counseling.

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3) Discuss the advantages of solution focused counseling.

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4.5 CONCEPT AND MEANING OF INTEGRATIVE COUNSELING

Counseling field is marked by a myriad of theories each with its own assumptions, procedure and techniques, contributing to the common goal of helping the client. Each theory has its own strengths and limitations. A practicing counselor is required to understand the basic concept of all the theoretical approaches to counseling. However, when it comes to implementation, the counselor may get bound by the applicability of a particular approach to the concerned situation/context. For instance, it will be difficult to apply psychodiagnostic counseling approach in the school context. Counselors have their own preferences for a particular counseling approach which may not always be applicable and effective to the concerned client's problem and situation.

Hence there is a need to be flexible and integrate the theories in order to develop an individualised counseling style. The concepts and techniques can be borrowed from a variety of theoretical models, integrated and applied to phases of the counseling process from initial to termination stages. Integrative counseling is the process of selecting concepts and methods from a variety of systems.

However, counselors need to have a clear in-depth understanding of various theories, then only they will be in a position to integrate. Simply put, practitioners cannot integrate what they do not know (Norcross & Newman, 1992).

Thus integrative counseling is a real challenge in the sense that the counselor needs to know the clients and his situation, culture, background thoroughly in addition to the theoretical knowledge of various approaches in order to deliver success/result. Rather than stretching the client to fit the dimensions of a single theory, practitioners are challenged to tailor their theory and practice to fit the unique needs of the client (Corey, 2009).

Since the early 1980s, psychotherapy has been characterised by a rapidly developing movement toward integration. The reason behind this movement is the growing awareness that human behaviour is so complex to be explained by a single theoretical approach or a set of techniques pertaining to a particular counseling approach. Because no one theory has a patent on the truth, and because no single set of counseling techniques is always effective in working with diverse client populations, some writers think that it is sensible to cross boundaries by developing integrative approaches as the basis for future counseling practice (Lazarus, 1996).

4.5.1 Approaches to Integrative Counseling

There are multiple pathways to achieving an integrative approach to counseling practice. Three of the most common are technical eclecticism, theoretical integration, and common factors (Arkowitz, 1997). Technical eclecticism refers to selecting suitable techniques from different theoretical approaches according to the client's needs and resources and using those to achieve the counseling goals.

Whereas theoretical integration refers to generating a new theory based on the best of different theoretical approaches. Each theory has its own strong points and merits. Theoretical integration aims at taking those best pars of each theory and formulating a new theory which will be the best. The *common factors* approach attempts to look across different theoretical systems in search of common elements.

Although there are differences among the theories, there is a recognisable core of counseling composed of nonspecific variables common to all therapies. This perspective on integration is based on the premise that these common factors are at least as important in accounting for therapeutic outcomes as the unique factors that differentiate one theory from another.

Arnold Lazarus (1997), the founder of multimodal therapy, espouses technical (or systematic) eclecticism. Multimodal therapists borrow techniques from many other therapy systems that have been demonstrated to be effective in dealing with specific problems. This approach has been widely used. However, it should not be a mere collection of different techniques from other theories, the counselor should be sound in understanding each theoretical approach and justify the selection of counseling techniques.

Thus the counselor may have preference for a particular theoretical orientation. But during the process of counseling, he may decide on a range of counseling techniques

derived from different theoretical approaches and apply these in the counseling setting. This becomes much more significant and relevant especially in the present day multicultural and multilingual context.

However, the challenge is for counselors to think and practice integratively, but critically. In order to develop integrative approach to counseling, counselors need to have in depth knowledge of all the theories, then only they will be in a position to synthesize and integrate. As already pointed out, it is not simply borrowing techniques from different theoretical approaches. Developing an integrative perspective is a lifelong endeavour that is refined with experience. It requires time, effort and experience.

4.5.2 Potentials and Limitations of Integrative Counseling

Human being is always considered along the three dimensions of thinking, feeling and behaviour. An integrative approach to counseling focuses on the thoughts, feelings and behaviour of the client. Effective counseling should address all these three aspects of behaviour to achieve desirable goals. Hence the counselor needs to make use of the cognitive, affective and behavioural counseling techniques. Such a combination is necessary to help clients *think* about their beliefs and assumptions, to experience on a *feeling* level their conflicts and struggles, and to actually translate their insights into *action* programs by behaving in new ways in day-to-day living.

Preston (1998) contends that no one theoretical model can adequately address the wide range of problems clients will present in therapy. He says it is essential for therapists to have a basic grasp of various therapeutic models and for them to have at their disposal a number of intervention strategies. For him, the pivotal assessment question is, "What does this particular person most need in order to suffer less, to heal, to grow, or to cope more effectively?" Preston recommends that a practitioner's selection of interventions should be guided by their assessment of the client.

The limitations of the integrative counseling depends on the sincerity and seriousness with which the counselor approaches this. An undisciplined way of picking techniques from different counseling approaches is a major drawback of integrative counseling which the counselor needs to guard against. Integrative counseling involves real work and thorough understanding of different approaches and careful selection of various techniques keeping in mind the client's values, resources and cultural background.

Self Assessment Questions

1) Explain technical eclecticism.

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2) Discuss the challenges to integrative counseling.

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4.6 LET US SUM UP

The present unit describes two significant approaches to counseling such as Solution focused counseling and Integrative counseling. It has explained the meaning and assumptions of both solution focused counseling and integrative counseling. Given the present day realities of fast-paced life, no one has the time for spending long sessions in counseling. Further in certain settings, for example in the school context, immediate solution is required. Solution focused brief counseling has the answer to it. It focuses on the solution and starts with the solution in mind; and then works back to find out the modalities to achieve it.

The Solution focused counseling puts a premium on the client, believing in the client's capability to identify the resources available with him, capitalise on these and find the solution with the help of the therapist. Clients are able to deal with a wide variety of concerns using SFC if they are able to set a goal for change. The method is effective for many of the concerns with which clients come to the counselor. Integrative counseling has also started gaining acceptance as it is based on flexibility and having the client's betterment as its ultimate goal. However, it requires real effort and in depth knowledge and experience to successfully practice integrative counseling.

4.7 UNIT END QUESTIONS

1) Explain the key assumptions of solution focused counseling.
2) Taking a case example, describe the procedure of solution focused counseling.
3) Discuss the merits of solution focused brief therapy in the present day school context.
4) Client plays a central role in solution focused counseling. Elaborate.
5) Discuss the meaning and approaches of integrative counseling.
6) Discuss the advantages of integrative counseling in the present day context.

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UNIT 1 ROGER'S CLIENT CENTERED COUNSELLING

Structure

1.0 INTRODUCTION

In this unit we will be studying about Rogers Client centered counseling which is also known as person centered counseling. This counseling technique is based on Humanistic psychology and has the phenomenology framework which will be explained in detail in this unit. Also we will learn in this unit the concept of self as visualised in client centered counseling and what is the importance of self in this counseling technique. An emphasis will also be placed on the disclosure by the therapist to the client as required and the typical approach and attitude that the counselor should have in order to make this therapy effective. One of the important requisites of this counseling technique is the unconditional regard and support that the therapist gives the client. Another basic premise on which this therapy works is the client counselor relationship which is the foundation over which the entire structure of therapy is built up. We will also learn about the self actualisation and its importance in this therapy.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define client centered counseling;
- Describe the various prerequisites of this counseling technique;
- Delineate the concept of self as visualised by Rogers;
- Explain the importance of self in this therapy;
- Elucidate the characteristic features of humanistic psychology;
- Apply these concepts to client centered counseling;
- Delineate the concept of relationship in counseling; and
- Describe the unconditional regard given to the client by the therapist.

1.2 INTRODUCTION TO ROGER'S COUNSELLING

The humanistic Counsellor focuses mainly on growth of the person and to motivate a person to utilise his/her maximum potentials rather than improving the past demerits of life. Due to this rationale Roger's Counselling throws light on human psychology on the one hand, and on the other hand Roger's psychology starts and ends with the subjective experiences of the individual within a phenomenological framework.

Inner experiences includes everything that is occurring with in the organism at a particular moment. All this experience, conscious and unconscious, is said to comprise the person's phenomenal field. Conscious experience, or awareness, is that aspect of the phenomenal field which can be symbolised. In other words, it can be verbalised or imagined. Unconscious experience, in contrast, is experience that cannot be verbalised or imagined by the person. Healthy individuals, in Roger's view, are those who can symbolise their experiences accurately and completely. Unhealthy people however distort or repress their experiences and are thus unable to symbolise them accurately and experience them fully.(Ryckman, 2004)

In Rogers' view, the subjective experiencing of reality serves as the basis for all the individual's judgments and behaviour. It is this phenomenological, inner reality, rather than external, objective reality, that plays the key role in determining the person's behaviour. This rationale tells us the phenomenological basis of Roger's client centered therapy/counselling.

1.2.1 Humanistic Psychology

Humanistic Psychology came into existence before forty years with the concept of development of human potentials for the overall growth of the individuals. It has roots in the earlier philosophy of humanism, European phenomenology and existentialism. The principles and values of humanistic psychology are understandable in terms of our everyday experiences and consonant with visions of a better life.

Humanistic psychology sees man as having purpose, values, options and the right to and capacity for self-determination, rather than being the helpless victim of his unconscious or of environmental reinforcement. Of his free will, he can maximise his potential for growth and happiness. The highest of human motives is the drive for self-actualisation.

According to Korchin (1986) the major tenets of humanistic psychology are :

- To understand personality, we must study the person as a whole, i.e., *holism;*
- We must have the individual's direct experience rather than his behaviour as viewed from outside, i.e., *phenomenology;*

The investigator must participate in the experiential field and not detached from it.

The intuitive and empathic understandings must not only form the empirical knowledge but also be valued.

Personal uniqueness should always be in focus, i.e., the *ideographic approach;*

Goals, values, aspirations, and the future matter more than historical or environmental determinants.

Human behaviour should not be viewed in mechanistic or reductionistic terms, but rather emphasis must be placed on distinctly human qualities such as choice, creativity, valuation, and self-actualisation.

Man is proactive as well as reactive, capable of positive striving as well as adjusting to demands on him.

The task of the therapist/counsellor is to release this potential by empathically coming to understand the unique, personal world-view and self-concept of the client.

Fostering full self-awareness by encouraging the client to experience all facets of himself, including those previously denied.

Encouraging full acceptance of the individual's unique self and of his freedom and responsibility in acting on his choices; and thus actualising his full potential as a person.

Above all else, counselling involves an authentic encounter between two real individuals, free of sham and role-playing, rather than technical acts of an interpretive, advising, or conditioning sort.

The goal of couselling is to move one from being a *deficiency-motivated* person, dependent on the world about to provide him with gratification and to affirm his value as a person, to a *growth motivated* person, striving to enrich and enlarge his experiences, knowing joy and true autonomy (Maslow, 1962).

Truly self-actualising people are rare, but all of us have the capacity for being more spontaneous and natural, free of anxiety, self-doubt, and feelings of alienation and unworth, and at least in *peak experiences*, to exist fully and vividly, to be completely absorbed and centered in experiences, which transcend the self (Maslow, 1967 in Korchin, 1986).

1.2.2 The Phenomenological Framework

A phenomenological position holds that what is real to an individual (that is, what reality is thought of, understood, or left to be by the individual) is what that exists within the concerned person's internal frame of reference, or subjective world, including every thing in his or her awareness at any point of time.

It follows that an individual's perceptions and experiences not only constitute that person's reality but also form the basis for his or her actions. One responds to events in accordance with how one perceives and interprets them.

One important implication of a phenomenological perspective for a theory of personality is that the best understanding of a person's behaviour is obtained through observation of his or her internal frame of reference. (Hjelle & Ziegler, 1992).

What we are and what we do is a reflection of our experience of the world and ourselves. Our consciousness of ourselves as sensate beings, memories of our past and visions of our future, give identity, continuity and purpose to our lives. We know "reality" out there only through the inside "reality" of personal and subjective experience which give it meaning and substance. To most of us, when we are not thinking like psychologists, these are simple and almost self evident propositions. These are philosophic elaboration and are called "phenomenology." (Korchin, 1986)

A wealth of social psychological research has accumulated showing that, even in relatively simple experimental situations, the expectations and personal meanings of both subject and experimenter are critical determinants of the eventual findings (R. Rosenthal, 1966).

Experience is of course important to most if not all psychotherapies, but it is centrally emphasised in the systems of Rogers and Perls. G. A. Kelly's (1955) psychotherapy, based on his psychology of personal constructs, is still another expression of the phenomenological orientation, as are those approaches which stress the *transactional* interplay between patient and therapist as they view and understand each other.

If a counsellor can understand the way the client is perceiving his world and if he can empathise with the experiences of the client he can help the client to make him come out of all his regrets and conflicts of life and also the counsellor can make the client realise to live in the present with the latest experiences.

1.3 CLIENT CENTERED COUNSELLING

Particularly in his later writing, Rogers placed primary emphasis on those *attitudes* of the counsellor which are the "necessary and sufficient conditions" for therapeutic change (1957). The particular techniques the counsellor uses, his training, technical knowledge, and skills are entirely secondary, compared .to these basic qualities of the counsellor. Success in therapy depends on the therapist/ counsellor communicating and the patient perceiving

1) the therapist's own congruence;
2) his unconditional positive regard for the patient, and
3) his accurate empathic understanding. (Korchin, 1986)

1.3.1 Concept of Self

The self is a differentiated portion of the individual's phenomenal or perceptual field defined as the totality of experience, and consists of the conscious perceptions and values of the 'I" or "me". The self concept denotes the individual's conception of the kind of person he or she is.

The self concept is one's image of oneself. Especially included in this are the awareness of being (What I am) and awareness of function (what I can do).

The self concept includes not only one's perceptions of what one is like but also what one thinks one ought to be and would like to be. This later component of the self is called the ideal self. The ideal self represents the self concept that the individual

would most like to possess. It is basically equivalent to the superego in Freudian Theory. (Hjelle & Ziegler, 1992)

Rogers postulates that when the self is first formed, it is governed by the organismic valuing process alone. In other words, the infant or child evaluates each new experience in terms of whether it facilitates or impedes his or her innate actualising tendency. Infants evaluate their experiences according to whether or not they like them, whether they are pleasing or displeasing, and so on. Such evaluations result from their spontaneous responses to direct experiences that is, they are completely natural.

The structure of self is subsequently shaped through interaction with the environment, particularly the environment composed of significant others (e.g. parents, siblings, relatives). In other words, as the child becomes socially sensitive and as his or her cognitive and perceptual abilities mature, the self concept becomes increasingly differentiated and complex. To a large extent, then the content of one's self concept is a social product.

We have our true self and according to Rogers we also have social self. Rogers believed that when we interact with significant people in our environment, like for instance with parents, brothers, sisters, friends, teachers, etc., we begin to develop a concept of self that is largely based on the evaluations of others. That is, we come to evaluate ourselves in terms of what others think and not in terms of what we actually feel. Such a self-concept carries with it conditions of worth.

With unconditional positive regard, the self concept carries no conditions of worth. In fact there is a congruence between the true self and experience, and the person is psychologically healthy

1.3.2 Counsellor's Congruence

Congruence or genuineness is the first and primary requirement, for nobody can respect others or be empathic unless he is himself open to experience, free of facade, and self deceit. The counselor should be aware of his own full experience and feelings, and should be able to communicate them to the client openly where and when necessary. This does not mean that the therapist necessarily burdens the client with his personal feelings at every turn, but he should know them himself and be willing and able to share them when necessary. Counselling or Therapy depends on the readiness of the client to share his deepest and most intimate feelings with the therapist. This is in fact hard enough to do under any circumstances, and it all the more difficult if the therapist is not a real person himself. (Korchin, 1986)

1.3.3 Unconditional Positive Regard

The therapist must communicate to the client a deep and genuine caring for him as a human being, with faith in his potential. This means making no judgments about the client, approving some but not all of his actions or feelings. There are no conditions on the therapist's acceptance or warmth. He is as ready to accept negative as much as he accepts the positive feeling from the client. It is an unpossessive caring for the client as a separate person, which allows the client freedom to have his own feelings and his own experiencing. (Rogers, 1966) in his later work with schizophrenics, came to realise that grossly immature or regressed clients may require more conditional regard, as for instance, telling the client, "I'd like you better if you acted in a more mature way." However, with most clients, unconditional positive regard remains one of the essential requirements of therapy. (Korchin, 1986)

Rogers contends that all persons posses basic desire to experience attitudes such as warmth, respect, admiration, love, and acceptance from significant people in their lives. The need for positive regard develops as the awareness of self emerges, and it is pervasive and persistent. It is first seen in the infant's need to be loved and cared for, and is subsequently reflected in the person's satisfaction when approved by others and frustration when disapproved. Rogers indicates that positive regard may be either learned or innately given to all persons, and although he prefers the former explanation, its origin is irrelevant to his theory.

Rogers stated that conditions of worth imposed on a child are detrimental to his or her becoming a fully functioning person. This is because the child tries to attain standards set by others rather than to identify and attain what she or he really is or wants to be. Thus, he comes to evaluate himself and his worth as an individual (what is valuable and what is not valuable about himself) in terms of only those of his actions, thoughts, and feelings that received approval and support. He or she will feel that in some respects he or she is prized and in others not. This process results in a self concept that is out of tune with organismic experience and hence does not serve as a solid foundation for psychological health. (Hjelle & Ziegler, 1992)

Rogers feels that it is possible to give or receive positive regard irrespective of the worth placed on specific aspects of a person's behaviour. This means that a person is accepted and respected for what he or she is, that is without any ifs and buts. Such unconditional positive regard is strikingly evident in mother's love for her child when regardless of the child's actions, thoughts, and feelings, the child is genuinely loved and respected.

It can be seen, then, that Roger's emphasis on unconditional positive regard as the ideal approach to child rearing does not imply an absence of discipline, social constraints, or other forms of behavioural control. What it does mean is providing an atmosphere in which a child is valued and loved for exactly what he or she is, that is a precious human being. When children perceive themselves in such a way that no self experience is more or less worthy of positive regard than any other, they are experiencing unconditioned positive self-regard. For Rogers the existence of unconditional positive self regard enables an individual to progress toward becoming a fully functioning person. In such an individual, the self is deep and broad, since it contains all the thoughts and feelings that the person is capable of experiencing. (Hjelle & Ziegler, 1992).

1.4 EXPERIENCE OF THREAT AND THE PROCESS OF DEFENSE

In Rogers theory, threat exists when a person recognises an incongruity between his or her self concept and its incorporated conditions of worth and actual experience. Experiences incongruent with the self concept are perceived as threatening. They are kept from entering awareness because the individual views himself as an honest person and his behaviour sows dishonesty and thus the self of this person is in a state of threat. Incongruity between self and experience need not be perceived at a conscious level. In fact, Rogers postulated that it is quite possible for an individual to feel threatened without being aware of it. Consequently, whenever incongruity between the self concept and experience exists and the individual is aware of it he or she is potentially vulnerable to anxiety and personality disorganisation. (Hjelle & Ziegler, 1992).

1.4.1 Defense Mechanisms

Rogers proposes only two basic mechanisms or defense: perceptual distortion and denial. Perceptual distortion is operative whenever an incongruent experience is allowed into awareness but only in a form that makes it consistent with the person's current self image. In the case of denial, there is a far less common defensive response, that is the individual perceives the integrity of his self structure by completely avoiding any conscious recognition of threatening experiences.

According to Rogers, if there is a significant degree of incongruence between one's self concept and one's evaluation of experience, then one's defenses may become non functional. In such a 'defenseless state, with the incongruent experience accurately symbolised in awareness, the self-concept becomes shattered. Thus personality disorganisation and psychopathology occur when the self is unable to defend against threatening experiences. (Hjelle & Ziegler, 1992).

1.4.2 Accurate Empathic Understanding

Progress in counselling requires the therapist to perceive feelings and experiences sensitively and accurately and to understand and convey their meanings to the client during the therapeutic counselling sessions. Accurate empathic understanding means that the therapist can sense the client's inner world as if it were his own. In addition, accurate empathic understanding involves the ability to then communicate this experience to the client in words and concepts meaningful to him so that he can gain further awareness of his experience. In this fashion, the client can recognise where his experience is incongruous with his self concept, and work toward bringing denied feelings into greater congruence with his self. (Korchin, 1986)

In fair measure, the success of therapy depends on the communication, and perception, of the therapist's attitudes. Growth in the patient involves, in effect, his incorporation and utilisation of these attitudes as part of himself. Therapy should, therefore, make him more congruent, be better able to give others unconditional positive regard, and be more accurately empathic in viewing himself as others. These three conditions describe the essence of client centered counselling, and figure prominently in Rogers' theory of personality and social philosophy. He and his co workers have done several studies to demonstrate the importance of these three attitudes as conditions of therapeutic progress. These have been recently reviewed by Truax and Mitchel (1971).

1.4.3 The Master Motive: Self Actualising Tendency

Within each of us, according to Rogers, there is an innate motivation called the self actualising tendency and active, controlling drive toward fulfillment of our potentials that enables us to maintain and enhance ourselves.

Rogers hypothesizes that all behaviour is energised and directed by a single, unitary motive which he calls the actualising tendency. This represents "the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the person." (Rogers, 1959). Thus the primary motive in people's lives is to actualise, maintain, or enhance themselves to become the best self that their inherited natures will allow them to be.(Hjelle & Ziegler, 1992).

Rogers views behaviour as motivated by the individual's need to develop and improve. A person is governed by a growth process in which potentialities and capacities are brought to realisation.

According to Rogers, the actualising tendency serves as criterion against which all one's life experiences are evaluated. Individuals engage in what Rogers describes as an organismic valuing process specially in the course of actualising themselves.

Rogers based this concept primarily on his varied and prolonged experience with troubled individuals in therapy. He noticed in them a growth tendency, a drive toward self actualisation. It is the urge which is evident in all organic and human life, which tries to expand, extend, become autonomous, develop, mature, etc. This tendency may become deeply buried under layer after layer of encrusted psychological defenses, and can come out only when proper conditions are created for these repressed feelings and tendencies to be released and expressed (Rogers, 1961)

1.4.4 The Fully Functioning Person (from Ryckman,2004)

If people are able to utilise their organismic valuing processes fully, they will inevitably begin to experience personal growth and movement toward realisation of their potentials. In Roger's terminology, they will be moving toward becoming fully functioning persons. According to Rogers such individuals have the following characteristics.

i) They are Open to experience

Fully functioning people are nondefensive individuals who are open to all their feelings-fear, discouragement, pain, tenderness, courage, and awe.

ii) They are characterised by existential living

They live their experiences as they occur in the present, without trying to superimpose preconceived meaning on them.

iii) They trust their organisms

Fully functioning people do what feels right. This does not mean they are inevitably right in their choices, but rather that they make their own choices, experience the consequences, and correct them if they are less than satisfying.

iv) They are creative

Creative products and creative living emerge when individuals are open to new experiences, able to trust their own judgements, and willing to take risks if they feel good about a new venture.

v) They live rich lives

They live the good life, not in the sense of happiness, contentment, security, and bliss-although fully functioning person experiences each of these feelings at appropriate times-but a life that is exciting, challenging, meaningful, and rewarding.

vi) They are honest and open

They reject the sham and hypocrisy of government, Madison, Avenue, parents, teachers and clergy. They are open in their dealing with others. These humanistically oriented people are opposed to highly structured, inflexible bureaucracies.

vii) They are indifferent to material comforts and rewards

They are not concerned with status but prefer to relate to people in informal, egalitarian ways.

viii) They are caring Persons

They have a deep desire to help others, to contribute to society. Their caring is gentle, subtle, and nonmoralistic.

ix) They have a deep distrust of cognitively based science and a technology that uses that science to exploit and harm nature and people

x) They have a trust in their own experience and a profound distrust of all external authority.

Self Assessment Questions

1) A phenomenal concept deals with

   a) One's objective experiences
   b) Some specific phenomenon
   c) Subjective experience of reality
   d) None of the above

2) A self-concept based on our actual feelings about our experiences is known as

   a) Ideal self
   b) Social self
   c) True self
   d) Artificial self

3) State of harmony that exists when there is no discrepancy between the person's Experiencing and his or her self-concept is known as

   a) Empathy
   b) Self actualisation
   c) condition of worth
   d) congruence

4) A fully functioning person

   a) Utilises his maximum potentials
   b) Live for society
   c) Are self centered
   d) Live for their own

5) During counseling the counselor tries to understand the client by putting himself In the client shoes This concept is known as

   a) Empathy
   b) Sympathy
   c) Apathy
   d) both a and b

6) According to Rogers all behaviour is energised and directed by a single, unitary motive which he calls the

   a) Self realising tendency
   b) Self actualising tendency
   c) Fundamental drive
   d) Basic drive

7) A total caring or prizing of the person for what he or she is, without any reservations or conditions of worth in therapy is called

   a) Need for positive regard
   b) Condition for Worth
   c) Empathy
   d) Unconditional Positive Regard

8) Rogers proposes following defense mechanism

   a) Rationalisation
   b) Denial
   c) Perceptual distortion
   d) Both a and b (e) Both a and c

9) Incongruence of which may lead to anxiety and personality disorganisation

   a) Self image and desires
   b) True self and real self
   c) Self-concept and experience
   d) None of the above

10) Roger's client centered counseling is best applicable for

   a) Psychotic persons
   b) Mentally retarded persons
   c) Neurotic persons
   d) Well integrated people seeking fulfillment in life

1.5 IMPORTANT POINTS TO REMEMBER FOR EFFECTIVE CLIENT CENTERED COUNSELLING

Rogers believed that people have the capacity for change within themselves and will change in constructive ways if the therapist creates the appropriate conditions for growth. These conditions are:

i) The client and the therapist are in psychological contact; that is, each makes an impact on the phenomenological field of the other.

ii) The client is in a state of incongruence and feels anxious about it.

iii) The therapist is congruent in the relationship.

iv) The therapist experiences unconditional positive regard for the client.

v) The therapist experiences an empathic understanding of the client's internal frame of reference.

vi) The client perceives the therapist's unconditional positive regard and the therapist's empathic understanding (Rogers, 1959).

If the above stated six conditions are operative, according to Rogers, the following changes will be observed in clients.

Clients will increasingly express their feelings about their lives and problems.

They will become increasingly accurate in their assessment of the meaning of their feelings.

1.6 SCIENTIFIC EVIDENCES AND RESEARCHES

Very few researches are there which can prove Rogerian therapy as a scientific tool. However in today's world of psychology his concepts of empathy, unconditioned positive regard and congruence are widely used in different psychotherapies and counselling.

There is a basic distrust of the scientific approach, certainly as conventionally defined. Rather than seeking a new human science which can encompass uniquely human and subjective phenomena, they are instead more prone to disavow the relevance of any scientific inquiry for human psychology. With the notable exception of the Rogers group, concepts and methods are rarely put to research tests instead, vague and romantic generalisations are put forth which cannot be ordered systematically or tested empirically. Some have seen the challenge of creating a new and broadened human science, breaking through the limits imposed by positivism and behaviourism, but the more general posture is simply antiscientific. (Korchin, 1986)

To determine whether or not this theory of therapy/counselling had any validity Rogers and his colleagues embarked on an ambitious research programme in the 1950s. In one study, Butler and Haigh (1954) found that the average correlation between actual and ideal self for 25 clients before therapy was -.01; this indicates that there was no link between perceived actual and ideal selves. Following counselling, the correlation was +.34; this figure suggests that clients had changed their view of themselves by moving toward their ideal self-picture.

Rogers (1954) analysed the case of a client known as Mrs. Oak, a dependent, inarticulate, passive person who had experienced rejection by others both at home and in social groups, as revealed by her self sort responses before therapy. Repeated

self sorts during the course of therapy were correlated with this pre-therapy baseline, with the 25th session, +.42; at the end of therapy, +.39; and 12 months after therapy, +.30. Following therapy, she perceived herself to be much more secure, confident, emotionally mature, and expressive, warmer in relationships, and less afraid than she was before therapy began.

1.6.1 Therapeutic Relation

In contrast to both psychoanalysis and behaviour therapy, humanistic therapists emphasise the relation between therapist and client. Each enters and shares the experiential field of the other. A proper relation, one in which the patient can safely trust his experience to an understanding therapist, is surely critical. The issue here, however, is whether it is a sufficient base for therapeutic change. (Korchin, 1986)

Rather than repairing past inadequacies, achieving symptom-relief or replacing maladaptive habits, humanistic therapists stress man's potential for growth and self-actualisation. The goal is increasing awareness, freedom, choice, and a person's options for a better life. Therapy is oriented to healthy strivings rather than pathological trends.

On the whole it is probably true that the humanistic approaches are best adapted to the problems of relatively well-integrated and functional people, who are seeking greater meaning and fulfilment in their lives. For less educated and articulate people, those suffering gross psychological disabilities or severe environmental stress, children, psychotics, and the mentally retarded, the aims and methods of humanistic therapies are less appropriate. (Korchin, 1986)

1.7 LET US SUM UP

In this unit we have dealt with how the humanistic counselor deals with a client and motivate the person to utilise his/her maximum potentials rather than improving the past demerits of life. Healthy individuals, in Roger's view, are those who can symbolise their experiences accurately and completely. Unhealthy people however distort or repress their experiences and are thus unable to symbolise them accurately and experience them fully. In Rogers' view, the subjective experiencing of reality serves as the basis for all the individual's judgments and behaviour. It is this phenomenological, inner reality, rather than external, objective reality, that plays the key role in determining the person's behaviour. This rationale tells us the phenomenological basis of Roger's client centered therapy/counselling.

Humanistic Psychology came into existence before forty years with the concept of development of human potentials for the overall growth of the individuals. Humanistic psychology sees man as having purpose, values, options and the right to and capacity for self-determination, rather than being the helpless victim of his unconscious or of environmental reinforcement. Of his free will, he can maximise his potential for growth and happiness. The highest of human motives is the drive for self-actualisation.

A phenomenological position holds that what is real to an individual (that is, what reality is thought of, understood, or left to be by the individual) is what that exists within the concerned person's internal frame of reference, or subjective world, including every thing in his or her awareness at any point of time.

It follows that an individual's perceptions and experiences not only constitute that person's reality but also form the basis for his or her actions. One responds to events in accordance with how one perceives and interprets them.

In client centered counseling the particular techniques the counsellor uses, his training, technical knowledge, and skills are entirely secondary, compared .to the basic qualities of the counsellor. Success in therapy depends on the therapist/ counsellor communicating and the patient perceiving (1) the therapist's own congruence; (2) his unconditional positive regard for the patient, and (3) his accurate empathic understanding.

We have our true self and according to Rogers we also have social self. Rogers believed that when we interact with significant people in our environment, like for instance with parents, brothers, sisters, friends, teachers, etc., we begin to develop a concept of self that is largely based on the evaluations of others. That is, we come to evaluate ourselves in terms of what others think and not in terms of what we actually feel. Such a self-concept carries with it conditions of worth. With unconditional positive regard, the self concept carries no conditions of worth. In fact there is a congruence between the true self and experience, and the person is psychologically healthy.

Rogers contends that all persons posses basic desire to experience attitudes such as warmth, respect, admiration, love, and acceptance from significant people in their lives. The need for positive regard develops as the awareness of self emerges, and it is pervasive and persistent. Rogers feels that it is possible to give or receive positive regard irrespective of the worth placed on specific aspects of a person's behaviour. This means that a person is accepted and respected for what he or she is, that is without any ifs and buts. For Rogers the existence of unconditional positive self regard enables an individual to progress toward becoming a fully functioning person. In such an individual, the self is deep and broad, since it contains all the thoughts and feelings that the person is capable of experiencing.

According to Rogers, if there is a significant degree of incongruence between one's self concept and one's evaluation of experience, then one's defenses may become non functional. In such a 'defenseless state, with the incongruent experience accurately symbolised in awareness, the self-concept becomes shattered. Thus personality disorganisation and psychopathology occur when the self is unable to defend against threatening experiences.

Progress in counselling requires the therapist to perceive feelings and experiences sensitively and accurately and to understand and convey their meanings to the client during the therapeutic counselling sessions. Accurate empathic understanding means that the therapist can sense the client's inner world as if it were his own.

In fair measure, the success of therapy depends on the communication, and perception, of the therapist's attitudes. Growth in the patient involves, in effect, his incorporation and utilisation of these attitudes as part of himself. Therapy should, therefore, make him more congruent, be better able to give others unconditional positive regard, and be more accurately empathic in viewing himself as others. These three conditions describe the essence of client centered counselling, and figure prominently in Rogers' theory of personality and social philosophy.

Within each of us, according to Rogers, there is an innate motivation called the self actualising tendency and active, controlling drive toward fulfillment of our potentials that enables us to maintain and enhance ourselves.

According to Rogers, the actualising tendency serves as criterion against which all one's life experiences are evaluated. Individuals engage in what Rogers describes as an organismic valuing process specially in the course of actualising themselves.

If people are able to utilise their organismic valuing processes fully, they will inevitably begin to experience personal growth and movement toward realisation of their potentials. In Roger's terminology, they will be moving toward becoming fully functioning persons.

Rogers believed that people have the capacity for change within themselves and will change in constructive ways if the therapist creates the appropriate conditions for growth.

In contrast to both psychoanalysis and behaviour therapy, humanistic therapists emphasise the relation between therapist and client. Each enters and shares the experiential field of the other. A proper relation, one in which the patient can safely trust his experience to an understanding therapist, is surely critical.

1.8 UNIT END QUESTIONS

1) Describe Rogers Client Centered Counselling
2) How does Humanistic psychology and phenomenological approach crucial to client centered counseling.
3) Describe the concept of self in client centered counseling and indicate how counsellor's congruence can be ensured?
4) What is meant by unconditional positive regard? How is important for client centered cousnelling?
5) What are the two defense mechanisms used by Rogers and why? How are these relevant to client centered counseling?
6) What are the important points to remember for effective client centered counselling?
7) What do you understand by congruence of self? How is it associated with unconditioned positive regard?
8) What are the characteristic of a fully functioning person according to Rogers? How a counselor can help a client to lead his or her life as fully functioning?
9) How do you explain the concept of empathy and its significance in couselling?
10) Explain with suitable examples the concept of phenomenology.
11) What are the specific role of a counselor who does client centered couselling with the client?

1.9 SUGGESTED READINGS

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Rogers, C. R. (1961) *On Becoming a Persn: A Therapist's View of Psychotherapy*, Houghton Mifflin. Boston.

Rogers C. R. (1977) *Carl Rogers on Personal Power*, Delacorte Press, Newyork

Sheldon J. Korchin (1986). *Modern Clinical Psychology*, CBS Publishers, New Delhi.

1.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) (c) 2) (c) 3) (d) 4) (a) 5) (a) 6) (b) 7) (d) 8) (d) 9) (c) 10) (d)

UNIT 2 PSYCHODYNAMIC COUPLE'S COUNSELLING

Structure

2.0 INTRODUCTION

This unit focuses on couples counseling. Initially we discuss the psychodynamic and psychoanalytic approach to counseling and then on to couple counseling. We then discuss how psychoanalysis is used in marriage counseling and family counseling.

This is followed by object relations theory which is one of the methods by which couples counseling used to be given. Here we discuss how the couples subsystem is considered for such counseling purpose. The next issue taken up is marriage counseling and it is differentiated from family counseling. The dynamics underlying marriage counseling are put forth and the uniqueness of couples problems are discussed. Then the counseling session as such is taken up and the stages in couples counseling sessions are described in detail. The importance of sexual counseling is then presented which is followed by the dealing with couples having domestic violence and mental illness.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe couples counseling;
- Explain the psychodynamic approach to couple counseling;
- Describe object relations theory as applied to couple counseling;
- Define and describe marriage counseling;
- Elucidate the various aspects involved in marriage counseling;
- Describe the various stages in couple counseling;
- Explain the importance of sexual counseling; and
- Analyse the techniques involved in working with couples having mental illness.

2.2 PSYCHODYNAMIC APPROACH TO COUNSELLING

Psychodynamic approach originates from Freud's work on the Id, ego and superego which are 3 parts of our psyche. While Id is impulsive and wants its needs to be gratified immediately, the ego which is the conscious self of us tries to find ways and means to gratify the needs in the most realistic manner. The superego however is the moral arm which is also in the subconscious and acts as a mediator of the Id's basic desires to make the ego find a solution that is socially acceptable and healthy. Freud's psychoanalysis is a holistic approach that looks not only at the here and now but also the past experiences and materials repressed in the unconscious. In the psychoanalytic therapy, an attempt is made to uncover the memories repressed in the unconscious in a controlled environment. This is done through the medium of client therapist relationship which is a trusting relationship.

Psychodynamic and psychoanalytic approaches began to extend their approach to include a family orientation in couples counselling in the late 1940's. The work of Nathan Ackerman (1958) was especially important in focussing the attention of psychoanalysis on family units. Before Ackerman, psychoanalysts had purposely excluded family members from the treatment of individual clients for fear that family involvement would be disruptive. Ackerman applied psychoanalytic practices to the treatment of families. Later on in couples counselling the psychodynamic therapy was used for couple and associated family members.

2.2.1 Psychoanalytic Theory vs. Pschodynamic Theory

Although the two terms psychoanalytic and psychodynamic are often used interchangeably, yet the term psychodynamic is the broader of the two. This term includes the underlying processes (feeling, ideas, impulses, drives etc.) which influence

much of overt behaviour. These underlying processes are often not at the conscious level and that humans frequently use defense mechanisms to keep anxiety provoking feelings, ideas and impulses out of conscious awareness. Theories that are psychodynamic in nature may or may not be psychoanalytic (Robbins, 1989 in Gelso, 1995).

Psychoanalysis is the most intensive and depth oriented form of therapeutic intervention. Sessions occur usually between three and five times a week, and analysis is virtually always long term. Length of treatment is typically from three or seven years. Anaysis is carried out by a certified psychoanalyst, who after completion of MPhil or Doctoral degree in psychology, receives several years of additional training in psychoanalysis from one of the many psychoanalytic training Institutes.

The client's main task is to free associate, that is, to say what ever comes to mind without editing or trying to formulate intellectually the meaning of dreams. Analysts believe that dreams provide a powerful way of accessing the client's unconscious. The analyst's task throughout the analysis is to be non interfering, to offer what Freud called as hovering attention, and to make interpretations of the emerging material from the client that makes sense to him or her. These interpretations should be as close to the client's level of awareness and experience as possible, or else if they become too far removed from what the client is feeling, the treatment can become a sterile, intellectual exercise.

During the course of analysis, as the client continues to free associate and the analyst carries out the tasks discussed above, the client naturally regresses in his or her associations. That is, the client's associations and memories continually move backward in time. As this happens, the client gets more and more into the childhood conflicts and issues that form the fabric from which the present problems derive. Also, as this occurs, transference reactions continue to develop and build.

It must be remembered that transferences are by definition distortions of the analyst. Transference is a repetition of past conflicts with significant others, displacing feelings, behaviours, and attitudes belonging rightfully in those earlier relationships onto the analyst or therapist. In psychoanalysis, the key to helping the client resolve neurotic conflicts resides in providing insight into the distortions involved in the transference. As the transference intensifies, the analyst maintains his or her ambiguity and neutrality, and this permits the continuing unfolding of these projections. The cure in analysis occurs as the transferences are repeatedly interpreted, worked through, and resolved. The analyst's timing in offering interpretations is crucial.

As the transference is worked through, the client develops deep insight into how his or her early conflicts caused him or her to distort and misperceive the self and others. The client's defenses become reduced so that he or she can lead a better life. Again, the aim of analysis is this depth insight, most centrally of the client's hidden needs and issues, as manifested in the transference. The working through the transferences in analysis deeply and positively affects the client's relations with others as well as with the self. It results in deep seated changes in personality structure.

2.3 PSYCHODYNAMIC MARRIAGE/ COUPLE COUSELLING

Psychoanalysis concentrates on individuals rather than social systems such as the families. An initial goal of psychodynamic family counselling is to change the

personalities of family members so that they can work with one another in a healthy and productive way. Nichols and Schwartz (1991) pointed out that psychodynamic counsellors who follow Ackerman most often employ an eclectic mix of psychoanalytic and systems concepts.

A unique contribution that psychodynamic counsellors have made to family counselling is the use of object relations as a primary emphasis in treatment. Object relations are internalised, residues of early parent-child interactions. In dysfunctional families, object relations continue to exert a negative influence in the present interpersonal relationships. Dysfunctional families are those with a greater degree of unconscious, unresolved conflict, or loss. (Paul and Paul,1975). Three main ways of working with these families are:

i) developing a stronger parent coalition,

ii) defining and maintaining generation bounderies, and

iii) modelling sex-linked roles (Walsh, 1982).

Overall psychodynamic family/couple counsellors concentrate on helping family members obtain insight and resolve family of origin conflict or losses, eliminating distorted projection, reconstructing relationships and promoting individual and family growth.

2.3.1 Psychoanalytic Marriage Counselling

Psychoanalytically based marriage counselling is based on the theory of object relations, which addresses how relationships are developed across the generations. Objects are significant others in one's environment such as a mother with whom children form an interactive emotional bond. Preferences for certain objects as opposed to others are developed early in parent child interactions. Individuals bring these unconscious forces into marriage relationships.

To help the marriage, the counsellor focuses with each partner on obtaining emotional insight into early parent child relationships. The treatment process may be both individual and conjoint. In the process, the counsellor uses the process of transference where each partner restructure internally based perceptions of, expectation of , and reactions to self and other and projects them on to the counsellor. Other techniques include taking individual history of each partner and a history of the marriage relationship. Interpretation, dream work and an analysis of resistance are often incorporated into the treatment (Baruth and Huber, 1984). Catharsis the expression of pent up emotions is a must. The goal of this approach is for individuals and couple to gain new insights into their lives and change their behaviours.

2.3.2 Psychoanalytic Family Therapy

Although the psychoanalytic family therapy tends to be more active and directive than the psychoanalytic individual therapy, this treatment is clearly nondirective in comparison to other family/couple approaches. In this therapy, the therapist listens a great deal, and although this listening is very active, he or she is relatively quiet. Interpretation is the primary technique used in this approach. One of the important aspects in these therapies is the transference that is encouraged which helps a great deal both in terms of catharsis and also developing of insight into one's own dynamics of behaviours. This transference is not only between the therapist and the client but also amongst family members and couples.

In this technique, transference specially to the therapist is less intense than in individual therapy. Both the real and transference reactions between and among other family members divert some of the energy ordinarily invested in the individual therapist.

The psychoanalytic family therapist usually prefers to work with families in a long term format than is obtained in other approaches. The goal is personality change in individual members of the family.

2.4 OBJECT RELATION THEORY

In this theory, objects refer to others in the family that is other than one's own self. Within the couples and family therapy domain, the major current theory of this nature is called object relations theory. In contrast to classic Freudian psychoanalysis, which focuses on biologically based drives revolving around sex and aggression, object relations theory posits an innate human need for relationships.

In fact, object relations theory consists of two aspects, viz,

i) the psychoanalytic study of the origin and nature of interpersonal relationship

ii) the intrapsychic structures that grow out of past relationships and remain to influence the present interpersonal relations.

It is well known that from birth on, the human being seeks sustaining relationships with significant others, especially with mother and father in early life. In the bringing up of children, parents do commit a large number of mistakes of which some are relatively more frustrating to the growing person. According to the psychodynamic approach if this frustration is too high during the early stages, the individual will repress the same and these frustrations and disappointments etc. will start appearing at a later stage in the individual's life. The important aspect in couples therapy is that these needs show themselves in the choice of and behaviour toward love objects, and in terms of one's strengths and weaknesses as a parent.

At the core of this object relations theory is the manner in which the early relationships are internalised or incorporated by the person, and how the person carries the same in terms of representations of early love objects such as parents. In fact these representations serve as blueprint of sorts for subsequent relationships. The internal object representations profoundly affect the choice of subsequent love objects, behaviour toward those persons, and perceptions of the objects. It must be understood that the internal representations only partly correspond to reality and they are always affected by the individual's existing needs and drives.

2.4.1 Object Relation Theory and Couple Subsystem

Although object relations therapists do work with the entire families and various family subsystems, it is important to note that most analytic work involves the couple subsystem. Some of the most fascinating object relations theory has recently been developed on how material patterns choose each other and respond to each other in a way that matches the internal representations of early objects, such as mother and father.

The concept of projective identification is used by most object relations therapists as a key to the troubled interactions of members of a couple and related family members. When using this defense, the person unconsciously projects hidden feelings and ideas (which in turn reflect hidden object representations from childhood onto the spouse or other significant object.

The person not only projects hidden parts of the self onto others but then identifies with those parts because these are, after all, part of the self. In couples and family interactions, projective identification, ordinarily a complex concept, is even more complicated. The object (in this context let us say spouse) takes on these projections and then acts them out. For example, let us say in the child's earliest experience the concerned object did not provide the needed nurturance. Such child then sees rejection and hostility in his wife even when it is not present in reality. Significantly, the wife 'takes in' this projection and acts out the role of the hostile, rejecting object. To carry this example further, the wife, too, has her internal object representations, for example, the cool, distancing father introject. She may project these into her husband, and he may in turn act them out.

2.5 MARRIAGE COUNSELLING

Couples seek marriage Counselling for a wide variety of reasons, including finances children, fidelity, communication, and compatibility.

Regardless of who initiates the request, it is crucial that the counsellor sees both members of the couple from the beginning. Trying to treat one spouse alone for even one or two sessions increases the other spouse's resistance to counselling and his or her anxiety. Moreover, if one of a couple tries to change without the knowledge or support of the other, conflict is bound to ensue.

After both partners have decided to enter marriage counselling, the counsellor may take a variety of approaches. Five of the main approaches are psychoanalytic, social learning, Bowen family systems approach, structural-strategic approach and the rational emotive approach.

2.5.1 Marriage/Couple Couselling versus Family Counselling

Marriage counselling and individual counselling share a number of assumptions. For instance, both recognise the importance the family plays in the life of the individual, and both focus on problem behaviours and conflicts between the individual and the environment. A difference is that individual counselling usually treats the person outside his or her family, whereas marriage or family counselling generally includes the involvement of other family members. Further marriage and family counselling works at resolving issues within the family as way of helping individual members better cope with the environment

2.5.2 Dynamics Underlying Marriage Counselling

The emphasis in marriage and family counselling is generally on process (dynamics) as opposed to content (linear causality). In other words, the dynamics behind marriage and family counselling generally differ from the individual and group therapy. In making the transition from an individual perspective to a family orientation, Resnikoff (1981) stresses specific questions that the counsellor should ask themselves in order to understand family functioning and dynamics in the case of couple or family counselling. The few questions are given below:

- What repetitive, non-productive sequences are noticeable?
- What is the basic feeling state in the family, and who carries it?

- What individual roles reinforce family resistance, and what are that most prevalent family defenses?
- How are family members differentiated from one another, and what are the subgroup/couple boundaries?
- What part of the life cycle is the family/couple experiencing, and what are its problem-solving methods?

2.5.3 The Uniqueness of Each Couple's Problem

Couple problems are usually composed of a complex mixture of ingredients which make up a whole that is individual and idiosyncratic. The component parts include each partner's own personal history and character, history of the relationship and the attendant circumstances at the time of presentation.

Most couple, by the time they seek counselling, are aware of the existence of a problem in their relationship, and may have had recourse to various forms of assistance. They have often tapped their own problem-solving skills. The specific advice of relative and of other professional, especially general practitioner, has commonly been sought.

They may have read the general advice of newspaper columnists and other authors. The existence of the problem may well have made the couple receptive to such advice and they may be keen to experiment with a variety of solutions The solutions arrived at from a course of counselling will be the product of an average of eight hours of energetic interpersonal interaction between the two or three individuals in the counselling room. It will typically be reinforced by at least an equal amount of time spent by each of the individuals reflecting on the process or engaged in related tasks. In the process considerable time would have been devoted to the couple's problem in a highly concentrated manner.

2.5.4 Defining the Couple Problem

Where a couple present a problem which they regard as common, or where one partner presents a problem which he or she wishes to work on as couple problem, the situation is comparatively simple. The only factor that might inhibit exploratory work would be if some aspects of one individual's behaviour or pathology suggested to the counsellor that it would be irresponsible to begin couple work, without first ensuring that the immediate systems were addressed. For example, one partner may be clearly suffering from acute mental illness, or actively suicidal or threatening to severely harm others. In the most extreme cases, severe individual pathology might prevent couple counselling ever being possible. However, such cases are very rare.

Firstly, even if the symptom is clearly affecting one partner more than the other, exploration may help mobilise both partners' helping capacity. It clarifies the joint aspects to the problem and to what extent it may be an individual one. It may also allow the partner who is less affected to explore whether his or her remedial action are truly helpful. Partners can often perpetuate rather than help an individual problem. Both partners may also find it helpful to explore the impact of the problem on the relationship and to vent some of their feelings caused by the problem as for example frustration or sadness.

2.6 STAGES IN COUPLE COUNSELLING

There are certain stages in couple counseling which are given below. A three stage model of counseling has been proposed:

- Stage One: Exploration
- Stage Two: Understanding
- Stage Three: Action

2.6.1 Stage One: Exploration

This is best achieved by a non judgmental empathetic approach and by use of the techniques of active listening, and so these skills are carefully taught and their importance emphasised. However, there are a number of tasks which do need to be addressed in the exploration phase.

Firstly, the client needs to be informed broadly of the nature of the service that is being given to them. As for confidentiality, they must know upto what limits it can be implemented as there may be something at some time to be conveyed to another professional treating the same person for some other referral. An initial contract needs to be made along with informed consent. Some basic information needs to be taken and a brief summary of the problem should be obtained. This is termed as the 'intake procedure.'

Once this has been done, any clear signs that have become apparent to indicate that the clients have other pressing therapeutic needs are addressed. Also assessment of appropriate depth is used and where needed a referral is made.

Where there are no indications of any other problem or disturbance, counselling begins and assessment progresses gradually during the initial exploration as the presenting problem is discussed. Both the counsellor and the clients get more chance to examine the problem and to experience the reality of working together. During this process, the counsellor will be using her skills to promote the formation of a therapeutic alliance with the clients.

This process will typically take from two to six weeks, depending on the complexity of the clients' situation and the ease of relationship with the counsellor.

Steps under Stage one- Exploration

a) Intake and assessment
   - Usually general
   - Detailed where necessary

b) Initial exploration

c) Formation of therapeutic alliance

d) Ongoing examination of presenting problem

e) Contracting for further work

Details of the Exploration stage includes the following:

- Specifying or crystallising the help that clients want with their problem
- The duration of the problem that has persisted
- Precipitating and aggravating factors that perpetuate the problem

- Current Major Life Issues
- How the partners Interact together
- The couples' social and cultural context
- Each Partner's physical and mental health, both now and in the past
- Each partner's family experience
- Legal proceedings in Hand
- Other Helpers or Agencies Involved
- Significant Interactions Concerning the couple that are not apparent
- Significant third parties Involvement in the Relationship.

2.6.2 Stage Two: Understanding

Particular patterns and struggles that a couple are having can be illuminated in part by looking back to earlier relationships and how these were experienced. In this, the psychodynamic position is considered. It is believed that relationships that conform to certain patterns do so not only out of conscious choice, but also due to the past experiences where many attitudes, feelings and behaviours have not been examined but taken as routine. Notions of what behaviour is acceptable and unacceptable, what roles are proper and improper, what emotions are to be welcomed or avoided would have all been part of this unexamined aspects which are at the unconscious level.

The memories of this type from the unconscious emerge through Transference which is created at times deliberately by the therapist or happens spontaneously as the client uninhibitedly expresses all suppressed and repressed feeling to the therapist / counselor.

Transference means the following. To give an example, let us say the client had felt angry towards the spouse on a certain matter in the past and could have expressed the anger physically or verbally. During the counseling session, the client treats the therapist/counselor almost as if it was his or her spouse and transfers all those anger and hostility on to the counselor. This is called transference. This happens at the unconscious level and the client is not aware that he or she is transferring those feelings and emotions of the past that was felt towards the spouse on to the counselor.

The counselor or the therapist on his part identifies and uses this transference in explaining to the client about what kinds of feelings they were and why those feelings were present and thus provides an insight into the client's behaviour as to why he/ she behaved as they did and this insight regarding the cause for one's behaviour makes the client understand and give up that behaviour.

Thus the therapist or the counselor explains how thoughts and feelings that are not conscious can influence our new relationships. To give a totally different example, let us say that someone who has been consistently bullied in the past may approach another with a timid demeanour, expecting to be hurt. However he may become pleasantly surprised to find that he is not bullied.

In some cases there is no correspondence, and either no relationship ensues or a new relationship is created which breaks the patterns of the past relationships. This kind of situation can arise in the case of client therapist relationships also. For instance, clients frequently produce similar reactions in a counsellor, who finds that she feels a pressure to adapt her behaviour and thinking. It is a powerful and significant process.

Where couple relationships are involved, the process will be happening on both sides and the resulting relationship will be all the more powerful, as each person corresponds to the other's conscious and unconscious expectations.

While we have understood what transference is and how it emerges and how it is handled by the counselor in the counseling session to develop insight into the client, there is also countertransference that may emerge which needs to be recognised. Countertransference is a reaction of the counsellor to the client's transference. Sometimes it is a conscious reaction to the observed behaviour of the client and sometimes it may be also an unconscious reaction to the felt, and not consciously understood, behaviour of the client.

2.6.3 Stage Three: Action

For many clients, an understanding of their problem is enough and they are able to modify their behaviour appropriately. Others need to engage actively in new behaviours to consolidate the understanding and to allow change to take place. Therefore, this 3rd stage of counselling is concerned with the action that will be taken as a result of the understanding gained by the counsellor and the clients in the previous stage. Some of these actions are for the clients to use in order to begin to develop a new way of looking at themselves and their relationships.

Other actions represent new ways of interacting in which, the active interventions are aimed at encouraging clients to see how the present reality differs from their assumptions about it. This in turn allows them to form a more objective and agreed view of the situation. They are thus able to channelise their energies into creating new patterns of relating which takes objectively the factors that exist in the present situation instead of glossing over it.

Some of the techniques used in this regard includes (i) communication (ii) genogram and (iii) sculpting. Let us take up each of these and discuss.

i) **Communication**

When a relationship has become problematic and partners have become distanced from one another, it is a clear indication that there is a communication problem. It also indicates that one has to re establish or re create adequate and appropriate communication between the partners. The encouragement of active communication is an extremely effective way by which this problem can be reversed, and each partner can be encouraged to begin to re engage with the other and re examine the unconscious preconceptions which have replaced active interaction.

ii) **Use of genogram**

Another technique that is useful in this context is the use of genogram. This is a diagram which represents the family of the couple in the form of a tree. This diagram includes the parents of the couple, their siblings, previous relationships and their children. On this family tree significant events and interactions are presented. A careful and sympathetic exploration of genogram with clients allows them to take account of attitudes, experiences and beliefs which have been with the clients since birth and they get to know how these have influenced their understanding of the present situation in ways of which they are not conscsiously aware.

iii) **Sculpting**

The third technique is sculpting. This is a further development of the genogram, which allows a visual representation of a family system to be made using simple objects such as stones, coins or buttons. It is the client's choice as to how to represent particular individuals and how to depict their closeness or distance from each other. This technique provides a powerful visual tool for representing situation as well as assumptions of which they were previously unaware. This technique is also remarkably effective in allowing clients to see the difference between their perception of the situation and their partner's perception.

Another important tool used in couples counseling is the Transactional Analysis (TA). In particular, the Ego State Model from TA allows clients to distinguish between their tendencies to act as a child, or as an adult or as a parent. The child and parent roles are both linked to the clients' past, whereas the adult role is entirely concerned with dealing with the present reality. This technique encourages clients to distinguish between what is part of the present situation and what precedes (predates) it. A great part of the value of this tool is its accessibility to the clients.

2.6.4 Important Steps in Action

Summarising

This involves summarising the themes and reflecting back what has been said to help clarify some of the issues that seem at odds with one another. It encourages the clients to thoughtfully challenge each other. It also encourages the couple to question the strong family belief that have never been acknowledged by either of them.

Introducing Unacknowledged Feelings

The counsellor may well become aware of a feeling that the clients might be denying. Simply sharing the feelings in the room and assuming that the counsellor judges it to be close enough to the clients' consciousness to be meaningful to them, may help clients gain new insights.

Pointing out the Discrepancies

When the discrepancies between verbal and non verbal language between the couple are pointed out it helps in a big way. This is so because neither of the partners may be aware of behaving in such a manner. Clients may say that they are angry but smile as they say it or , conversely, verbalise something benign in a different tone.

Challenging Clients for Action

Most important of the techniques is to have the trust of the clients before challenging them for Action. The aim of challenging is to focus on disccrepancies in thoughts, feelings and behaviours that become apparent during the Exploring and Understanding stages.

Self Assessment Questions

1) According to which theory underlying processes (feeling, ideas, impulses, drives etc.) influence much of overt behaviour, that these underlying processes are often not at the conscious level:

   a) Psychoanalytic
   b) Psychodynamic
   c) Analytical
   d) Both a and b

2) Who started first psychoanalysis approaches in family counselling:

a) Nathan Ackerman b) Sigmund Freud

c) Alfred Adler d) None of these

3) The process, in which is a repetition of past conflicts with significant others, displacing feelings, behaviours, and attitudes belonging rightfully in those earlier relationships onto the analyst or therapist, is called:

a) Resistance b) Countertransference

c) Free association d) Transference

4) The internalised residues of early parent child interactions are known as:

a) Interpersonal Relations b) Parent-child relations

c) Object Relations d) None of these

5) What are the three stages of counselling approach?

a) Exploration, understanding, action b) Understanding, dealing, negotiating

c) Exploration, doing, understanding d) Exploration, understanding, explaining

2.7 SEXUAL COUNSELLING

When considering the various areas of couple relationship, sexuality is clearly an important part. Sexuality is as amenable to the three stage model of exploration as any other aspect of couple's life. However, because of the unique importance of this area in any couple relationship and the tendency for it to be inadequately dealt with, (owing to embarrassment on the part of either the couple or the counsellor) there is a need for excellent training of the counselors, who can ask questions in related matters and help couple adequately.

In this context it is worth noting that Jack Anon, a clinical psychologist working at the University of Honolulu, devised and amplified a version of the model to describe various levels of help with sexual difficulties. This is known as PLISSIT.

P= Permission (Exploration)

LI= Limited Information (Understanding)

SS= Specific Suggestions (Action)

IT= Intensive Therapy

Let us take up each of the above and discuss in detail to understand their significance.

2.7.1 Importance for Permission

One has many assumptions in regard to sexual matters which are given below. Hence it is important that before sexual indulgence, the concerned partners must take permission from the other so that sex is natural and spontaneous. Some of the assumptions are

- Men are always ready for sex.
- Do not show affection to a man, he will expect sex.
- Performance is what counts for men.

- There is something wrong with a man who has a lower sex drive than his partner.
- You must orgasm together.
- Men should know all about sex.
- Women expect men to know about sex.
- Women must wait for men to initiate.
- All gay men are promiscuous.
- A large penis stimulate more than a small one.
- Men must take charge of sex.
- Having sex always ends in orgasm.
- Good sex always ends in orgasm.
- Good sex means the man always must have an erection.
- Most gay and lesbian partners adopt an active or passive position in their sexual relationship.

2.7.2 Importance for Limited Information

Information about sex is readily available but it can be misunderstood in the simplest way by the myths and taboos we have mentioned. It is not only the content that has to be absorbed but also the way the information is processed. Not many people have been able to ask for clear, honest sexual information and received an equally honest response. In sexual counselling this is what is encouraged between the couple. The counsellor will check how much the clients do know during the exploration stage. The counsellor herself or himself must have a good working knowledge of the anatomy and physiology of sexuality.

2.7.3 Importance for Specific Suggestions

Some clients may need more than permission and information. They may benefit from suggestions about how they can make changes in attitudes and behaviours as a result of their new understanding. It may start with exploring their own body in order to examine their own self image. It may be touching and talking exercises or rethinking positions for intercourse. The tasks are better discussed in session so that they are manageable and achievable. It is vital that the counsellor appreciates the difference between behavioural tasks in sexual therapy and sexual counselling.

2.7.4 Importance for Intensive Therapy

Psycho Sexual therapy is a treatment plan to remove a specific dysfunction, while sexual counselling facilitates the sexual communication and understanding between the couple.

Psycho Sexual Therapy should not be attempted by the counsellor unless qualified. Inappropriate task setting will have negative results as in general couple counselling. The couple will feel further failure and be less inclined to start again. In therapy if the counselor finds that even simple tasks given to the couple is not being managed and there is considerable difficulty, then the counselor has to rethink and re plan the therapy programme. Probably it may require further exploration of more underlying emotional issues which have to be probed further and understood or where necessary to refer the couple to some other expert to overcome neurological o rother related problems.

2.8 COUPLES AND DOMESTIC VIOLENCE, MENTAL ILLNESS

2.8.1 Domestic Violence

Where ongoing domestic violence exists, the first priority is to address what steps can be taken to end the violence. Counselling may be one, but so also the individual therapy, separation and legal restraints.

Social control is sometimes necessary to stop violence, as violence is a criminal act for which legal sanctions are appropriate. Counselling should not become a diversion from this. Therefore, it is important not to offer counselling if legal action is in process. In other cases a careful assessment is needed initially to ascertain the following points:

- Tracking actual arguments in detail
- Considering how the couple behave when they are separate and when they are together.
- Looking at the couple's history with a view to understanding how issues of gender difference, power and control were handled.

This kind of work can very powerful, and it is important that when the counsellor is concentrating on one partner the other does not feel neglected, as this may recall previous life experiences of neglect. Therefore, the counsellor needs to acknowledge this possibility and allow it to be voiced if need be.

Similar feelings of abandonment may well arise when the couple separate rather than become involved in violence, and these feelings need to be normalised.

Work is done with the perpetrator to emphasise that he has the choice as to whether to be violent or non-violent and has exercised this choice in the past. This allows him to acknowledge that violence is not an integral part of the person, and thus allows the individual to regain dignity and control.

Similarly, emphasis is placed on challenging the notion of 'being provoked', emphasising that the perpetrator has the choice of whether or not to respond. Once the perpetrator has understood this, he is freed of the feeling that he must have control over his partner to have control of his own life.

2.8.2 Principles to Work with Mentally Ill Clients

Mental illness is a phenomenon for which there exists formulated medical diagnostic and remedial practice. Couple counselling is unlikely to have a curative effect on mental illness apart from on mild reactive conditions. Resolving couple's problems and increasing their relationship skills may result in benefits to their general mental well being.

Once the presence of an illness is noted and understood, great care needs to be taken to assess what work, if any, is possible and to ensure any work that is undertaken is appropriately focused and that it does not increase clients' distress by inducing confusion or anxiety.

Care needs to be taken to ensure that clients with severe mental disturbance are recognised and if possible directed to an appropriate source for help.

2.8.3 Intention of Suicide by a Partner

The clients may have a variety of reasons for expressing an intention to commit suicide during the time they are going through counselling sessions with a therapist or counselor. One should not ignore the overt threat if mentioned by either of the partners. It would be ideal for the counselor to help the concerned partner to express him or herself and vent their feelings as to why they consider such extreme step. The counsellor's work must focus on to engage the client in a nonsuicide pact.

At best this is a promise from the client to do him or herself no harm. This non suicide pact could be for a fixed period of time (e.g. during the initial counselling contract or until this marriage problem is resolved or until the next session). At the minimum there should be a firmly expressed hope on the counsellor's part that the client will take care of him or herself.

Once the session is over the counsellor will need to make prompt contact with a family member or even the spouse to allow to share the deep ambivalent feelings that client's threatening suicide can engender and to consider further action in regard to the same.

It is important that the counsellors should be aware of such suicidal threats and should exercise particular vigilance when there is a suggestion of suicidal intent.

The couple therapy is a sensitive issue to tackle. Whatever form of therapy one may use, it is important to note that the partners may be from different background and culture and thus to make them both see eye to eye on various conflicting issues will be rather difficult.

There might also be communication problems. Each partner may have different personalities and habits. Also there may be family issues which may affect the couple relationship. Whatever approach the counselor uses the couple therapy needs training and knowledge and it is very much challenging for the counsellor himself.

2.9 LET US SUM UP

In this unit we learnt about couples counseling and the various issues related to the same. The counseling techniques based on psychoanalysis and psychodynamic factors were taken up and discussed. It was then applied to couples counseling and the various steps in regard to couple counseling were delineated and discussed. A discussion regarding how to consider the couple in session as a subsystem and how to apply the object relations theory to the same was then taken up. Marriage counseling was described and differentiated from family counseling. The various dynamics underlying marriage counseling was then discussed in detail. The problems of the couple was then taken up and showed the uniqueness of such problems as related to each couple. Then we defined couples problem and put forward the method to define the same. The next aspect was couple counseling as such and the three important stages of couple counseling were discussed in detail. We then pointed out the importance and significance of sexual counseling and the various techniques to handle the same. While dealing with couples counseling it is also important to deal with domestic violence which brings the couple to counseling. Also many times the conflicts between the couple may arise due to one of the partners or both suffering from mental illness. In this unit we tried to see how such cases could be effectively handled.

2.10 UNIT END QUESTIONS

1) What do you understand by psychodynamic approach and how it differs from psychoanalytic approach?
2) What is object relation theory ? How it can be applied for a couple's couselling?
3) What are the three stages of Couples counselling?
4) What are the roles of a good couple counselor?
5) Other than interpersonal relationship what could be the other factors which can influence marriage
6) Discuss how to handle couple with mental illness

2.11 SUGGESTED READINGS

Christopher Butler and Victoria Joyce (2001) *Counselling Couples in Relationships (An Introduction to RELATE Approach)*, John Wiley & Sons, New York.

Gelso Charles J. and Fretz Bruce R (1995). *Couselling Psychology*, Prism Book Pvt. Ltd., India.

Gladding Samuel T. (1996), *Couseling : A Comprehensive Profession*, Prentice Hill Inc., New Jersey.

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) (b) 2) (a) 3) (d) 4) (c) 5) (a)

UNIT 3 FAMILY AND GROUP COUNSELLING

Structure

3.0 INTRODUCTION

In this unit we will be discussing about the intervention methods other than the psychoanalytical and psychodynamic oriented counseling. Here we introduce group and family counseling as two important interventions for the individuals to overcome their problems. This unit describes the different approaches used in family and group counseling. The group process and group dynamics are explained in terms of family and group interventions. The unit then puts forward the techniques of family counselling.

Since the group counseling differs from family counseling, the kind of groups that are formed for group counseling are explained. This is followed by the criteria for selecting the group members as all sorts of persons cannot be put into a group. Every group has a purpose in terms of intervention and thus the criteria are put forward to decide who would be the members of the group. This unit then presents the entire process in group and family counseling.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define family and group counseling;
- Describe the characteristic features of group and family counseling;
- Explain the various group settings for counseling;
- Analyse the process of group and family counseling;
- Elucidate the values of group and family cunselling;
- Delineate the various approaches to group and family counselling; and
- Analyse the types of communication that may cause disturbance in the families.

3.2 INTRODUCTION TO GROUP AND FAMILY

Humans are social animals and they enjoy one another's company and in the process they learn more. Individuals seek their social needs through group and they learn how through groups they can achieve their social needs. In group counseling the concept of this gratification of needs through groups is considered in great detail as the counselor uses these groups to help the individual to overcome not only individual problems but also how to get maximum satisfaction through interacting with the members of the group.

When we talk about groups, family is also a group of one type. If a counsellor wants to deal with the emotional life of the person, the family of this person has to be contacted as through the family the counselor will be able to learn about the typical interaction patterns amongst family members and also will be able to help the client to modify his interaction pattern through group or family therapy.

Family is the place from where an individual starts his/her first learning. Whatever a person learns, he does so from his family members through communication, imitation and dealings with day to day life problems. He enters the world with those knowledge based on the experiences which he had in his family and in all his interactions with the family members. So the family is the first platform which provides the foundation to the individual to face the world as the individual grows up into an adult.

It is the belief of counsellors and all mental health professionals that if a person is having any type of emotional problem, not only the person should come to the counsellor to resolve his conflicts but also he should bring in his very close family members and others so as to improve the communication among family members and the family structure.

Family oriented counsellor always focuses on family system and if possible restructures it. If the family structure is not cohesive and if there are communication gaps among the family members, a person's mental health might be detrimentally affected. Family oriented counsellors believe that counselling of significant persons along with the client can improve the interpersonal relations and resolve the emotional conflicts of a person.

Group counselling also plays an important role to enhance mental health. Webster's Third New World International Dictionary (unabridged) defines a group as a number of individuals bound together by a common interest, purpose, or function. In the present day context, the groups are functional and also goal oriented. Aggregate groups without interaction of the members are not functioning groups.

More than a hundred years ago, the psychologist William James (1890) wrote that man is not only a gregarious animal liking to be noticed by fellow humans, he also experiences a terrible punishment when he is left alone and other humans do not take notice of him. Hence interaction is very essential for humans to keep good mental health.

Therapists too in general agree that human relationships are important not only for gratifying people's basic needs but also it influences the day to day life adjustment of the individual. Group counselling makes an individual to learn the skill which makes strong the interpersonal relationships. These relationships if become strong they would facilitate positively the emotional life of a person.

In groups, an individual experiences dealing with significant others in the outside world and environment, and in the process learns the group values. These group values are beneficial for all interpersonal relationships whether of friends, authority or family members.

The family itself may be viewed as a small system or network of relationships. The network of relationships can be understood in terms of (i) multigenerational approach (ii) interpersonal relationship approach and (iii) structural approach.

3.2.1 Multigenerational Approach

Murray Bowen identifies two central forces in interpersonal functioning. The first is a movement toward individuality, the second a movement toward togetherness. According to object relation theory of infant development there are two trends in mother-child interaction , that is (i) The desire for separation and (ii) The desire for attachment.

Desire for separation indicates individuality and the desire for attachment is equal to the togetherness.

Bowen focuses on the concept of differentiation that is an ability to involve others but simultaneously remains on own self. According to him a person develops his ways of differentiation through his relationships in family. He also suggests that even images of grand parents or morals are also the parts of the development. There are generation to generation family messages running in family. They affect the cognition and behaviour of an individual. The aim of his approach is to aware family members about their history and impact of it on the client's emotional life. It is a very hard task to aware all family members and change their attitude and behaviour in a family.

3.2.2 Approaches in Interpersonal Functioning

Milton Erickson, Watzlawick, Weakland, and Fisch have put forward four basic steps for producing change in families. According to them the family therapy should

i) define the family problem;

ii) determine what the family has done to resolve the problem;

iii) establish family goals; and

iv) construct therapeutic interventions designed to disrupt the typical pattern of interaction sustaining the problem.

This approach tells about the expectation the counselor has from the client rather than restructuring of the family. The cognitive understanding of the therapist about the client's conflicts may interfere with the unconscious and it may lead to change.

3.2.3 Structural Approaches

This technique basically focuses on modification of family system. The study of the family system was given by Salvatore Minuchin. According to him, the power and degree of influence of family members on the overall family system is significant and where the defect in interaction is noted the family system has to be restructured. Also any negative incident or wrong happening e.g. death of a significant member, divorce or separation of parents, also influences the family structure.

The environment of the family may cause interpersonal conflicts and emotional problems. The family members may act out due to some problem in the family environment. Whatever the communication pattern of the family, the most important things that matter are the feelings of attachment and separation towards each other.

The goal of structural approaches is to involve the persons in a system of relationships that is adequately differentiated, but still related to others. In other words, the task is to facilitate a cognitive and behavioural balance of the individual and / or the family in relation to the environment.

Therapeutic task with families is to restructure the power and rules of the family with the ultimate goal of balancing enmeshment and detachment through culturally appropriate boundaries between individuals. Important in this process is returning the family "hierarchy" to a situation where parents are in charge, rather than the children.

3.3 GROUP PROCESS AND GROUP DYNAMICS

In group activities two terms are often used, viz., (i) process and (ii) dynamics. Although some time these terms are also used interchangeably , in counselling they have different meaning.

Group Process refers to the continuous, ongoing movement of the group toward achievement of its goals. It represents the flow of the group from its starting point to its termination. It is a means of identifying or describing the stages through which the group passes.

Group dynamics, on the other hand, refers to the social forces and interplay operative within the group at any given time. It describes the interaction of a group and can indicate the impact of leadership, group roles, and membership participation in groups.

It is a means of analysing the interaction between and among the individuals within a group. Group dynamics is also used on occasion to refer to certain group techniques, such as role playing, decision making, rap sessions, and observation.

Counsellors may view various group activities as occurring at three levels.

- Group Guidance
- Group counseling and
- Group therapy

Group guidance refers to group activities that focus on providing information or experiences through a planned and organised group activity. The content could include educational, vocational, personal or social information, with a goal of providing group members with accurate information that will help them make more appropriate plans and life decisions.

Group counselling refers to the routine adjustment or developmental experiences provided in a group setting. Group counselling focuses on assisting counselees to cope with their day to day adjustment and other concerns. Examples might focus on behaviour modification, developing personal relationship skills, concerns of human sexuality, values or attitudes, or career decision making:

Group therapy provides intense experiences for people with serious adjustment, emotional, or developmental needs. Therapy groups are usually distinguished from counselling groups by both the length of time and the depth of the experience for those involved. Therapy group participants often are individuals with chronic mental or emotional disorders requiring major personality reconstruction. Group therapists obviously require a higher level of training.

3.4 GROUP APPROACHES

Group approaches are of many types according to different psychological theories. According to psychoanalytic approach the client learns during the group counselling about the faulty psychological development associated with the past experience. Also the client learns the corrective emotional experiences.

According to Adler in *group counselling* the client explores his/her basic life assumptions and achieves a broader understanding of lifestyle.

In *psychodrama* for instance, the client learns to release his pent up emotions and learns to develop new and more effective behaviours. According to Existential approach the client learns to maximise his self awareness and discover his meaning of life.

According to *Person cantered therapy* the client learns in group participation to utilize his maximum potentials.

Gestalt approach enables the client to pay close attention to moment to moment experiences. He/she integrates the disowned aspects of himself/herself.

According to *transactional analys*is the client learns to re-examine his communication and interactions. The client makes new ones on the basis of awareness.

In *behaviour group therapy* a client do rehearsals in groups. He learns to remove maladaptive behaviour. His appropriate behaviour is reinforced.

According to *rational emotive behavior therapy* the client learns in group how to eliminate his irrational outlook. And he learns to have a rational one.

In *reality therapy* in group, group members revaluate their behaviour whether it is realistic and responsible or not. They also decide a plan of action for change.

3.5 TECHNIQUES OF FAMILY THERAPY

Some of the important techniques of family therapy are described below:

Joining

Since the counselor has to understand the structure and basic rules of the family, he joins the family and participates as a member to make them understand the utility of each rule for the growth of the family. He can convey the positive meanings of conversations amongst family members. He also makes the family members realise about the misconversations that retard the growth of the family.

Enactment

This is similar to role playing as it might be used in assertiveness training. Changes may be produced and suggested by the therapist. Added to enactment may be a paradoxical directive in which the therapist instructs the family to continue what they are already doing to exaggerate the behaviour.

Tracking

In tracking the counselor carefully listens to the conversations among the family members and tries to understand the patterns and order. The counselor suggests the immediate re enactment of the conversations and makes the family members realise the positive impact of the tracking which they can do now.

Restructuring techniques

In this the therapist suggests the different patterns of conversations which the family members can practice when they do transactions with each other, as for example, at the dining table.

Circular questioning

In this the therapist asks one member of the family to say what another member of the family is thinking. This he repeats with every member of the family in a number of situations. It helps the family members to correct their perceptions and also to know their part in the conversations.

Reframing

The aim here is to see each and every member of the family and his or her problem as a problem of the family as a whole. They are able to realise the goal behind solving the problem and to see the problem from different perspectives.

Accommodation

This is parallel to empathy and is another word for acceptance of what is present in the family. The family members also work on the body language practice which sometimes gives wrong impression to others.

3.6 TYPES OF GROUPS IN COUNSELLING

In counseling different types of groups are used depending on the nature of intervention needed. These groups are given below:

3.6.1 T-groups

T-groups are training groups and they represent an effort to create a society in miniature with an environment designed especially for learning.

T-groups are relatively unstructured groups in which the participants become responsible for what they learn and how they learn it. This enables client how to function and behave in a group. It is beneficial when the relationships are authentic.

3.6.2 Sensitivity Groups

A sensitivity group focuses on personal and interpersonal issues and on the personal growth of the individual. Emphasis in sensitivity groups is on self insight, which means that the central focus is not the group and its progress but it is rather the individual member.

3.6.3 Encounter Groups

Rogers (1967) defines an encounter group as a group that stresses personal growth through the development and improvement of interpersonal relationships via an experiential group process. Such groups seek to release the potential of the participants. After practicing the individual feels safe to drop some of his/her defenses. He will come to understand himself and his relationship to others more accurately. He will change in his personal attitudes and behaviour and will subsequently relate more effectively to others in every day life situation.

Extended encounter groups are often referred to as *marathon groups.* The marathon en-counter group uses an extended block of time in which massed experience and accompanying fatigue are used to break through the participants' defenses.

Although encounter groups offer great potential for the increased self awareness of the group members, as well as increased sensitivity towards others, such groups can also create high levels of anxiety and frustration. Obviously, if encounter groups are to have maximum potential and minimal risk, they must be conducted by highly skilled and experienced counsellors.

3.6.4 Task Groups

Task groups are organised to meet organisational needs through task forces or other organisational groups or to serve individual needs of clients through such activities as social action groups. These groups are frequently useful to organisations seeking ways to improve their functioning. In agency counseling centers, task groups may be organised to assist clients in dealing with a wide spectrum of needs ranging from spiritual to educational.

3.6.5 Psychoeducation Groups

Psychoeducation groups emphasise cognitive and behavioural skill development in groups structured to teach these skills and knowledge. Psychoeducational groups are oriented more toward guidance than toward counseling or therapy. These groups

tend to be short term in duration and focused on specifically delineated goals. Attention is directed at current life situations, and interactions within the group are related to the group theme.

3.6.6 Mini Groups

Although technically two or more people can constitute a group, the use of the term *minigroup* has become increasingly popular in recent years to denote a counselling group that is smaller than usual. A minigroup usually consists of one counsellor and a maximum of four clients. Because of the smaller number of participants, certain advantages can result from the more frequent and direct interaction of the group members. Withdrawal by individuals and the development of factions or cliques are less likely in minigroups.

3.6.7 In Groups and Out Groups

Although *in-groups* and *out-groups* are not formal groups organised or overseen by counsellors, they often have important influences on client behaviours. These groups can be based on almost any criteria: socio-economic status, athletic or artistic accomplishments (in schools especially), a particular ability, racial or cultural origins, and so forth.

In-groups are characterised by association mostly with peers who share the defining characteristic, and out groups consist of those who are excluded from in groups. In many counseling situations, it is important for counselors to understand how clients see themselves and others in terms of in or out groups.

3.6.8 Social Networks

Although not a group in a formal sense, a social network results from the choices that individuals make in becoming members of various groups. As counselors we may be concerned with how these choices are made and what their impact is on individuals.

Sociologists engage in social network analyses to determine how the interconnectedness of certain individuals in a society can produce interaction patterns influencing others both inside and outside the network.

3.7 SELECTION OF GROUP MEMBERS

When the counselling groups are constituted, they are made according to certain criteria. The Counsellor must have factual information about the subjects' personality traits, their emotional problems and their life style. According to the criteria, members can be selected to be a part of the group based on the following:

1) One can ask family members or significant others of the client regarding the problem of the client and place them in the group according to the problem.
2) The adjustment and achievement of group members may be another criteria. For instance, the educational level of the person or the job that they are holding could be another criteria to place the individual in a certain group as members.
3) Homogeneity could be another criteria, that the persons being placed in the group are from the same background or having similar family structure etc., or belonging to the same age group.

4) Sometimes heterogeneity could also be a criteria in that persons with opposite personality traits could be placed together. For instance, aggressive person with a submissive person, an extrovertive person with a person who is introvert etc.

Other criteria include the following:

a) common interest

b) volunteer or self-referred

c) willingness to participate in the group process, and

d) ability to participate in the group process.

After the groups have been formed it is important to take the feedback of group members in terms of whether the person likes to be in the group, whether the person is able to express himself in the group, whether he is able to analyse the conflicts and other emotional problem and able to modify his behaviour. Only if the individual is agreeable to be part of a group, he would be put in a particular group.

The following should be considered during the process of screening interviews for possible group membership: According to Gibson Robert L. & Mitchell Mariance H. (2008), the cunsellor should identify the ground rules that group members are expected to follow. These would include

a) the right of all group members to express their views,

b) the suggestion that no personal viewpoint is unimportant, and

c) the absolute necessity for confidentiality.

Self Assessment Questions

1) Describe how a counseling group develops and functions. Special attention should be given to how the group members individually can benefit the most from the group experience.

.....

.....

2) Emphasise honesty and openness as critical components throughout the duration of the group.

.....

.....

3) Point out that although an objective of the group is to help members enhance interpersonal relationship skills, frustrations and disappointments are likely; how-ever, these should be considered opportunities for personal growth.

Discuss guidelines pertaining to the duration of group therapy.

MCQ

1) The modification of family system is suggested by which approach:

a) Multigenerational b) Interpersonal functioning

c) Structural d) None of the above

2) A which group focuses on personal and interpersonal issues and on the personal growth of the individual

a) Sensitivity group b) T-Group

c) Encounter group d) Task group

3) In which technique of family the counselor careful listens the conversations among the family members and tries to understand the patterns and order

a) Enactment
b) Tracking
c) Restructuring Techniques
d) Joining

4) Which groups are training groups and they represent an effort to create a society in miniature with an environment designed especially for learning.

a) Sensitivity groups
b) T-Groups
c) Encounter groups
d) Task groups

5) The aim of the family counselling is to see that the problem of each and every member of the family is the problem of the family as a whole. This is known as:

a) Enactment
b) Reframing
c) Restructuring
d) Joining

6) Murray Bowen identifies two central forces in interpersonal functioning. The first is a movement toward individuality, the second a movement toward togetherness.

a) Multigenerational
b) Interpersonal functioning
c) Structural
d) None of the above

7) According to which group approach the client learns in group how to eliminate his irrational outlook.

a) Adlerian approach
b) Rational emotive behaviour approach
c) Psychoanalytic approach
d) Cognitive approach

8) It is the continuous, ongoing movement of the group toward achievement of its goals.

a) Group process
b) Group dynamics
c) Group activity
d) None of the above

9) Group dynamics, on the other hand, refers to the social forces and interplay operative within the group at any given time.

a) Group process
b) Group dynamics
c) Group activity
d) None of the above

10) It refers to the routine adjustment or developmental experiences provided in a group setting

a) Group counselling
b) Group guidance
c) Group therapy
d) None of the above

3.8 PROCESS IN GROUP AND FAMILY COUNSELLING

The initial group time is used to acquaint the new group membership with the format and processes of the group, to orient them to such practical considerations as frequency of meetings, duration of group, and length of group meeting time.

Additionally. the beginning session is used to initiate relationships and open communications among the participants.

The counselor also may use beginning sessions to answer questions that clarify the purpose and processes of the group.

The establishment of the group is a time to further prepare members for meaningful group participation and to set a positive and promising group climate.

The group counselor must remember that in the initial group sessions the general climate of the group may be a mixture of uncertainty, anxiety, and awkwardness. The group members may not know each other and may feel strange to express in a group which has members who are unknown to them or unfamiliar to them. It is therefore important for the counselor to introduce each member to the group and break the ice before starting any session. The counselor must provide a lot of opportunities for the members to interact with each other so that the feelings of unfamiliarity or strangeness will reduce and the group members will start interacting with less inhibition.

It is important in this initial stage of group establishment for the leader to take sufficient time to ensure that all members of the group have their questions and concerns addressed. The counselor should ensure that they understand the process and begin to feel comfortable in the group. Of course, the impression that the group counselor makes in this initial stage is of utmost importance to the smooth and successful process of the group.

3.8.1 Determining the Characteristics of the Group

Size of the group

First of all the size of the group is to be decided. The size should be appropriate for the activities planned and outcomes anticipated. Size will also have an influence on the operational format of the group. Format planning includes determining the types of activities of the group, the length of time allotted for each group session, the number of sessions, and the setting.

Role of the counsellor

Another important thing is the role of the counsellor whether active or passive.

Invited or voluntary participation

Sometimes the group members are voluntarily participating in the group activity/ counselling or sometimes they are asked/invited for the same.

The characteristics of the group are decided and then the members are selected. The counsellor must verify that what strategies he/she is going to apply on group each and every member of the group should get benefit from it .

Structure or operational format

In establishing the membership of the group, the leader must verify that the planned activity will respond to the needs of the individual member and that the structure or operational format will be comfortable for the group member.

In large groups, such as those organised for orientation purposes, career needs, or other special information purposes, this is not necessarily essential, but for smaller, intimate groups, it is an important consideration.

3.8.2 Monitoring the Ongoing Activities

Once the activities start the counsellor observes not only the benefit accrued to the group members but also the behaviour of all members is taken into consideration and the interactive effect of their communication with one and other are noted. Whatever changes take place in the members as result if interaction in the group are noted by the counsellor which may be used by him in individual sessions also.

The counselor must, therefore, be constantly on the alert to detect such changes and symptoms and to use his or her skills to minimise these effects. The ongoing activities of the group are meaningful only as long as they promote the progress of the group and its members toward their goals.

Also the productivity of group members in the right direction is necessary. It is checked by the counsellor from time to time.

3.8.3 Evaluating Outcomes and Productivity

The counsellor also evaluate the outcome of the group members. The goals and measures of the group counselling should be clear. The counsellor should monitor the ongoing process in this regard. Criteria for measuring outcome should also be decided. This would decide which method and activity is more effective

Such evaluations can assist counselors and others involved to determine which group guidance activities are most effective and which techniques within groups are most and least effective.

3.8.4 Values Development Activities for Groups

It is believed that rights are equal for man and woman, education of all, freedom to express emotion, respect for elderly these all are values. The counsellor also takes care of the value of society, family, culture etc. to the group members.

The values also represent what a person considers important in life, and these ideas of what is good or worthwhile are acquired through the modelling of the society and the personal experiences of the individual.

3.8.5 Values of Group Counseling

1. Individuals can explore, with the reinforcement of a support group, their developmental and adjustment needs, concerns, and problems. Groups can provide a realistic social setting in which the client can interact with peers who not only are likely to have some understanding of the problem or concern that the client brings to the group but who will, in many instances, also be sharing the same or a similar concern.

The counseling group can provide the sense of security group members need to interact spontaneously and freely and take risks, thus promoting the likelihood that the needs of each of the members will be touched on and that the resources of peers will be utilised. The old saying that misery loves company may fact provide a rationale for group counseling. People are more comfortable in sharing a problem with others who have similar experiences, and they may also be more motivated to change under these conditions.

Group counseling may give the client an opportunity to gain insights into his or her own feelings and behaviour. Yalom (2005), in discussing the group as a social microcosm, stated that “a freely interactive group, with few structural restrictions,

will, in time, develop into a social microcosm of the participant members" (p. 31). He also points out that given enough time in the group setting, clients will begin to be themselves, interact with others, and create the same interpersonal universe they have experienced, including the display of maladaptive, interpersonal behaviour to the group. Yalom also states that corrective emotional experiences in groups may have several components, including the following:

- A strong expression of emotion which is interpersonally directed and which represents a risk taking on the part of the patient.
- A group supportive enough to permit this risk taking.
- Reality testing which allows the patient to examine the incident with the aid of consensual validation from the other members.
- A recognition of the inappropriateness of certain interpersonal feelings and behaviour or of the inappropriateness of certain avoided interpersonal behaviours.
- The ultimate facilitation of the individual's ability to interact with others more deeply and honestly.

As clients gain new insights into their behaviours and feelings from interactions with members of the counseling group, their self concept may also undergo a change. Because self concept has significant influence on an individual's personal social adjustment and his or her perception of school and career decision making, the opportunity to bring about positive change in self concept through new insights provided by the group counseling experience can be a very valuable benefit.

Group counseling provides clients with an opportunity to develop positive, natural relationships with others. The personal interactions that take place within the group counseling structure provide an excellent and continuous opportunity for group members to experiment with and learn to manage interpersonal relations. This includes developing sensitivities to the needs and feelings of others. It also provides opportunities for members to learn of the impact their behaviours have on others. Thus, through the group process and its interactions and sharing of experiences, clients may learn to modify earlier behaviour patterns and seek new, more appropriate behaviors in situations that require interpersonal skills.

Group counseling offers opportunities for clients to learn responsibility to themselves and others. Becoming a member of a counseling group implies the assumption of responsibilities. Even when clients show initial tendencies to avoid assuming responsibility for their own behaviour, or avoid contributing to the group's interactions, or refusing to accept their "assignment" within the group etc., these avoidance techniques will usually fade as group relationships develop and group goals are established

The interactions within the group motivate us to plan and act and serve as a standard for judging the worth of activities, achievements, things, and places. In short, values give direction to life and, hence, behaviour. On the other hand, people who do not know what they value often engage is meaningless, nonproductive, and usually frustrating behaviour.

In both individual and group counseling, understanding the client's values can help the counselor understand the client's behaviour, goals or lack of goals, and what is or has been of significance in the client's life.

3.8.6 Termination

For these same reasons, members may resist the termination of a counseling group. The very nature of counseling groups with their emphasis on interpersonal relationships, open communication, trust, and support promises the development of a group that the membership may want to continue indefinitely.

It is therefore important from the very beginning that the group counselor emphasises the temporary nature of the group and puts forth if appropriate, specific time limitations. The counselor also reminds the group, as the time approaches, of the impending termination. This does not mean that the counselor alone is responsible for determining the termination point of a group.

Although the counselor may, of course, assume this responsibility, termination may also be determined by the group members or by the group members and the counselor together.

Termination, like all other phases or stages of the group counseling experience, also requires skill and planning by the counselor. Termination is obviously most appropriate when the group goals and the goals of the individual members have been achieved and new behaviours or learnings have been put into practice in everyday life outside the group.

The group will also be ready to terminate when, in a positive sense, it has ceased to serve any meaningful purpose for the members. Under less favorable circumstances, groups may be terminated when their continuation promises to be nonproductive or harmful, or when the group progress is slow and long term continuation might create overdependency on the group by its members.

3.9 LET US SUM UP

Humans are social animals and they enjoy one another's company and in the process they learn more. Individuals seek their social needs through group and they learn how through groups they can achieve their social needs. In group counseling the concept of this gratification of needs through groups is considered in great detail as the counselor uses these groups to help the individual to overcome not only individual problems but also how to get maximum satisfaction through interacting with the members of the group.

Family is the place from where an individual starts his/her first learning. Whatever a person learns, he does so from his family members through communication, imitation and dealings with day to day life problems. He enters the world with those knowledge based on the experiences which he had in his family and in all his interactions with the family members. So the family is the first platform which provides the foundation to the individual to face the world as the individual grows up into an adult.

In groups, an individual experiences dealing with significant others in the outside world and environment, and in the process learns the group values. These group values are beneficial for all interpersonal relationships whether of friends, authority or family members.

The family itself may be viewed as a small system or network of relationships. The network of relationships can be understood in terms of (i) multigenerational approach (ii) interpersonal relationship approach and (iii) structural approach.

In group activities two terms are often used, viz., (i) process and (ii) dynamics. Although some time these terms are also used interchangeably , in counselling they have different meaning.

Group Process refers to the continuous, ongoing movement of the group toward achievement of its goals. It represents the flow of the group from its starting point to its termination. It is a means of identifying or describing the stages through which the group passes.

Group dynamics, on the other hand, refers to the social forces and interplay operative within the group at any given time. It describes the interaction of a group and can indicate the impact of leadership, group roles, and membership participation in groups.

Counsellors may view various group activities as occurring at three levels, VIZ., Group Guidance, Group counseling and Group therapy.

In counseling different types of groups are used depending on the nature of intervention needed. These groups are T groups, sensitivity groups, encounter groups, task groups, psychoeducation groups, mini groups, in groups and outgroups, and social networks. This discussion is then followed by the process and techniques used in group and family counseling.

3.10 UNIT END QUESTIONS

1) Define groups and family counseling.
2) What do you understand by the term group process and group dynamics? Explain
3) What are the various group approaches?
4) Discuss the techniques of family therapy / family counseling.
5) What are the various types of groups that are used in counseling?
6) What are the various criteria that are used to select members for a group?
7) Describe in detail the process in group counseling.

3.11 SUGGESTED READINGS

Gibson Robert L. & Mitchell Mariance H. (2008) *Introduction to Counselling And Guidance,* Pearson Prentice Hall Inc., New Delhi, India.

Corey, Gerald (2008). *Theory and Practice of Group Counseling.* Thomson Books, Belmont, CA

3.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) (c) 2) (a) 3) (b) 4) (b) 5) (b) 6) (a) 7) (b) 8) (a) 9) (b) 10) (a)

UNIT 4 ECLECTIC COUNSELLING

Structure

4.0 INTRODUCTION

In this unit we will be presenting the eclectic approach in counselling. Eclectic approach is first defined and in this unit as a therapy which combines more than one approach in intervention. The unit traces the history of eclectic approach and theory and gives justification for this approach in counselling. The unit presents the various forms of psychological interventions and presents the various forms of psychotherapy

and how and which therapies are generally combined. The cognitive therapies are then discussed and how these are combined with psychotherapy to suit the individual client needs. The various eclecticism approaches are described and the common ground for integrated perspective in counselling is presented. Lazarus multimodal therapy is described in terms of the characteristic features of the therapy as an eclectic one. This is followed by reality therapy and choice theory with a brief account of feminist and systemic therapy. Finally the advantages and disadvantages of eclectic therapy approach are presented.

4.1 OBJECTIVES

On completing this unit, you will be able to:

- Define and describe eclectic theory and approach;
- Define psychotherapy and present how other therapies could be combined with it to make it eclectic;
- Discuss the pathways of integrative approach in counselling;
- Analyse how different psychoanalytic therapies could be made eclectic;
- Define and describe multimodal therapy;
- Explain reality therapy and feminist and systemic approaches; and
- Evaluate the advantages and disadvantages of the eclectic approach in counselling.

4.2 HISTORY BEHIND INTEGRATED/ECLECTIC APPROACH TO COUNSELLING

Most therapists work with their clients to determine the most effective treatment plan even when it does not include their preferred orientation or just one specific technique. This can sometimes involve elements of several different types of therapy, for example, a combination of behavioural therapeutic techniques and psychodynamic therapeutic techniques, becoming what is referred to as an "eclectic approach" to therapy.

Eclectic therapy is a style of therapy that uses techniques drawn from several different schools of thought. At one time, most therapists rigidly adhered to a single style, but today eclectic therapy is the most common. It is a more flexible approach that allows the therapist to adapt to each client's individual needs.

Some therapists adhere largely to a single orientation, such as psychoanalysis or cognitive behavioural theory, but use eclectic techniques as needed. Others self identify as eclectic in orientation, utilising whichever techniques work best in any given situation.

Either way, it is important that the therapist possesses a solid understanding of each theory for which techniques are being used.

4.2.1 Eclecticism Theory and Therapy

There are many forms of eclecticism, and in a way eclectic therapy is a pragmatic approach to therapy, meshing the various approaches together to fit the individual client who has approached for help.

Good eclecticism is neither messy nor confused. For example, a typical eclectic approach in therapy is to view an individual from a psychodynamic perspective, but to use more active interventions, such as you might find in a cognitive behavioral approach. In eclecticism, there is no one right or guaranteed way of approaching any given problem. Each problem is tainted and changed by that individual's own history and way of viewing or perceiving his or her own problem. Therapists are flexible, working as a teacher for one patient, as a guide for another, or as a combination of all of the above for yet another.

Eclectics use techniques, as mentioned above, from all schools of therapy. They may have a favorite theory or therapeutic technique that they tend to use more often or fall back on, but they are willing and often use all that are available to them. After all, the main purpose here is to help the patient as quickly and as effectively as possible.

Eclecticism is not a new development. Psychoanalysis and its derivatives were the first theories to develop and most of those therapists who were not eclectic adhered to some form of psychoanalysis or psychodynamic therapy. The so called Minnesota point of view of Patterson (1966, 1986) was an eclectic position. The percentage of therapists who called themselves eclectic during the 1940's and 1950's is not known, however according to Kelly (1961) who conducted a survey found 40% of the respondents identified themselves as eclectic. It appears that 50% of the practitioners today claim themselves to be eclectic.

4.2.2 Definition of Eclecticism

Now let us see what is eclecticism in psychotherapy / counseling. Most discussions of eclectic therapy involve combining two theories or approaches and this is usually psychoanalysis and behaviour therapy. At the same time it is stated that there are as many eclectic approaches as there are eclectic therapists. Each therapist operates out of his or her unique set of techniques based on the particular training, experience and beliefs. There are no specific guidelines or principles for eclectic therapy. Yet it has been recognised for more than 5 decades (Patterson, 1989) that there are basic common factors or elements in the diverse approaches to psychotherapy.

The common factor at the simplest but concrete level is that two persons talking to each other. The same therapy at the abstract level can be considered as an interpersonal relationship in which the therapist's personality is the most important element. In between there are (i) therapist behaviours such as expertise, authority, rapport, support etc., and (ii) the therapist's credibility, trustworthiness and attractiveness.

Certain common elements of therapy include catharsis, suggestion, reassurance, persuasion, guidance, advice and direction. Yet some more elements which may not be very common to all therapies include permissiveness, non judgementalness, respect etc. Traux and Carkhuff (1967) pointed out three sets of characteristics which they called the central therapeutic ingredients and these were

i) The therapist's ability to be integrated, mature, genuine and congruent

ii) The therapist's ability to provide a non threatening, trusting, safe and secure atmosphere by his acceptance, nonpossessive warmth, unconditional positive regard or love

iii) The therapist's ability to be accurately empathic, be with the client, be understanding or grasp the patient's meaning.

It appears that there is a general agreement that the relationship provided by the therapist is the basic common characteristic of all approaches to psychotherapy.

4.2.3 Psychotherapy

Before we take up eclectic therapies, let us understand what is psychotherapy. As is well know psychotherapy refers to special and systematic process for helping people to overcome their psychological difficulties such as anxiety, fear, depression etc.

All forms of psychotherapy have three things in common, viz.,

i) Client

ii) Therapist

iii) Contacts between client and therapist.

The therapy consists of a set of principles and techniques employed in accordance with a particular theory of change. As many as 400 forms of therapy are being practiced today. Two broad categories are: (i) Global therapies and (ii) Problem focused therapies.

Global therapies help people recognise and change general features of their personalities that the therapist believe are the root cause of their problem. These therapies include the following:

- Psychodynamic or psychoanalytic
- Humanistic
- Existential
- Client centered therapy
- Gestalt

Problem focused therapies focus on the symptoms and specific complaints of the person. They include

- Behavioural therapies
- Cognitive therapies
- Biological therapies

In addition to the above two major groups of therapies, we have the following formats for therapies.

- Individual therapy
- group therapy
- family therapy
- Couple therapy

Individual therapy is one in which the therapist sees the client alone for some period of time usually weekly.

Group therapy is one in which the therapist sees clients in a specially formed group such as psychodrama and self help groups.

Family therapy is a format in which the therapists meet with all members of the family and point out problematic behaviours and interactions and work on the whole family to change.

Couple therapy is one in which the therapist works with two people who share a long term relationship.

Thus one may state that Psychotherapy is the use of psychological techniques along with 'therapist client relationship' to produce emotional, cognitive, and behavioural change. Today, the largest group of mental health professionals describe themselves as eclectic, meaning they use different treatments for different disorders.

4.2.4 Brief Historical Perspective

When we try to trace the history of treatment of psychological disorders, it is seen that there are two broad groups of interventions that come about (i) spiritual/religious healing and the (ii) naturalistic/scientific healing. While the scientific approaches have advanced to a great extent with research focussed treatment interventions and evaluations, spiritual religious interventions are getting relatively more accepted than before in scientific circles duem to research and evaluation studies.

The rapidly developing movement of integrated approach of psychotherapy and counseling came in early 1980s. This movement is based on combining the best of differing orientations so that more complete theoretical models can be articulated and more efficient treatments developed (Goldfried & Castonguay, 1992).

In 1983 an international organisation was formed for the exploration of integration of psychotherapy. The reason for this integration approach was that a single approach is not sufficient to understand the complexities of human behaviour. Also it was believed that no one theory has a patent on the truth, and because no single set of counselling techniques is always effective in working with diverse client populations. Hence some therapists thought it better to develop integrative approaches as the basis for future counseling practice (Lazarus, 1996).

However it must be kept in mind that eclectic therapy is not haphazardly picking of different techniques from different therapies but it is a planned strategy with theoretical and scientific rationale. Pulling techniques from many sources without a sound rationale can only result in syncretistic confusion (Lazarus, 1986).

4.3 PATHWAYS OF INTEGRATIVE APPROACH IN COUNSELLING PRACTICE

According to Arkowitz (1997) there are three pathways of integrative approach in counselling practice, viz (i) technical eclecticism approach (ii) theoretical integration approach (iii) common factors approach. These are being discussed below in detail

4.3.1 Technical Eclecticism Approach

Technical eclecticism tends to focus on differences, chooses from many approaches, and is a collection of techniques. This path calls for using techniques from different schools without necessarily subscribing to the theoretical positions that spawned them.

Technical eclecticism seems especially necessary in working with a diverse range of cultural backgrounds. Harm can come to clients who are expected to fit all the specifications of a given theory, whether or not the values espoused by the theory are consistent with their own cultural values.

Rather than stretching the client to fit the dimensions of a single theory, practitioners are challenged to tailor their theory and practice to fit the unique needs of the client. This requirement calls for counselors to possess knowledge of various cultures, be

aware of their own cultural heritage, and have skills to assist a wide spectrum of clients in dealing with the realities of their culture.

4.3.2 Theoretical Integration Approach

This refers to a conceptual or theoretical creation beyond a mere blending of techniques. This path has the goal of producing a conceptual framework that synthesizes the best of two or more theoretical approaches under the assumption that the outcome will be richer than either of the theories alone (Norcross & Newman, 1992).

4.3.3 Common Factors Approach

The common factors approach attempts to look across the different theoretical systems in search of common elements. Although there are differences among the theories, there is a recognisable core of counseling composed of nonspecific variables common to all therapies.

Arnold Lazarus (1997) is the founder of multimodal therapy. Multimodal therapists borrow techniques from many other therapy systems that have been demonstrated to be effective in dealing with specific problems.

Lazarus raises concerns about theoretical eclecticism because he believes that blending bits and pieces of different theories is likely to confuse and confound matters. He contends that by remaining theoretically consistent but technically eclectic, practitioners can spell out precisely what interventions they will employ with various clients, as well as the means by which they select these procedures.

Practitioners who are open to an integrative perspective will find that several theories play a crucial role in their personal counseling approach.

Each theory has its unique contributions and its own domain of expertise. By accepting that each theory has strengths and weaknesses and is, by definition, "different" from the others, practitioners have some basis to begin developing a theory that fits for them. It is important to emphasize that unless counselors have an accurate, in depth knowledge of theories, they cannot formulate a true synthesis. Simply put, practitioners cannot integrate what they do not know (Norcross & Newman, 1992).

The challenge is for counselors to think and practice interactively, but critically. Developing an integrative perspective is a lifelong endeavor that is refined with experience.

4.4 COMMON GROUND FOR INTEGRATIVE PERSPECTIVE OF COUNSELING

The question here is how one can use rationally the different techniques from various psychotherapeutic approaches in an integrated manner. While there are advantages in incorporating a diverse range of techniques from many different theories, it is also possible to incorporate some key principles and concepts from the various theoretical orientations. There are some concepts from the experiential approaches that can blend quite well into the psychotherapeutic and psychodynamic systems. Let us see how this can be done. Let us take up Freud's Psychoanalytical approach and consider integration of other therapies.

4.4.1 Freudian Approach

Whatever technique a counselor apply he/she has to in the initial phase of counseling use free association and catharsis as important techniques in order to release the pent up emotions and feelings. These two techniques of Freudian approach is also the back bone of every therapy.

In other therapies free association can be named as listening to the problems and conflicts going on in the mind of the client but it is just similar to Freud's Free Association. No client will tell the exact problem in the initial phase of counseling if he is suffering from certain mental disorders. After the initial stage, the client may start revealing all those aspects of life which he sees negatively.

Catharsis is also known as making the person feel less burdened by emotions and that which make him fell light and that which makes him give vent to his feelings by crying, shouting, anger outbursts, stress release etc. These ofcourse to an exten advanced forms of Freud's catharsis.

4.4.2 Adlerian Approach

Adler always believed that a person becomes complex either due to his piled up failures or due to obstacles from the environment. Adler was concerned with the client's family and social system which influenced the client's life to a great extent. Adler always found that in his clients, there is a mistaken belief about their own selves. Mistaken in the sense that they viewed themselves and their environment inappropriately or inadequately ignoring their positive aspects. Therefore in his therapeutic sessions, his focus was to make the person realise the deficiency in their thinking and belief and tried to remedy the same so that the client can readapt himself in the society.

Whatever therapeutic technique one follows, the above approach is used quite widely in the present day therapies. In behaviour therapy, psychodrama or group therapy, a client learns through rehearsals, and in cognitive therapy the client learns to change his faulty perception through cognitive restructuring.

From the Adlerian perspective, therapy is a cooperative venture and it is geared toward challenging clients to translate their insights into action in the real world. One of the strengths of the Adlerian approach is its relationship to technical eclecticism. The Alderian model lends itself to versatility in meeting the needs of a diverse range of clients (Watts, 1999).

In Adler's concept there is further focus on to improve the life style. If a person improves his life style in holistic way it not only improves his functioning, but the client is able to explore his own self that makes a difference to their own life and to the life of his significant others.

Contemporary Adlerian theory is valuable in the sense that it is an integrative approach. The theory is an integration of cognitive, psychodynamic, and systems perspectives, and in many respects, it resembles the social constructionist theories.

The contemporary social constructionist theories, or constructivist therapies, share common ground with the Adlerian approach. Some of these common characteristics include: an emphasis on establishing a respectful client/ therapist relationship, an emphasis on clients' strengths and resources, and an optimistic and future orientation.

4.4.3 Behavioural Approach

This approach is based on learning theories such as classical and instrumental conditioning approaches. These therapies take the here and now approach rather than digging in the past. Every attempt is made to find out what makes the person behave as he does and the various factors that contribute to that particular behaviour right at that point of time. In this the individual's cooperation and participation are important as he has to observe his behaviour and find out under what conditions the undesirable behaviour occurs. If the particular behaviour is linked to certain aspects of his thinking or the environmental factors he has to change the same so as to make sure that the undesirable behaviour does not occur.

In this type of counseling, there is also behaviour rehearsal that is the person is asked to practice certain behaviours, like relaxing exercises, self instructions to think in a positive way, to write something when certain thoughts occur and so on. This behaviour rehearsal is very important as the client is able to adapt this behaviour to his daily routine life and thus give up the undesirable behaviour.

In eclectic approach, along with psychotherapy, the individual is made to do some exercises which the counselor feels necessary that the client should do. This can be role play, maintain daily routine, desensitize himself/herself from the fearful or anxiety provoking stimulus events, etc. In this some time the counselor teaches or gives psychoeducation and training to the care giver of the client. Some times through group therapy or family therapy the counsellor makes the client and family person to learn the appropriate behaviours. If a child is a client it might be play, drama etc. If a client is an adult it might be progressive relaxation, anxiety or anger reducing techniques or behavioural modification techniques.

4.4.4 Cognitive Behavioral Approach

In cognitive approaches apart from behavioural training the counselor also focuses the perceptions, emotions and thought processes of the client. His target is to break the negative schema (firm beliefs) and modify the negatively altered information processing of the client. In eclectic counseling whenever the counselor finds the client having wrong perceptions and due to this he is unable to maintain his relationship with his significant persons, the therapist applies different techniques of cognitive therapy. For example if some thoughts which are automatically comes in the client's brain and he is not able to control it. The client knows very well that these thoughts do not have any logical reasons. In such cases, the counsellor tries to know the frequency and intensity of these thought and the situations in which they arise. Also the counselor asks the client to tell about the emotions that come with these thoughts. Then the counselor gives the client different alternative or balanced thought to rehearse. After practicing these exercises taught by the counsellor, the automatic thoughts get reduced.

With the cognitive restructuring if the counselor applies behavioural techniques then the approach is known as cognitive behavioural approach. In its behaviour part the client learns different coping strategies to deal with his inner conflicts and his interpersonal misunderstandings. In eclectic counseling many a times a client needs to change his cognition, perception, emotion and behaviour through cognitive behavior approach.

4.4.5 The Experiential Approaches

Sometimes in eclectic approach the counselor asks the client to do experiment in life. He provides different strategies to the client and asks him to apply it in those situations which he does not want to face or for which he is having certain negative schema. The goal of the counselor here is to make the client realise the reality of the situation and adapt different strategy to cope up with his problems. For example if a person is having the false belief that people are talking about him when he goes to buy grocery, the client may be asked to listen to the conversation once. The client might realise that the other person was talking about the cricket match and might involve himself in the conversation. In this way his false belief disappears. Also in another behaviour modification technique, called as the flooding, the client is exposed to the real life situation and his fear is reduced gradually.

4.4.6 Humanistic Existential Approach

In eclectic counseling if the client is educated and intelligent and wants to go through counseling in order to improve himself etc., then the humanistic approach of Rogers' client centered therapy will be the most useful. In Rogers' therapy the client is helped to realise his potentials and counselor's focus is on making him fully potential.

Existential approach throws light on searching a meaning of life. Every client wants his life to be meaningful and purposeful. It is the counselor's responsibility to make the client realise the significance of his life. Every person should be aware of his psyche (soul or being) as well as his activities. Every human should have enough freedom to develop in their own way. Also they should be aware about the surroundings and human values. On the one hand their growth should not be retarded, while on the other the growth should be holistic and must not be against the basic human values. It also makes the client understand the universal human concern. This approach also deals with the personal freedom and courage that the individual should have.

Bugental and Bracke (1992) see the possibility of a creative integration of the conceptual propositions of existential therapy with psychodynamic or cognitive approaches. They indicate that experienced clinicians of contrasting orientations often accept some existential concepts and thus operate implicitly within an existential framework.

4.4.7 Gestalt Approach

Gestalt approach focuses on awareness of the client. The client should be aware of his own thoughts, feelings, sensations, perceptions and emotions that are passing within himself. If he sees everything in a holistic way not in bits and pieces, he may be able to understand the reality. The therapist or counselor tries to enhance the awareness of the client about each and every aspect of an event, a person or a situation.

The client is provided many Gestalt experiments to do, so that he can improve his awareness for those things which are making him stressful. Also, it helps the client to be aware about those aspects which the client was not aware of earlier and that can change the thinking of the person in a positive way. The client becomes capable to see the world as a whole rather than in bits and pieces after the counseling and that makes him positive.

4.4.8 Psychodrama

Psychodrama is an approach in which the client acts out or dramatises past, present, or anticipated life situations and roles. This is done in an attempt to gain deeper understanding, explore feelings and achieve emotional release, and develop behavioural skills.

Psychodrama is primarily a group approach. It also helps individuals to realise their role in life. The counselor writes the scripts according to problems of different group members and direct this script. The group members stand in a semicircle and play the script. By their dialogue delivery they can understand their problems better. They are also motivated to change their roles from father to daughter, brother to sister, mother to father and so on. In this role rehearsals are used which are considered beneficial to understand the real situation and the day-to-day life problems and interpersonal relationships.

Significant events are enacted to help the client to get in touch with unrecognised and unexpressed feelings, to provide a channel for the full expression of these feelings and attitudes, and to broaden the role repertoire.

Integrated into other systems-such as psychodynamic, experiential, and cognitive behavioural approaches-psychodrama offers a more experiential process, adding imagery, action, and direct interpersonal encounter. In turn, psychodrama can utilise methods derived from the other experiential approaches, and the cognitive behavioural approaches as well, to involve clients to experience a meaningful process.

According to Blatner (1996), a major contribution of psychodrama is that it supports the growing trend toward technical eclecticism in psychotherapy. Practitioners are challenged to draw on whatever tools will be useful in a given situation. Yet psychodrama is best viewed as an optional set of tools, rather than a single approach for all clients (Blatner, 1996).

Psychodrama uses a number of specific techniques designed to intensify feelings, clarify implicit belief, increase self-awareness, and practice new behaviors. One of the most powerful tools of psychodrama is role reversal, which involves the client taking on the part of another person. Through reversing roles with a significant person, the client is able to formulate significant emotional and cognitive insights into his or her part in a relationship. This technique also creates empathy for the position of another person.

Variations of role playing and role reversal have many uses in both individual and group counseling. A few other techniques of psychodrama that practitioners can utilise include self-presentation, soliloquy, coaching, modeling, role training, behavior rehearsal, and future projection.

According to Blatner (1997) and Corey (2004), psychodrama's value lies in the fact that its methodology can be integrated with other therapeutic approaches rather than acting in seeming competition.

4.4.9 Action-Oriented Approach

According to Corey's (2001) Case Approach to counselilng and psychotherapy the counseling should be action oriented. Whatever techniques the counselor uses it should change the person in a positive way. Clients should be able to practice and perform so as to make them mentally healthy. The technique should be easily adapted by the client to the situation concerned and it should be suitable to the emotional state of the client.

4.5 MULTIMODAL THERAPY

This is a branch of behaviour therapy and is a comprehensive, systematic, holistic approach to behaviour therapy developed by Arnold Lazarus. Based on social learning theory, Lazarus endorsed techniques from just about all of the therapy models. In his integrative model, he keeps adding new techniques constantly, while refining the existing techniques.

The Counselor must understand the whole case history of the client. According to the personality and family structure of the client the strategies of the therapy are planned. The counselor should make a frame work of different techniques of different approaches to give interrogated and rational treatment in eclectic counseling. The counselor must select and apply those techniques on which the counselor has the best expertise. And the techniques used should be in accordance to physical and mental status of the client.

In many respects, rational emotive behaviour therapy (REBT) can be considered as a comprehensive and eclectic therapeutic practice. Numerous cognitive, emotive, and behavioural techniques can be employed in changing one's emotions and behaviours by changing the structure of one's cognitions. REBT is open to using therapeutic procedures derived from other schools, especially from behavior therapy.

Aaron Beck's cognitive therapy is truly an integrative approach, since it draws from so many different modalities of psychotherapy (Alford & Beck, 1997).

However cognitive approaches is like a bridge between psychodynamic approaches and behavioural approaches. While Cognitive behavioural approaches are more focused, structured and time bound, the psychodynamic approaches are not structured to the same extent and are not time bound.

4.6 REALITY THERAPY/APPROACH AND CHOICE THEORY

If the phenomenological and existential perspectives are considered, here the focus is on what the person experiences and what he realises about his existence. In other words, the reality therapy requires both these aspects that is the experienced of the person and what he realises about his existence. More specifically, here treality therapy stresses on the fact that the he client is responsible for his feelings.

Choice theory on the other hand challenges clients to accept their part in actually creating their feelings. For example, depression is not something that simply happens to people, but often is a result of what they are doing and how they are thinking.

Glasser (1998, 2000) speaks of *depressing* or *angering*, rather than *being depressed* or *being angry*. With this perspective, depression can be explained as an active choice that a client makes rather than the result of being a passive victim. Clearly, the emphasis of choice theory is on how people think and act, and in this sense, it shares many of the themes of cognitive behavioral approaches.

All behaviours are made up of four inseparable but distinct components: *acting, thinking, feeling* and the *physiology.* The key to changing a client's total behaviour lies in choosing to change what he or she is *doing* and *thinking* and these are the behaviours that a person can control. If clients markedly change the doing and thinking component, then the feeling and physiological components will change as well (Glasser, 2000).

Self Assessment Questions

1) Who is the founder of multimodal therapy:

   a) Arkowitz
   b) Corey, Gerald
   c) Arnold Lazarus
   d) Sigmund Freud

2) Which approache of psychotherapy focuses on meaning of life:

   a) Gestalt
   b) Cognitive Behavioural
   c) Psychodynamic
   d) Existential

3) Through which approach one can alter his perception, thought and emotions.

   a) Cognitive behavioural
   b) Cognitive
   c) Behavioural
   d) Gestalt

4) 'Style of Life' is a important concept in which Therapeutic Approach:

   a) Adlerilan
   b) Reality Theory
   c) Freudian
   d) Choice Theory

5) The strategy planned for the psychotherapy is based on the concepts and methods taken from a number of psychological approaches, is known as:

   a) Gestalt: a holistic Approach
   b) Phenomenological Approach
   c) Eclectic or integrated Approach
   d) None of the above

6) An approach in which the client acts out or dramatises past, present, or anticipated life situations and roles is:

   a) Behaviour
   b) Role plays
   c) Psychodrama
   d) Action oriented appraoch

7) If there is discrepancy (incongruence) in what you are doing and what you want to do, which approach is best to apply in counseling:

   a) Roger's Person's centered approach
   b) Gestalt's holistic approach
   c) Beck's cognitive approach
   d) All of the above

8) According to Arkowitz (1997) an integrated approach of counseling have following three factors:

   a) Technical, Educational and Common
   b) Technical, Theoretical and Common
   c) Technical, Theoretical and behavioural
   d) None of the above

9) Which of two techniques of Freud is most used in other forms of therapy and counselling:

   a) Free association and hypnosis
   b) Free association and catharsis
   c) Hypnosis and interpretation
   d) Dream analysis and interpretation

10) Which theory most challenges client to accept his/her part in actually creating their feelings:

a) Cognitive Apprach
b) Rational emotive approach
c) Choice Approach
d) All of the above

4.7 FEMINIST AND SYSTEMIC THERAPY

Feminist therapy is generally relatively short term therapy aimed at both individual and social change. The major goal is to replace the current patriarchal system with feminist consciousness and thus create a society that values equality in relationships that stresses interdependence rather than dependence, and that encourages women to define themselves rather than being defined by societal demands.

Some of these strategies are unique to feminist therapy, such as gender role analysis and intervention, power analysis and intervention, assuming a stance of advocate in challenging conventional attitudes toward appropriate roles for women, and encouraging clients to take social action.

Therapists with a feminist orientation understand how important it is to become aware of typical gender role messages clients have been socialised with, and they are skilled in helping clients identify and challenge these messages.

According to systemic approach an individual's dysfunctional behaviour grows out of the interactional unit of the family, the community, and social systems. Thus, solutions to an individual's problems need to be designed from a contextual perspective.

Feminist counselors apply different interventions e.g. role playing, bibliotherapy, assertiveness training, behaviour rehearsal, cognitive restructuring, psychodramatic techniques, identifying and challenging untested beliefs, and journal writing. Feminist therapy principles and techniques can be applied to a range of therapeutic modalities such as individual therapy, couples counseling, family therapy, group counseling and community intervention.

Both feminist and systemic approaches are based on the assumption that individuals are best understood within the context of relationships. Most of the traditional counseling theories do not place a primary focus on the role of systemic factors in influencing the individual.

4.8 ADVANTAGES AND DISADVANTAGES OF ECLECTIC COUNSELLING

4.8.1 The Benefits of Integration

Effective counseling involves proficiency in a *combination* of cognitive, affective, and behavioural techniques. Such a combination is necessary to help clients *think* about their beliefs and assumptions, to experience on a *feeling* level their conflicts and struggles, and to actually translate their insights into *action* programs by behaving in new ways in day to day living.

Preston (1998) contends that no one theoretical model can adequately address the wide range of problems clients will present in therapy. He says it is essential for therapists to have a basic grasp of various therapeutic models and for them to have

at their disposal a number of intervention strategies. For him, the pivotal assessment question is, "What does this particular person most need in order to suffer less, to heal, to grow, or to cope more effectively?" Preston recommends that a practitioner's selection of interventions should be guided by their assessment of the client. This lends weight to the concept of integrating assessment with treatment. Once a clinician knows what the client's target problems and goals are, it makes sense to design specific techniques tailor-made to the client.

4.8.2 The Limitations of an Integrative Approach

There are some drawbacks to encouraging the development of an integrative model, as opposed to sticking primarily with one theory. An undisciplined eclectic approach can be an excuse for failing to develop a sound rationale for systematically adhering to certain concepts and to the techniques that are extensions of them. If counselors merely pick and choose according to whims, it is likely that what they select will be a reflection of their biases and preconceived ideas. It is important to avoid the trap of emerging with a hodgepodge of unamalgamated theories thrown hastily together.

4.8.3 Eclectic Approach: A Case Illustration

It is a case of a woman who was feeling fear of hospitals, doctors and pain. After marriage she has to consult gynecologist just because she was having fear of pain during the relationship with her husband. The doctor advised her to go to a counselor for it. Counselor elicited the case history very carefully with the husband and the wife. The counselor was able to know that some memories of traumatic childhood have been suppressed in the girl's unconscious mind. The counselor made an intervention strategy from different therapeutic approaches which appeared best suited to the woman's personality and family life. This strategy included some techniques of cognitive behaviour therapy, some of the components of psychoanalysis and some of the client centered therapy and couple therapy. The main problem was that the woman was not accepting the husband because she thought that husband is not as handsome as she thought he would be and compared to herself she felt he was not good looking. Through cognitive therapy the girl could understand those qualities of her husband which she was ignoring to see and his very loving and caring nature for his wife.

Through psychoanalysis it was revealed that when she was just 2 years old, she fell down from the stairs and was brought to hospital where she developed in herself fear about death. When she was of 5 years of age a doctor friend of her father tried to touch her in a very awkward way that she could not understand. She developed a fear of doctors and sex. Through behavior therapy deconditioning and desensitization it was possible to remove the fears from her mind. Through client centered counseling the girl was made to realise her potentials and she was helped by the counselor to uses her potentials to make her home and family a healthy and happy one. The woman benefitted through this eclectic approach. Now she is happy in her in-laws family and blessed with a baby boy.

4.9 LET US SUM UP

Counselors would do well to consider their own personal style in the process of developing their integrative approach. The art of integrative counseling implies that there are no prefabricated models that fit any practitioner perfectly. Instead, the challenge is to customize a counseling approach that is tailored for each practitioner.

4.10 UNIT END QUESTIONS

1) What do you understand about eclectic counseling? Give a historical background behind its concept?

2) Give with examples Freudian, Adlerian and Gestalt therapies can be used as eclectic approach?

3) In today's scenario how behaviour, cognitive behaviour and multimodal approaches are useful to give counseling in integrated way?

4) Give the advantages and disadvantages using eclectic approaches.

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4.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) (c) 2) (d) 3) (b) 4) (a) 5) (c) 6) (c) 7) (d) 8) (b) 9) (b) 10) (c)

UNIT 1 TEACHING AND TRAINING FOR COUNSELLING

Structure

1.0 INTRODUCTION

Every person in this world needs counselling at some or different times. Sometimes counsellor himself/herself needs counselling when he/she is in stress. In today's scenario each area needs counsellors as there are interpersonal conflicts, poor decision making, and poor job satisfaction, less emotional maturity among individuals; also increased demands and decreased resources. It is required to train more and more persons in counselling. In schools, universities, industries, families etc sometimes counsellors are appointed but most of the individuals are not aware about how much counselling can affect positively individuals' physical and mental health.

Most of the persons do not have much time to go to a psychologist or to go through proper psychotherapy; and also there is a social taboo to go to a psychiatrist or a mental health professional.

But in their own working place counsellors can be appointed. Whenever people need to release their stress the counsellors must be readily available to them. In this unit different training skills would be explained along with their theoretical backgrounds.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- teach a person learn about the theoretical concepts of counselling;
- train a person how to do counselling; and
- different techniques of counselling given by different psychologist or psychotherapist.

1.2 BEFORE START OF COUNSELLING

There are some factors necessary to control as it would minimise the disparity between client and counsellor.

1.2.1 Culture and Race

Clients may come from different cultures and have different belief systems. It is necessary to know that the person who wants to get counselling belongs to which culture; the basic values of that culture. Nothing is inappropriate in terms of the cultures. Only the counsellor should focus what is beneficial and what is obstacle in person's growth. If a person can carry the cultural values with his or her positive growth then counsellor should not intervene with it.

Not only the culture but race is also necessary to know sometimes. The information is not to discriminate the person, but rather not to hurt the person in any ways. Persons of different races have different physical characteristics. Race sensitive issues should be dealt delicately by the counsellor.

1.2.2 Social Status

The socio-economic status of the person is also important to know. Number of sessions would depend on that. The language, income, educational background, the occupational status of the client should be checked. There should not be any sense of rejection by the counsellor by any verbal or non-verbal gesture during the counselling session.

1.2.3 Demographic and Personal Data

It is also necessary to know the personal details sometimes e.g. age of the person his occupation, habits and also the daily routine. Family background and about the significant others of the person and interpersonal relationships and conflicts are the important things to note.

1.2.4 Marital Status

For a married person the meaning of life might be different than comparison to unmarried person. The person might be divorced, separated, the widowed, he or she might remarried or in living relations.

1.2.5 Sex-Orientation

It is necessary to know whether the person is heterosexual or homosexual. Sometimes the person is bisexual. The counsellor's attitude should be empathetic. Sometimes it is required to know whether it is a sex orientation or it is his or her sex preference.

1.2.6 Age

Age of the person is also an important factor. The counselling of a child would be different from an adult. The adults are more rigid to change in comparison to children. Adolescents have their different view points because of their biological and psychological changes at that time.

1.2.7 Physical or Mental Disability

If a person is physically or mentally challenged his thinking might be affected because of that. It should take care by the counsellor with full acceptance and empathy.

The counsellor should not show sympathy with the client. Rather one should accept that disability and give the counselling according to that.

1.2.8 Religion or Philosophy

Sometimes religion and philosophy affects the counselling. Counsellor has to show regard for the client's religion.

Some person's are influenced by some spiritual or philosophical thinking. Do not try to break it, it might hurt the person. The counsellor should fit his frame of reference according to the client's frame of reference; then only the client can understand the messages of counsellor.

1.2.9 Gender Role Identity

Mostly the person's behaviour, thoughts, feelings and actions are affected by their gender (Masculine or Feminine). Sometimes a person has contradictory feelings than his or her Gender. The tendency is opposite to his or her gender because of some biological causes or learned behaviour. Sometimes the client is apprehensive due to gender of the counsellor. If the resistance comes the client should be referred to another counsellor.

1.3 APPROACHES TO COUNSELLING

1.3.1 Psycho Analytic Approach

First of all the techniques given by Sigmund Freud would be discussed. Free association is the central technique in psychoanalytic therapy, in which the client is encouraged to say whatever comes to mind, regardless of how painful, silly, trivial, illogical, or irrelevant it may be. In essence, clients flow with any feelings or thoughts by reporting them immediately without censorship. Second important technique is 'catharsis' in which the focus is to release the suppressed emotions of the client. The 'interpretation' technique consists of the analyst's pointing out, explaining, and even teaching the client the meanings of behaviour that is manifested in dreams, free associations, resistances, and the therapeutic relationships itself. Interpretation includes identifying, clarifying and translating the client's material.

Dream analysis is an important technique for uncovering unconscious material and giving client insight into some areas of unresolved problems. Freud sees dreams as the 'royal road to the unconscious'. Dreams have two levels of contents. Latent content consists of hidden, symbolic, and unconscious motives, wishes, and fears. The second one is manifest content, which is the dream as it appears to the dreamer. The unconscious sexual and aggressive impulses that make up latent content are transformed into the more acceptable manifest content. According to Freud their are also usual resistances defensive approaches in daily life known as resistances. They need to be recognised as devices that defend against anxiety but that interfere with the ability to accept change. If handled properly, resistance can one of the most valuable tools in understanding the client. The another technique is transference which manifests itself in the therapeutic process at the point where clients' earlier relationships contribute to their distorting the present with the therapist. It makes sense that clients often react to their therapist as they did to a significant person. Through the relationship with the therapist, clients express feelings, beliefs, and desires that they have buried in their unconscious. Through appropriate interpretations and working through of these current expressions of early feelings, clients are able to change some of their long standing patterns of behaviour.

Alfred Adler uses the term *fictional finalism* to refer to an imagined central goal that guides a person's behaviour. He stresses that striving for perfection and coping with inferiority by seeking mastery are innate. The human beings experience inferiority; they are pulled by the striving for superiority. According to Adler the term lifestyle refers to an individual's basic orientation to life, or one's personality, and includes the themes that characterise the person's existence. The counsellor's goal is to fostering social interest, helping clients overcome feelings of discouragement and inferiority, modifying clients' views and goals – that are, changing their lifestyle, changing faulty motivation, assisting clients to feel a sense of equality with others and helping clients become contributing members of society.

However according to Carl Jung the human beings have both constructive and destructive forces, and to become integrated, it is essential to accept the dark side of our nature with its primitive impulses. Acceptance of this dark side (shadow) does not imply being dominated by this but simply recognising that this is a part of our nature. Jung teaches that many dreams contain messages from the deepest layer of the unconscious. He calls it as collective unconscious. Jung sees a connection between each person's personality and the past, not only childhood events but also the history of the species. Thus dreams reflect both individual's personal unconscious

and collective unconscious. Content of the collective unconscious is called archetypes. The therapist deals the complexes buried in these unconscious parts. The persona is one of the archetypes. It is a mask, or public face, that we wear to protect ourselves. The animus and the anima represent both the biological and psychological aspects of masculinity and femininity, which are thought to coexist in both the sexes. The shadow represents our dark side, the thoughts, feelings, and actions that are socially reprehensible and that we tend to disown by projecting them outward.

Another approach is self psychology or object relation theory. The *object relations* are interpersonal relationships as they are represented intra-psychically. The term object refer to that which satisfies a need. It is used interchangeably with the term *other* to refer to an important person to whom the child, and later the adult, becomes attached. *Others* are perceived by an infant as objects for gratifying needs. According to Margaret Mahler the individual begins in a state of psychological fusion with the mother and progresses gradually to separation. The unfinished crises and residues of the earlier state of fusion, as well as the process of separating and individuating, have a profound influence on later relationships. Object relations of later life build on the child's search for a reconnection with the mother.

According to Mahler the first phase of self development is *normal infantile autism*. Here the infant is presumed to be responding more to states of physiological tension. The infant is , in many respects, unable to differentiate itself from its mother, and according to Melanie Klein perceives parts-breast, face etc. rather than a unified self. The adults show the most extreme forms of lack or psychological organisation and sense of self due to fixations at this most primitive infantile stage.

The second phase called *symbiosis*. It starts roughly through eighteen month. Here the infant has pronounced dependency on the mother. The infant seems to expect a very high degree of emotional attunement with its mother.

The third stage calls the *separation process*. During this time of differentiation, the child experiences separation from significant others yet still turns to them for a sense of confirmation and comfort. These relationships can provide a healthy self-esteem if the child develops his sense of self. Children who do not differentiate, may later suffer from narcissistic character disorders (a grandiose and exaggerated sense of self importance and exploitive attitude towards others). People with a borderline personality disorder have moved into separation process but have been thwarted by maternal rejection of their individuation.

Mahler's fourth phase involves a move toward constancy of self and object. By now others are more fully seen as separate from the self. Ideally, children can begin to relate without being overwhelmed with fears of losing their sense of individuality, and they may enter into the later growth with a firm foundation of selfhood.

1.3.2 Existential and Humanistic Approaches

Existential approach believes that human beings are free and therefore responsible for our choices and actions. They are not victims of circumstances; rather they are what they choose to be. The aim of therapy is to encourage clients to reflect on life, to recognise their range of alternatives, and to decide among them. Once clients begin the process of recognising the ways in which they have passively accepted circumstances and surrendered control, they can start on a path of consciously shaping their own lives. Existential therapy is a process of searching for the value and meaning in life. The counsellor's basic task is to encourage clients to explore their options for creating a meaning existence. One can begin by recognising he should not have to

remain passive victims of our circumstances but instead can consciously become the architect of his life.

Viktor Frankl developed logotherapy, which means 'therapy through meaning'. It is aimed at challenging individuals to find meaning and purpose through, among other things, suffering, work, and love. Rollo May emphasises that it takes courage to "be: , and our choices determine the kind of person we become. The struggle is between the security of dependence and the delights and pains of growth. James Bugental views therapy as a journey that delves deeply into the client's subjective world. The counsellor contacts with the client's phenomenological (experiential) world. Irvin Yalom has developed an existential therapy that focuses on four ultimate human concerns: death, freedom, existential isolation and meaninglessness.

The humanistic approach is based on a system of values and people's abilities to develop their human potential. Carl Rogers person-centered approach focuses on the client's responsibility and capacity to discover ways to become fully functioning. With growing self awareness a client can develop more appropriate behaviours. The approach emphasises the phenomenal world of the client. The therapists concern themselves mainly with the client's perception of self and the world. In Roger's view the aim of therapy is to assist clients in their growth process, so that they can better cope with problems they are now facing and with future problems The therapist experiences unconditioned positive regard and acceptance for the client. And also he has an empathic understanding of the client's internal frame of reference and he strives to communicate this experience to the client. Empathy is the total understanding of the client's inner world. Unconditioned positive regard means a counsellor is having regard toward the client without and expectation any condition. Maslow emphasises enhancing clients' abilities to experience their feelings and think and act in harmony with their underlying tendencies to actualise themselves as unique individuals.

1.3.3 Behavioural Approach

In classical conditioning any response can be elicited by an unnatural stimulus rather than its natural stimulus through continuous association of that response with the unnatural stimulus. The response then is known as the unconditioned response. The conditioning can be done to make a person learn any new behaviour. Also if a person learned any inappropriate or unacceptable behaviour the de-conditioning can be done.

In operant or instrumental conditioning, the person can learn to operate any behaviour through rewards. These are called reinforcements. They might be positive or negative. The counsellor sometimes uses these techniques to de-sensitise the client from the anxiety or fear inducing stimuli. Sometimes a counsellor uses a positive reinforcement to make a child learn the appropriate behaviours.

In behaviour therapy the therapist attempts to get information about situational antecedents, the dimensions of the problem behaviour, and the consequences of the problem. Counsellor clarifies the client's problem, designs target behaviour and formulates the goals for therapy. He makes strategy to give therapy in which appropriate behaviours are reinforced and others are not.

1.3.4 Cognitive Behavioural Approach

In cognitive behaviour therapy the counsellor not only does behavioural rehearsals to modify the inappropriate behaviour of the client, but also tries to change the

negative perceptions and thinking of the person through cognitive therapy. The counsellor assesses client's distortions in thoughts and his maladaptive behaviours; then he intervenes to help them to practice for balanced behaviour and thoughts through different techniques. One of the technique is to interchange the automatic thoughts coming in the client's mind with the balanced or alternative thoughts without the suppression of automatic thoughts in the subconscious mind of the client. Different types of relaxation techniques are also used in that.

However in Rational Emotive Therapy (REBT) the counselling involves disputing clients' irrational beliefs and replacing them with more rational beliefs.

The therapist educates the client about the nature and course of their problem and how thoughts influence their emotions and behaviours. Homework is often used as a part of cognitive therapy. The purpose of homework in cognitive therapy is not merely to teach clients new skills, and to come back to perform the skills they can; but also to enable them to test their beliefs in daily-life situations.

1.3.5 Gestalt Approach

Gestalt therapy, developed by Fritz Perls and his wife Laura in 1940s. The approach is phenomenological because it focuses on the client's perception of reality; and existential because it says that people are always in the process of becoming, remaking, and rediscovering themselves. According to Latner, holism is one of the fundamental principle which emphasises on the integration or whole, how the parts fit together, and how the individual makes contact with the environment with this holistic view point.

The field theory of gestalt counselling is grounded on the principle that the organism must be seen in its environment as part of the constantly changing the field. Everything is relational, in flux, interrelated, and in process.

The Figure-Formation Process describes how the individual organises the environment from moment to moment. The undifferentiated field emerges from the background and becomes the focal point of the individual's attention and interest. The figure-formation twined with the principle of 'organismic self-regulation', a process by which equilibrium is disturbed by the emergence of a need, a sensation, or interest. Organisms will do their best to regulate themselves, given their own capabilities and the resources of their environment.

Polster and Polster (1973) describe five major channels of resistances: introjection, projection, retroflection, deflection and confluence. Introjection is the tendency to uncritically accept others' beliefs and standards without assimilating them to make them congruent with who we are. Projections are those attributes of our personality that are inconsistent with our self-image are disowned and put onto other people.

Retroflection consists of turning back to ourselves what we would like to do to someone else or doing to ourselves what we would like someone else to do to us. This process seriously restricts engagement between the person and his or her environment.

In deflection the individuals engage their environment on an inconsistent basis, which results in their feeling a sense of emotional depletion.

Confluence involves a blurring of the differentiation between the self and the environment. It is shown by the clients who have a high need to be accepted and liked.

Techniques of Gestalt therapy include the internal dialogue exercise, making the rounds, the reversal technique, the rehearsal exercise, the exaggeration exercise and staying with the feeling. In internal dialogue exercise is done using two empty chairs. They are two roles/attitudes played by the client himself. One is top dog i.e. righteous, authoritarian, moralistic, demanding, bossy and manipulative. The underdog plays the role of disobedient child who struggles for control.

Making the round is Gestalt exercise that involves asking a person in a group to go up to others in the group and either speak to or do something with each person. The purpose is to confront, to risk, to disclose the self, to experiment with new behaviour, and to grow and change.

In the reversal technique the counsellor could ask the client who claims to suffer from severe inhibitions and excessive timidity to play the role of an exhibitionist.

In the rehearsal exercise the client share their rehearsals out loud with the therapist, they become more aware of the many preparatory means they use in bolstering their social roles.

In the exaggeration exercise the client is asked to exaggerate the movement or gesture repeatedly, which usually intensifies the feeling attached to the behaviour and makes the inner meaning clearer.

Staying with the feeling is the technique in which the therapist may urge the clients to stay with their feeling. He may encourage the client to go deeper into the feeling or behaviour they wish to avoid. Facing, confronting, and experiencing feelings not only takes courage but also is a mark of a willingness to endure the pain necessary for unblocking and making way for newer levels of growth.

1.3.6 Reality Approach

Reality therapy is based on choice theory which is developed by Glasser (2000). Choice theory posits that we are not born blank slates waiting to be externally motivated by forces in the world around us. Rather, we are born with five genetically encoded needs-survival, love, and belongingness, power, freedom and fun- that drive us all our lives. Everyone has these needs but may vary in strengths. Reality therapists begin by asking clients what they want from therapy. They also enquire about the choices clients are making in their relationships. There is always a major unsatisfied relationship, although in the beginning the client may deny. In the first session the counsellor looks for and defines the wants of the clients. The therapist also looks for a key unsatisfying present relationship-usually with a spouse, a child, a parent or an employer.

Glasser advises therapist to help the client see how an unsatisfying present relationship is at the core of his or hers problem. When client begins to realise that he or she can not control only their own behaviour, therapy is under way. The rest of therapy focuses on how clients can make better choices.

1.3.7 Family System Approach

Alfred Adler, Murray Bowen, Virginia Satir, Carl Whitaker and Salvador Minuchin, Jay Haley and Cloe Madanes are the best known psychotherapists focus on family system approach. The central principle of family system approach is that the client is connected to living systems and that change in one part of the unit reverberates throughout other parts. A treatment approach that comprehensively addresses the other family members and the larger context as well as an 'identified' client is required.

Because a family is an interactional unit, it has its own set of unique traits. It is not possible to accurately assess an individual's concerns without observing the interaction with and mutual influence between the other family members, as well as the broader contexts in which the person and the family live. To focus on the internal dynamics of an individual without adequately considering interpersonal dynamics yields an incomplete picture.

Systemic therapists do not deny the importance of the individual in the family system, but they believe an individual's affiliations, and interactions have more power in the person's life than a single therapist could ever hope to have.

Bowen assumes that multigenerational and influences are central in understanding present nuclear family functioning. What occurs in one generation will probably occur in the next because key unresolved emotional issues tend to be played out over generations. He devised a 'family diagram' or genogram, as a way of collecting and organising important data over at least three generations. It is a tool for both the therapist and family member to understand critical turning points in the family's emotional processes and to note dates of births, deaths, marriages and divorces. The genogram also gives information about some of these characteristics of family: cultural and ethnic origins, religious affiliation, socio-economic status, type of contact among family members, and proximity of family members.

The therapist task also includes checking the functional versus dysfunctional communication in families, defences stances in coping with stress, family roles and family triads.

The goal of the therapy are mainly generating hope and courage in the family members to formulate new options; accessing, strengthening, enhancing, or generating coping skills in family members; and encouraging members to exercise options that will result in health as opposed to the mere elimination of symptoms. (Satir & Bitter, 2000)

1.4 THE COUNSELLING PROCESS

The process of counselling is systematic, and previously planned before starting the session. This is based on the symptoms, resources, personality, family and environment support and belief system of the client. The following steps are necessary to include in the counselling process.

1.4.1 Starting and Structuring

The counsellor should maintain a professional relationship with the client. The counselling is given only in the fixed sessions. It should be assured that on phone, on the way or any other informal place the counsellor will not talk to the client in an informal manner.

Each and every word said during the counselling session should be directional and a part of counselling, there should not be any further talking, and personal interest in any part of life of the client.

The language and communication patter and tone of the counsellor should be comfortable for the client. If there is very much discrepancy between the languages and understanding counselling should not be carried out. The counsellor's tone, pauses, patience, adding affirmations, acceptance, cross question in very subtle way would decide the direction of counselling. Good empathic responses from counsellor elicit honest self-exploring responses from clients.

To give a well planned counselling to a client the counsellor should listen carefully the client and try to get details of his case study from various resources (Informants, medical and psychological reports, information given by the client himself etc.).

1.4.2 Development of Insight and Making Rapport

Active listening is a major step of counselling. A client comes to a counsellor with lots of bad experiences, negative emotions, complexes, conflicts etc. He does not know what his exact problem is. So many things are going the brain of the person. When the counsellor gives relaxation to the client and ready to accept every thing going to be said by the client, the client starts saying on and on. It is counsellor's duty to let him speak first and decide which part of the client's life he will deal first.
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The client may be given some motivational sessions, relaxations and psycho-education to develop insight about the current problem. The client should be assured that the personal information shared by him would be kept confidential. Any information given by the client should not be discussed with any of the family member without the consent of the client. When it is required then the counsellor should do it very carefully in indirect manner.

1.4.3 Paraphrasing and Release of Emotions

Paraphrasing is just reflecting back what is communicated by the client in other words. This is done to assure the client that the counsellor has understood the exact meaning conveyed by client's internal frame of reference. But sometimes the counsellor has to repeat the same words instead paraphrasing.

The client feels free to express his feeling in an empathetic atmosphere. By his gestures (e.g. slightly nodding of head or through eye lash movement) the counsellor shows acceptance to client's feelings and wordings as he is paying full attention to understand it. The client starts releasing his emotions. The counsellor should not intervene in between the release of the emotions.

1.4.4 Taking Care of Present Demands, Ultimate Goals and the Obstacles

The counsellor should see that the clients need what in present circumstances and what is his ultimate goal. How these two can be put in same direction. How the client is made satisfied and what are the obstacles are in his way. If the person himself is responsible, it is the duty of the client to realise him. If others are creating problems, then the counsellor make the client feel confident to deal with them through cognitive behavioural rehearsals.

1.4.5 Training Relaxation and Making the Client Accept the Things

The counsellor prepares the client to accept the things happened in past and start a new journey of life. The counsellor teaches the client different relaxation techniques. These might be according the symptoms of the client e.g. breathing exercises, Jacobson's muscle relaxation technique, meditation, diversion of attention exercises, rehearsal of balancing thoughts or sleeping exercises etc.

1.4.6 Interpersonal Relationships, Conflicts, Behaviour and Personality of the Client

The counsellor has to check the behaviour and personality traits of the client. The counselling would include these issues also. If interpersonal conflicts are there, they may be dealt through role playing. The client would be realised how much others are important for one's life. How would he seek help from others and how he would maintain his interpersonal relationships? Sometimes the significant persons may be called to understand the issues.

1.4.7 Facilitating Problem Solving and Behavioural Rehearsals

To cope up with real life problems the counsellor make the client do behavioural rehearsals in front of him. He desensitise the client, and make him practice on positive thinking n so that he can apply it in real life situations.

1.4.8 Improving Client's Cognitive Distortions and Cross Questioning

To improve clients perception and thinking the counsellor assures the client through evidences that this is his thinking and perception not reality. The purpose is to give exposure the client and realise whether it happens really. For this sometimes counsellor do cross questioning to the client. Sometimes the counsellor probes the client to ask questions to the counsellor and he gets satisfied by searching answer in his questions.

1.4.9 Family Structure and Belief System

The family structure and belief system of the client can not be ignored. The client has to be made understood by the counsellor in a very scientific way why this structure of family or belief system was made. Is it required to modify or not. How much help he could get from his significant others? Can he change his views without disturbing others or not. If required family therapy can be provided.

1.4.10 Negotiating Homework and Monitoring

The counsellor provides the homework to set the daily routine of the client and to raise his self confidence that now I a doing something. Counsellor tries to highlight on those activities which he did so the client is encouraged to become more active. Initially very simple tasks are given to perform. Gradually the counsellor gives the complex ones.

Counsellor asks the care giver to do monitoring; also self monitoring by the client is done. Counsellor asks the care giver to observe the client (whether he is doing home work or not), not to intervene in the counselling.

Self Assessment Questions

1) In which technique given by Freud the focus is to release the suppressed emotions of the client:

   a) Free association
   b) Resistance
   c) Catharsis
   d) Interpretation

2) When the clients react to their therapist as they did to a significant person, it is called:
   a) Hypnosis b) Free association
   c) Dream Analysis d) Transference

3) Alfred Adler uses which term to refer to an imagined central goal that guides a Person's behaviour
   a) Fictional finalism b) Inferiority
   c) Life style d) Superiority

4) According to Jung Archetypes is the content of the:
   a) Unconscious b) Collective unconscious
   c) Personal unconscious d) Subconscious

5) According to Mahler infant is unable to differentiate itself from its mother,
   a) Symbiosis b) Normal infantile autism
   c) Separation process d) None of the above

6) Who developed logo therapy, which means 'therapy through meaning?'
   a) Viktor Frankl b) James Bugental
   c) Irvin Yalom d) None of the above

7) In one of the gestalt technique the client plays role of righteous, authoritarian, moralistic, demanding, bossy and manipulative. It is called;
   a) Underdog b) Top dog
   c) The leader d) Making round

8) Which approach of psychotherapy is based on choice theory developed by Glasser:
   a) Existential approach b) Humanistic approach
   c) Reality approach d) Gestalt approach

9) In which approach of counseling the focus is on client's distortions in thoughts and his maladaptive behaviours.
   a) Humanistic approach b) Existential approach
   c) Cognitive Behaviour appraoch d) Behaviour appraoch

10) The ethical issues in counseling is important to deal. For this following is necessary to do;
   a) To take informed consent b) To keep information confidential
   c) To have profession relationship d) All of the above

1.4.11 Offering Challenges and Feedback

Sometimes the feedback given by the client is not satisfactory however it might be due to several reasons e.g. the client is not practicing the things, family members are not supportive, there might be all of sudden something happens in the life of the counsellor that again makes him discouraged for the counselling or financial problems. These are the challenges for the counsellor himself. The counsellor analyses the things and decides now in which way the counselling can be proceeded. whether the counselling is continued by the same counsellor or the case should be referred to

other counsellor. If resistances comes the counsellor should manage it or should refer the case to other therapist.

1.4.12 Termination

The counselling is successful if the client himself asks the counsellor to discontinue. The reason must be the client is enough capable now to manage his day to day life problems. Generally termination occurs after 10-12 sessions. But sometimes due to some ethical issues, resistances or saturation the counsellor has to terminate the counselling.

1.5 ETHICAL ISSUES

Set healthy boundaries in the therapeutic relationship. Informed consent is to be taken before applying any testing or therapeutic technique on the client. The client's problems should be dealt very professionally. The counsellor must not take benefit from any situation, in any way. The client should be informed prior if there is any circumstance which can affect the confidentiality.

1.6 LET US SUM UP

In this unit we were dealing with the teaching and training for cunselling. We discussed culture and race and how these affect counselling process. We put forward the various socio economic, socio demographic factors that have to be considered before taking up the person for counselling. Also, whether the person has any physical or mental disability which needs any other forms oif interventions needs to be assessed and attended to. Then we presented the various approaches to counselling such as the psycho Analytic Approach, the existential and humanistic Approaches, behavioural approach and family systems approach etc. This was followed by the elucidation of the counselling process itself. How to start and structure the process, how to help client develop insight etc. The section also explained as gto how to improve the client's cognitive distortions and explained the family structure and the belief system which all may influence the counselling process. How to negotiate and give homework to the clients and how to monitor the progress re all some of the issues that were dealt with in this unit. Then the ethical issues were delineated and put forth.

1.7 UNIT END QUESTIONS

1) What are the different techniques used by the Freud and other psychoanalytical therapists?
2) How a client's perception, thinking and emotions are restructured through cognitive behaviour therapy? Give examples.
3) What are the essential steps a counsellor follows in counselling of a client?
4) Write down the different conditions which are necessary to control the disparity between a client and a counsellor?
5) Discuss the various ethical issues to be taken care by the counsellor during counselling sessions.

1.8 SUGGESTED READINGS

Gerald Corey (2001) *Theory and Practice of Counseling and Psychotherapy*, Wadsworth, Brooks/Cole Thomson Learning, United States.

Ram Nath Sharma (2004*)* *Guidance and Counselling*, Subjeet Publications, Delhi, India.

Richard Nelson-Jones (2008). *Basic Counseling Skills: A helper's manual*, Sage Publications, New Delhi.

1.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) c), 2) d), 3) a), 4) b), 5) b), 6) a), 7) b), 8) c), 9) c), 10) d).

UNIT 2 CURRENT STATUS OF COUNSELLING WITH SPECIAL REFERENCE TO INDIA

Structure

2.0 INTRODUCTION

This unit deals with the development of counselling educational centres in India and different courses in counselling psychology. After that the focus would be on the counselling centres which provide counselling to the individuals who faced different day to day life problems e.g. family problems, marriage problems and individual mental health and adjustment problems.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Be aware of the status of counselling psychology in India;
- Follow the procedures to become a professional counsellor;
- Acquire knowledge about the different courses and centres which are providing education and training in the area of counselling psychology; and
- Develop knowledge about the centres which give counselling services to the masses.

2.2 DEVELOPMENT OF COUNSELLING AND GUIDANCE CENTRES IN INDIA

2.2.1 Calcutta University

Calcutta University set up the first psychological laboratory in India in the year 1915. A separate section of research in Applied Psychology was opened under the direction of Dr. G. S. Bose in 1936 in order to adopt psychological tests prepared in America to suit the Indian conditions and to satisfy the vocational needs of Indian students.

2.2.2 Bombay University

In 1941, Batliboi Vocational Guidance Bureau was established in Bombay.

2.2.3 Patna University

A Department of Psychological Services and Research was established in 1945, offering personal and vocational guidance to students and constituting a number of psychological tests.

2.2.4 Parsi Panchayat

The Trustees of the Parsi Panchayat Funds and Properties established the Parsi Panchayat Vocational Guidance Bureau in 1947. Dr. H.P. Mehta, its first Director, published the journal of Vocational and Educational Guidance.

2.2.5 The Uttar Pradesh Government

In 1947, the U.P. Government established the Bureau of Psychology at Allahabad on the recommendations of Acharya Narendra Deo Committee.

2.2.6 The Bombay Government

The Bombay Government in the year 1947, set up the Vocational Guidance Bureau in Bombay renamed as Institute of Vocational Guidance in 1957. In 1952, the Vocational Guidance Association of Bombay was formed to coordinate the efforts of various individuals and agencies in the field of guidance in Bombay.

2.2.7 Workshop and Seminars at Delhi

In March 1953, Dr.W.L. Barnette, an American Professor, held a workshop at the Central Institute of Education, Delhi. A second seminar was held in November 1954 at the same place. It was decided to form an All India Educational and Vocational Guidance Association and to affiliate it to the International Association for Vocational Guidance.

2.2.8 Secondary Education Commission (1952-53)

On the recommendations of Secondary Education Commission (1952-53), the old unilateral education system was replaced by a scheme of diversified courses. The Commission provided for seven different streams at the Secondary Stage-humanities, science, agriculture, commerce, technical, fine arts, and home science.

2.2.9 Central Bureau of Educational and Vocational Guidance

In 1954, the Ministry of Education, Government of India, set up the Central Bureau of Educational and Vocational Guidance.

In July, 1958 it started a ten months' course for training counsellors in the field of student personnel work in the Central Bureau's premises in the Central Institute of Education, Delhi. Earlier a part of the Ministry of Education, the Bureau has become a part of the Department of Psychological Foundations of the National Institute of Education under the National Council of Educational Research and Training. The Extension Services Department of the Central Institute of Education, Delhi, conducted two long-term courses in Educational and Vocational Guidance. during 1957 and 58 to provide in-service training of teachers so that they should work either as career-masters or as teacher-counsellors. (R.N. Sharma, 2004)

2.2.10 State Bureaus of Educational and Vocational Guidance

These were established to perform the following functions:

a) Organisation of sample group guidance activities for a few schools.
b) Collection of occupational information and production of information material, establish state level information centres
c) Development and adaptation of translation of tests, questionnaires, check lists, etc.
d) Training of guidance workers.
e) Planning, coordination and supervision of guidance service within the State.
f) Consultative and field services.
g) Research
h) Organising courses in guidance and counselling
i) Individual Counselling and group guidance

j) Organise short term training programmes and orientation programmes

k) Standardization of psychological test

l) Publications

2.3 THE SECONDARY STAGE SERVICES OF GUIDANCE AND COUNSELLING PSYCHOLOGY IN INDIA

In India Guidance and counselling services at the Secondary stage are organised at the following four levels:

2.3.1 Central Government (Ministry of Education)

The Union Ministry of Education and the National Council of Educational Research and Training, are concerned with guidance services in higher secondary schools at the Central Government level.

The Ministry has promoted the development of guidance by providing financial assistance as well as professional leadership to States offered through the Central Bureau of Educational and Vocational Guidance established as a part of the Ministry of Education and later the Bureau was made a part of the Central Institute of Education under the Ministry of Education and at last merged with the National Council of Educational Research and Training (N.C.E.R T.).

2.3.2 National Council of Educational Research and Training (NCERT)

National Council of Educational Research and Training (NCERT) was established on 1st September 1961, as an autonomous organisation to function as an academic adviser to the Ministry of Human Resource Development, Department of Education, Government of India. The Ministry draws upon the expertise of the NCERT in formulating and implementing its policies and programmes in school education.

The National Council of Educational Research and Training (NCERT), in collaboration with Commonwealth of Learning (COL), Canada, is offering an International Diploma Course in Guidance and Counselling.

As a technical wing of the Ministry of Education it, undertakes the different types of activities in the field of guidance and counselling e.g. Leadership, researches, training, extension services, field services, publications. There are two journals of the N.C.E.R.T. *viz.*, Indian Educational Review and the N.I.E. journal**.**

2.3.3 National Employment Service

This organisation is primarily concerned with the offering of vocational guidance to school youth and adults through its Vocational Guidance Units. Its Vocational Guidance Officers assist the State and private organisations in conducting training courses for career masters through talks on career and organisation of career conferences

2.3.4 Guidance Services at the State Level

State Bureaus of Educational and Vocational Guidance have been set up in almost all the States and Union Territories, some of them administratively a part of the Directorate of Education others either a part of the State Council of Educational

Research and Training as in Andhra Pradesh or of the State Institute of Education as in Kerala and Delhi.

2.3.5 Educational and Vocational Guidance Bureaus in India

These were established in different parts of the country. The list is given in then table below:

S. No.	State/Union Territory
1. Andaman& Nicobar Islands	State Bureaus has not been established
2. Andhra Pradesh	Department of Educational Foundations, SCERT, Hyderabad
3. Arunachal Pradesh	There is no State Bureau
4. Assam	The State Bureau is attached to the office of the DPI
5. Delhi	The Bureau is a Unit of the SCERT
6. Gujarat	Institute of Vocational Guidance, Ahmedabad
7. Haryana	Guidance and Counselling Wing is a part of the SCERT, Haryana
8. Himachal Pradesh	State Bureau exists under the Directorate of Education, Himachal Pradesh
9. Karnataka	S.B.E.YG. is a part of Department of SCERT under the Directorate of Public Instruction
10. Kerala	S.B.E.YG.is a part of the State Institute of. of Education.
11. Madhya Pradesh	S.B.E.V G. is a part of the Educational Psychology and Guidance, Jabalpur
12. Maharashtra	Institute of Vocational Guidance and Section with a Sub-Bureau at Pune
13. Manipur	S.B.E.YG. is a part of the office of the Director of Education
14. Mizoram	E.YG. Unit is attached to SCERT, Mizoram
15. Orissa	——
16. Pondicherry	——
17. Punjab	S.B.E.VG. exists separately under the Department of Education
18. Rajasthan	S.B.E.V G. is a part of the SCERT
19. Sikkim	——
20. Tarnil Nadu	——
21. Tripura	S.B.E.V G. has been set up independently under the Dapartment of Education
22. Uttar Pradesh	Bureau of Psychology functions under the control of State Director of Education and the Director, SCER. It functions at the regional and school levels
23. WestBengal	——
24. Meghalaya	E.YG.B. is a part of SCERT
25. Dadra & Nagar	S.B.E.VG. exists under Directorate of Education

2.3.6 Area of State Directorate of Employment and Training

1) Organisation of occupational information programme.
2) Employment market information programme.
3) Careers study centres.
4) Foreign employment and training information centres.
5) Selection of courses and institutions.
6) Admission matters.
7) Scholarships, fellowships, assistantship and apprenticeships.
8) Information about passport and visa.
9) Employment prospects and Part-time employment.
10) Special units for the handicapped.

2.3.7 Training in Colleges and Universities

These offer courses in guidance in programme for the degrees of B.Ed. and M.A. in Psychology. Some of these also train career masters through organising short-term courses.

2.3.8 Private Guidance Agencies

Some private guidance agencies have been sponsored by charitable trusts, social welfare organisations or educational societies in India.

2.3.9 Guidance Services in Secondary Schools

Guidance Services in secondary schools are conducted by the following guidance personnel conducting well-equipped guidance services in schools:

i) The Principal and his colleagues.
ii) A guidance counsellor.
iii) Teacher-counsellor or career masters.
iv) Specialists in specific areas of service (part-time or full-time), which include the following:
    a) Social worker.
    b) Psychologist.
    c) Doctor, dentist, nurse.
    d) Parents.
    e) Community health, welfare and guidance agencies.

2.4 COUNSELLING PSYCHOLOGY: EDUCATION AND TRAINING

2.4.1 Qualifications for Counselling Courses

Certificate, Diploma and PG Diploma courses on counselling are offered by various institutes all over India. For pursuing a PG Diploma in Clinical and Community

psychology, you need to have a graduation in Psychology. For admission to diploma program in Guidance and counselling, some institutes prefer candidates with a Bachelors degree in Home Sc., Education or Arts, whereas others admit candidates with a M.A/ M.Ed. (psychology) degree.

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

2.4.2 Eligibility for Clinical and Counselling Psychology

The successful completion of an M.A. or M.Sc. Degree in Psychology with a minimum of 55 per cent marks in aggregate is the minimum eligibility criteria for pursuing a professional course in counselling psychology.

The aggregate percentage marks are relaxable by five percent for the students belonging to the Scheduled Castes, Scheduled Tribes and Other Backward Classes.

2 Years of practical experience in offering counselling services is also an eligibility criteria at several institutes.

Students, who have merely completed their Post graduation in Social Work or in Psychology, are also offering counselling services, even though they are not registered under the RCI.

The RCI issues a registration number to every Clinical Psychologist and counsellors which has to be renewed after every 5 Years.

2.4.3 Institutions Offering Courses on Counselling

The Maharaja Sayajirao University of Baroda in Gujarat

- NCERT in New Delhi
- All India Institute of Physical Medicine and Rehabilitation in Maharashtra
- Annamalai University in Tamil Nadu
- SNDT Women's University in Maharashtra
- University of Madras in Tamil Nadu
- Rani Durgavati Vishwavidyalaya in Madhya Pradesh
- Regional Institute of Education in Madhya Pradesh
- Regional Institute of Education in Karnataka

2.4.4 Benefits of Counselling Courses

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

2.4.5 Scope for Counselling in India

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

2.4.6 Scopes for Counselling Abroad

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

2.5 CAREERS IN CLINICAL AND COUNSELLING PSYCHOLOGY

One needs to be kind and compassionate in nature in order to be a good Clinical Psychologist since this profession entails the practitioners to understand and solve the problems of people through counselling. One should have a good understanding of the workings of the human mind and should also have a natural propensity to unravel the deepest mysteries of the human mind.

The counselling is a very good tool to prevent the mental health and stress oriented problems. It is a difficult task to deal with patients exhibiting abnormal mental behaviour; hence a lot of patience is required on the part of a counsellor. In the profession of Clinical Psychology, a counsellor picks up a lot of negative thoughts and emotions from the patients. Hence, one should have the ability of ventilating all the negativity picked up during counselling.

Moreover, one should also have strong skills of persuasion in order to help patients break their mental blocks. Effective communication skills are also required, since one has to uncover the innermost workings of the patients' mental processes by talking with them.

2.5.1 Clinical and Counselling Psychology Programmes

Various courses in Clinical Psychology are offered by universities and institutes across the country. One can go in for an M. Phil. Program of 2 Years duration.

2 Year M. Phil Programs are available at the Central Institute of Psychiatry (CIP) in Ranchi (Jharkhand), the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore (Karnataka) and at the Institute of Human Behaviour and Allied Sciences (IHBAS) in New Delhi. The IHBAS inducts its M. Phil. Program every Year.

Each of the above mentioned institutes conducts independent, All India level entrance examinations for candidates wishing to get admission into M. Phil Programs at these institutes. The candidates who qualify in the written examination also have to clear an interview in order to get admission. Diploma courses and Certificate courses in Clinical Psychology are also offered by several institutes across the country.

The Jamia Millia Islamia (New Delhi) and a few regional centres of the NCERT (National Council of Educational Research and Training) offer Diploma courses in Clinical Psychology. The RCI recommends a practice - oriented curriculum for students pursuing any course (Degree, Diploma or Certificate) in Clinical Psychology and counselling. The Rehabilitation Council of India (RCI) recommends an OPD (Out Patient Department) in every institute offering a course in Clinical Psychology. It also recommends the restriction of theory - related teaching to only 30 per cent of the syllabus while laying more stress on practical learning.

2.5.2 Careers in Clinical and Counselling Psychology Prospects

One who has done a course in Clinical Psychology will be able to find jobs in the government sector. One will also be able to find jobs in the licensed psychiatric nursing homes. Clinical Psychologists are also required in the non - governmental organisations (NGOs) who are engaged in offering counselling services.

One can also find a job as a full time career counsellor in a school, since the Central Board of Secondary Education (CBSE) has directed for the appointment of at least one full time career counsellor in each and every school under its affiliation. One can also specialise in marital counselling if one has obtained a professional degree in Clinical Psychology. Moreover, the prospects of earning name and fame are quite bright if one sets up a clinic and starts counselling independently.

2.5.3 List of Colleges Offering the Clinical and Counselling Psychology Courses

Course Name	Institutes offering the courses
M. Sc. Psychology	Bangalore University, Bangalore (Karnataka), Jnana Bharathi, Bangalore - 560 056.
	Sri Venkatehswara University, Tirupati (Andhra Pradesh) Tirupati - 517 502, Chittor, Andhra Pradesh.
	University of Calcutta, Kolkata, West Bengal - 700 073.
	University of Mysore, Mysore (Karnataka), Mysore Viswavidyalaya Karya Soudha, Crawford Hall, P.B. No. 17, Mysore - 570 005.
M.Sc. Holistic Psychology	Bangalore University, Bangalore (Karnataka), Jnana Bharathi, Bangalore - 560 056.
M.Phil. in Psychology	Gujarat University, Ahmedabad (Gujarat) PB No.4010, Navrangpura, Ahmedabad - 380 009.
	Gurunanak Dev University, Amritsar, (Punjab).
	Sardar Patel University, Gujarat (Gujarat), Vallabh Vidyanagar - 388 120, Gujarat.
	University of Mysore, Mysore (Karnataka), Mysore Viswavidyalaya Karya Soudha, Crawford Hall, P.B. No. 17, Mysore - 570 005.
M. Phil. in Rehabilitation Psychology	Mahatma Gandhi (M.G) University, Kerala (Kerala) Priyadarsini Hills P. O., Kottayam, Kerala, India - 686 560.
	National Institute for the Mentally Handicapped, Manovikas Nagar, Secunderabad - 500 009, (Andhra Pradesh).
	National Institute for the Mentally Handicapped, Manovikas Nagar, P.O. Bowenpally, Secunderabad - 500 011.
P.G. Diploma in C.A.H Psychology	Maharaja Sayajirao University of Baroda, Vadodara, (Gujarat) Fatehgunj, Vadodara-390 002.

P.G. Diploma in Clinical and Community Psychology (CCP)	Maharaja Sayajirao University of Baroda, Vadodara, (Gujarat), Fatehgunj, Vadodara - 390 002.
Ph.D. in Clinical Psychology	Bangalore University, Bangalore, (Karnataka) Jnana Bharathi, Bangalore - 560 056.
	Gurunanak Dev University, Amritsar, (Punjab).
Post Graduate Diploma in Counselling Psychology	Punjabi University, Patiala, (Chandigarh) Arts Block No. 1, First Floor, Patiala - 147 002, India.
M.A. (Psychology)	Barakatullah Vishwavidyalaya, Bhopal, (Madhya Pradesh).
	Behrampur University, Bhanja Bihar, Orissa - 760 007.
	Bhagalpur University, (Bihar), Bhagalpur - 812 007.
	Devi Ahilya Vishwavidyalaya, MGM Medical College, AB Road, Indore - 452 001.
	Gujarat University, Ahmedabad, Gujarat - 380 009.
	Gurunanak Dev University, Amritsar, (Punjab).
	Himachal Pradesh University, Summer Hills, Shimla - 171 005.
	Jamia Millia Islamia, Jamia Nagar, New Delhi - 110 025.
	Jodhpur University, Jodhpur, (Rajasthan), Jodhpur - 313 001.
	Kurukshetra University, Kurukshetra, Haryana - 136 119.
	Lalit Narayan Mithila University, Darbhanga, Bihar - 840 004.
	Magadh University, Bodh Gaya, Bihar - 824 234.
	Maharaja Sayajirao University of Baroda, Vadodara - 390 002.
	Maharshi Dayanand University, Rohtak, (Haryana).
	Mahatma Gandhi (M.G) University, Priyadarsini Hills P.O., Kottayam, Kerala, India - 686 560.
	Mohanlal Sukhadia University, Udaipur - 313 001.
	North Eastern Hill University, (Meghalaya), Shillong - 793 001.
	Punjabi University, Patiala, (Chandigarh), Patiala - 147 002.
	Sambalpur University, Burla, Orissa - 768 019.
	Sardar Patel University, Gujarat, Gujarat - 388 120.
	Saurashtra University, Rajkot, Gujarat - 360 005.
	South Gujarat University, Surat, Gujarat - 395 007.
	University of Calicut, Kozhikode - 673 008.
	University of Delhi, Delhi, (Delhi), Delhi - 110 007.
	Utkal University, Bhubaneshwar, Orissa - 751 004.

Self Assessment Questions

1) When was the Central Bureau of Educational and Vocational Guidance set up?

   a) 1958 b) 1957

   c) 1954 d) 1945

2) Which of the following journals is not published by NCERT?

   a) Indian Educational Review

   b) N.I.E. journal

   c) Indian Journal of Guidance and Counseling

   d) None of the above

3) After how many years does the RCI registration no. for professional counselor needs to be renewed?

   a) 5 years b) 4 years

   c) 7 years d) 10 years

4) What are the minimum eligibility criteria for admission in a professional counseling psychology diploma or degree?

   a) Graduation with psychology

   b) Post Graduation in psychology with 55% Marks

   c) Post Graduation with 55% Marks

   d) Graduation in psychology with 55% Marks 5.

5) Which of these diploma courses is offered by the NCERT?

   a) International Diploma Course in Guidance and Counselling.

   b) National Diploma Course in Guidance and Counselling

   c) National Diploma Course in Counselling

   d) International Diploma Course in Guidance

6) Which of these states does not have a regional institute under NCERT?

   a) Bhopal b) Mysore

   c) Jodhpur d) Bhubaneswar

7) Which of these following Institutes provides degree in M.Sc. Holistic Psychology?

   a) University of Calcutta b) Sri Venkatehswara University

   c) University of Mysore d) Bangalore University

8) In India Guidance and counseling services at the Secondary stage are organized at which of the following levels?

   a) Central Government

   b) Guidance Services at the State Level

   c) Private agencies and schools

   d) All of the above

9) Which of the following university offers a Post Graduate Diploma in Counselling Psychology?

   a) Bangalore University, Bangalore

   b) Punjabi University, Patiala

c) Gurunanak Dev University, Amritsar

d) Maharaja Sayajirao University of Baroda

10) What is the name of department of psychology at NIMHANS, Bangalore.

a) Department of Mental Health and Social Psychology

b) Department of Mental Health and Psychology

c) Department of Neuropsychology and Social Sciences

d) None of the above

A lot of opportunities are also open for students of Psychology in the UK, the US, Australia and Singapore. Some Institutions are also running M.Phil. in counselling psychology.The profession of Clinical Psychology is in a very young stage in India but is set to expand more in the near future. Together with it, the career scope of students, who do a course in Clinical Psychology today, will also expand in the near future.

2.6 INDIA'S TWO LEADING ORGANISATIONS

2.6.1 Department of Mental Health and Social Psychology (NIMHANS, Bangalore)

It was started in the year 1954 as the Department of Psychology and Human Relations. It is one of the oldest and largest departments in National Institute of Mental Health and Allied Neuro-Sciences (NIMHANS), Bangalore. In tune with the guiding philosophy of NIMHANS, the department is engaged in clinical service, human resource development and research activities. The department has a sanctioned strength of 18 faculty members, 1 senior scientific officer, 2 junior scientific officers, 6 clinical psychologists and a teacher for the mentally-challenged persons.

Here Psychological intervention services are provided for adults, children and adolescents, couples as well as families. The approaches utilised for interventions include supportive, cognitive- behavioural, emotion-focused, interpersonal and brief dynamic psychotherapies, marital and family therapies, humanistic-existential therapies, behaviour modification as well as rehabilitation and cognitive retraining procedures. These services are individually tailored. In addition, the department is involved in providing various outreach services for mental health education, awareness and training. These include school mental health programs, stress management programs, training in basic counseling skills, parenting- skills training and other programs for the promotion of mental health and well being for various target groups in the community.

The department has been offering child and adolescent psychological services since its inception. At present, the services include assessment of cognitive functions such as attentional skills, intellectual abilities, memory, specific learning abilities/disabilities (academic abilities such as reading, writing, spelling and maths), self-concept, stress and interpersonal relations, fantasy life and internal world of children as well as parenting skills. The methods of intervention include play therapy, art and narrative work with children, individual psychotherapy for adolescents, parental counseling for children and adolescents with mental retardation, autism and learning disabilities and parent- management training for children with severe behaviour problems such

as conduct and oppositional defiant disorders. In addition, remediation-training for young children with learning difficulties and behavioural intervention for children with attention deficit hyperactivity disorder, emotional and behavioral problems are also utilised. Services are offered on appointment basis. Since the services offered generally involve in-depth assessment and individually-tailored, intensive interventions for addressing multiple problem- areas; the entire process for a given client may usually span two-to three months.In addition, the psychological services are offered to schools in terms of school mental health - workshops for teachers and parents to identify and deal with academic and psychological problems in children and adolescents. Programs for enhancing mental health of parents and children are also offered.

The clinical psychology services offered for clients with substance use /dependence are individually tailored and include psychological assessment of various domains such as intelligence, personality and interpersonal relationships. Neuropsychological assessments are also carried out when necessary. The range of psychological interventions offered includes motivation enhancement therapy, methods for relapse prevention, individual psychotherapy, marital/family therapy, parental counseling, cognitive retraining and yoga.

In the Family Psychiatry Centre, therapeutic services are offered for couples and families who may be referred from adult and child and adolescent mental health units as well as those who are self- referred. The services are offered on inpatient as well as outpatient basis. The clinical psychology consultants are an integral part of the multidisciplinary team and provide intensive inputs in the process of assessment, intervention and training. Systemic, structural, behavioural, emotion-focused, strategic and psycho-education are some of the therapeutic approaches utilised.

2.6.2 The National Council of Educational Research and Training

The National Council of Educational Research and Training (NCERT) was established for providing academic support in improving the quality of school education in India. The focus of the Council is reflected in its emblem. The three intertwined swans symbolise the integration of three aspects of the work of the NCERT, namely, Research an d Development, Training, and Extension. All these functions are tuned to achieve the main objective of improving the quality of school education. The activities taken up by the NCERT include development of curriculum, textbooks and instructional materials, training of the key functionaries and research in various dimensions of school education.

i) Department of Counselling and Guidance

Qualitative improvement of education, through the application of the disciplines of educational psychology and counselling and guidance, particularly at the elementary, secondary and senior secondary levels, is the major concern of the Department of Educational Psychology, Counselling and Guidance of the NCERT. It has been engaged in research, development and training activities related to counselling and guidance, identification and development of talent, behaviour technology and development of syllabi and instructional materials. Its projects/programmes aim at the optimal development and self actualisation of the learner, in all aspects of his/her potentialities and functioning. It took steps towards implementing the recommendations contained in the National Policy on Education (NPE) and Programme of Action (FOA), bearing on educational Psychology, counselling and guidance. (R.N. Sharma, 2004)

The NCERT functions through its eight constituent units, viz. (a) National Institute of Education (NIE), (b) Central Institute of Educational Technology (CIET) – both located at New Delhi, (c) Pandit Sunderlal Sharma Central Institute of Vocational Education (PSSCIVE), Bhopal and five Regional Institutes of Education (RIEs) at Ajmer, Bhopal, Bhubaneswar, Mysore and Shillong. This National Institution draws on the expertise of as many as 600 members of the faculty located in the network of its constituent units.

ii) **International Diploma Course in Guidance and Counselling (IDGC)**

NCERT, through the Department of Educational Psychology and Foundations of Education (DEPFE), has been training the in-service school teachers, teacher educators, educational administrators as well as untrained guidance personnel through its diploma courses for many years. In order to make the course accessible to larger numbers, this course has now been redesigned with components of both distance/ online as well as face-to-face modes. The course is developed and offered by DEPFE, NIE, New Delhi and other five study centres at Regional Institutes of Education of NCERT.

The course aims to train in-service teachers, teacher educators, educational administrators and untrained guidance personnel as counsellors/teacher counsellors to guide and counsel students in school and other related settings. The course provides opportunity for interaction among candidates from different cultures and helps to promote international understanding, harmony and peace among people from various regions of the world. It has therefore been designed with a special focus on counselling in a multicultural context.

2.7 COUNSELLING PSYCHOLOGY: AN OVERVIEW

Counselling psychology is not an established profession in India, at least in the formal sense. While psychology in India is represented by a number of key professional bodies, including the Indian Association of Clinical Psychologists, there has not been a move to develop a distinct identity for psychologists involved in counselling. A limited number of courses on counselling are on offer, but the quality of training is not monitored for these. What is apparent from a consideration of the situation in India regarding psychology and counselling, is the need for both western and Indian philosophies and ideas to come together to form theories and approaches that have greater face validity to the Indian population and which therefore might more adequately meet identified needs. For example, Arulmani (2007) draws attention to the fact that traditional Indian psychology, referred to as Mano Vidya, or 'mind knowledge', is recorded in ancient Indian writings documenting the existence of psychological ideas and techniques that 'bear a startling resemblance to ideas put forth by modern Western psychology and yet predate these efforts by two millennia' (p. 71). Apparently, there is now some activity in this direction, with the development of psychological inventories that draw on traditional Indian psychology (Wolf, 1998). The challenge that these developments present to counselling psychology highlight the need to contextualise concepts and approaches within a framework that can cope with different cultural subjectivities, and by doing so recognise the contextual nature of knowledge and research activity. (Counselling psychology in India).

2.8 LET US SUM UP

In this unit we have considered the current status of counselling with special reference to India. Development of Counselling and Guidance Centres in India. We traced the establishment of counselling psychology courses in the different universities in India such as the Calcutta University, Bombay University etc. Then we elucidated the efforts of the various governments in establishing counselling psychology in different institutions. Then counselling was discussed in the context of UP government, Delhi and how it was brought under the rubrics of secidary education commission. This was followed by the establishment of the Central Bureau of Educational and Vocational guidance and the State of Educational and Vocational guidance. Then we elaborated on the Secondary Stage services of Guidance and Counselling Psychology in India. We then took up the establishment of NCERT by the government, the National Employment Services, Guidance services at the state level and the establishment of the Educational and vocational guidance bureau of India. Also we took up the training for counselling in colleges and universities, in private guidance agencies etc. Then we took up the training issues concerned with counselling, the qualifications and eligibility requirements for undergoing training in counselling. We then delineated the Careers in clinical and counselling psychology and the list of colleges offering clinical and counselling psychology courses.

2.9 UNIT END QUESTIONS

1) What are the different Organisations offering courses on guidance and Counselling in India.
2) The department of mental health and social psychology, NIMHANS, Bangalore provides psychological intervention counselling services in which areas?
3) Explain the functions of State Bureaus of Educational and Vocational guidance in brief.
4) Discuss the current status of counselling psychology in India.
5) Write short note on functioning of NCERT.

2.10 SUGGESTED READINGS

Ram Nath Sharma (2004) *Guidance and Counselling,* Subjeet Publications, Delhi, India.

Careers in clinical and counseling psychology in India recruited on 19th January 2011 from www.winentrance.com/career_courses.

Counseling courses in India. recruited on 9th January 2011 from www.indiaedu.com/career-courses/

Counsellling psychology in India. from The Social and Historical Context of CounsellingHE SOCIAL AND HISTORICAL CONTEXT OFCOUNSELLING PSYCHOLOGY PDF file www.uk.sagepub.com/upm-data On 19th January 2011

Department of Mental Health and Social Psychology, Recruited on 9th January 2011 from www.nimhans.kar.nic.in

The National Council of Educational Research and Training (NCERT) recruited on 19th January 2011 from www.ncert.nic.in/announcements

2.11 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) c), 2) c), 3) a), 4) b), 5) a), 6) c), 7) d), 8) d), 9) b), 10) a).

UNIT 3 FUTURE DIRECTION

Structure

3.0 INTRODUCTION

In today's scenario counselling is not only advisable but has become the requirement of the individuals. Not only the person who is suffering from any type of mental problem, but many times counselling is a demand by the persons who feels any type of stress, conflict, pressure, frustration or any type of adjustment problems. Day by day new academic and training courses are being started in the area of counselling by different organisations. But still it is lacking in most of the sectors.

Now-a-days individual counselling can be received by the person working in any organisation related to any filed due to the appointment of trained counsellors in these fields. Also for managing the time and financial problems, the online counselling is also coming forward. Online counselling is also known as E-counselling. Individual counselling takes time to go to the place of counsellor and approach the counsellor regularly. In previous unit techniques of individual counselling have been discussed. In this unit focus would be more on E-counselling as it is modern up-coming approach.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the masses about the development and advancement of counselling in different countries;
- Enlist the benefits and limitations of online counselling and career opportunities in this area; and
- Elucidate the necessity of counselling in different areas that may affect not only the mental health of the person but also to improve the growth of any individual, organisation or country.

3.2 APPLICATION OF COUNSELLING PSYCHOLOGY

Now-a-days the world is going very fast. Each and every child faces lot many hurdles in their growth and development. The child can not enjoy his or her childhood because he has to run in the race since beginning starts from his or her developmental stage. Some times they can face the problems and some times they can not cope up and feel stress. The elders can not understand the child psychology. In this way it is necessary that every school should have at least one counsellor with whom the child may share his feelings. Because of training the counsellors are capable to assess the problem of the child. They can help the child to release their emotions and they can help them to search a meaning in their life. With the help of the counsellor the child learns to cope up with their day to day life problems. Unfortunately only some schools has counsellors.

In college also a special wing should be of counselling which can deal with the emotional problems of the youths. Every second person in the world is dissatisfied with his or her day to day problems, environment or with job etc . If he or she is satisfied; may feel pressure of work or stress to complete the responsibility at hand. The people are facing interpersonal problems everyday. Every person at some time or other time needs counsellor who would have empathy and a positive unconditioned regards towards him. Who can listen the person carefully and who can let him motivate to adapt the best coping skills suitable for a person's further growth.

In industry or any organisation counsellor can work to improve for better interpersonal skills for the employer or can develop team spirit in a group or they motivate the employee or employer to control their emotional aspects so that over all growth of the individual and organisation can be enhanced.

In hospital setting not only in psychiatric wing but also in every department counsellors are required. In every chronic or terminal illness the chances to develop anxiety, depressive features, conflicts, stress, negative thoughts etc. are high. If the counsellor go to visit and counsel the patient like other doctors, the patient would feel good. But it should not be for the commercial purpose. In humanitarian ground the every person should take breathe of relief and feel satisfied with life.

In some countries they have arrangements like they have family counsellors or personal counsellors. In society and communities the members can also have a counsellors' club to deal with the emotional issues. The human being is some time tapped with emotions. They do every thing to make themselves happy but do not think about to control or cope up with their emotional issues. The counselling especially psychological counselling helps them a lot.

3.3 DEVELOPMENT OF COUNSELLING

Counselling psychology has now been given division status in the International Association of Applied Psychology (IAAP). This came about at the 2002 Congress of Applied Psychology in Singapore, where the Board of Directors of IAAP voted to create Division 16 of Counselling Psychology (Leong & Savickas, 2007). An International Review was planned, to consider the discipline of counselling psychology in 12 different countries across the world.

The USA has the longest established independent profession in counselling psychology. In 1946 the American Psychological Association (APA) reorganised Personnel and

Guidance Psychologists with Division 17. A change which reportedly came about through senior members of Division 17 using the term 'counselling' rather than 'personnel'. This was in large part driven by the awareness raised by Carl Rogers (a psychologist) who in 1942 had published his first book, Counselling and Psychotherapy, followed in 1951 by his major work Client Cantered Therapy. Following an important conference sponsored by Division 17 in 1951 on the training of counselling psychologists, the impetus was set in motion for a further name change to Division 17, Counselling Psychology and the confirmation of this field as a specialty (APA, 1956).

In 1974, the foundation of the National Register of Health Service Providers in Psychology focused on the training and accreditation of counselling psychologists in the USA and included the specification of 'psychology' in the title of accredited programmes and the doctoral level training for counselling psychologists.

In 2003, the Division changed its name to the Society of Counselling Psychology, emphasis was on 'unity through diversity'. The Society of Counselling Psychology has proved to be popular as a division within the APA, and currently has the second largest division membership after clinical psychology.

Two national organisations are recognised as having influenced the development of the profession of counselling psychology in **Canada**, the Canadian Psychological Association (CPA) and The Canadian Counselling Association (CCA) in 1986. The CPA outlines the requirements for training in the different regions, with requirements covering both doctoral and masters level One interesting aspect of counselling psychology in Canada arises from the fact that officially the country is bilingual and multicultural, yet the development of counselling psychology appears to have taken somewhat different routes in the French-speaking and English-speaking areas.

According to Brown and Crone (2004) the term 'counselling psychology' was first officially used in discussion at the **Australian** Psychological Society (APS) in 1970. The Division of Counselling Psychologists of the APS was formally established in 1976. In 1983 the division became the Board of Counselling Psychology. The current title, the College of Counselling Psychology, introduced in 1993. and pointing to the growth of private practice. Also, there are only five accredited training courses in counselling psychology throughout the country, all offered by universities. Notwithstanding these factors, counselling psychology as a profession is well recognised in Australia, with work opportunities across a wide range of domains.

The **New Zealand** branch of the BPS was made in 1947 and later the independent New Zealand Psychological Society (NZPsS) was established in 1967, the passing of the Psychologists Act in 1981, and its replacement with the Health Practitioners Competence Assurance Act of 2003. A Division of Counselling Psychology formally came into being in 1985 with an initial membership of 32. The Institute of Counselling Psychology was established at the annual conference of the NZPsS. Currently, the field of counselling psychology in New Zealand continues to expand to become a separate identity and the establishment of a solid training ground.

Counselling psychology in **Hong Kong, China, Korea and Japan** The Hong Kong Psychological Society (HKPS) now has four professional divisions covering the domains of clinical, educational, industrial/organisational, and the most recent one, the Division of Counselling Psychology established in 2006. Due to the relative lack of formal counselling psychology training opportunities in Hong Kong, this

professional group is made up of people who have done a first degree in psychology and then gone on to undertake counselling/therapeutic training

The situation in China is rather different from that in Hong Kong. Since 1978 China has opened its doors to a broader influence in the support of economic development; the influence of counselling psychology theories and practices have some way to go. In China, this helping profession is rooted in the medical model and medical settings. Also practice of psychological therapy e.g. psychoanalysis was carried out by medical doctors in hospitals as The Chinese Association for Mental Health (CAMH), established in 1985, was also composed mainly of medical practitioners. The rapid rate of change since the political shift from agriculture to industry is seen as positive for the growth of counselling psychology in China with the series of workshops in the late 1980s by the German–Chinese Academy of Psychotherapy.

Counselling psychology achieved its independence in 1987 with the establishment of its own division; entitled the Korean Counselling Psychological Association (KCPA).The division publishes the Korean Journal of Counselling and Psychotherapy since 1988. KCPA operates a certification system which demands evidence of high standards of training, practice and supervision and which has also been instrumental in promoting the image of a highly trained, ethical and professional group of practitioners.

Although there has been an influx of ideas derived from the American setting in Japan, there has been no concerted effort to establish a local professional identity.

Counselling psychology has been a recognised and legislated in South Africa since 1974, along with the specialties of clinical, research and industrial psychology. Originally established to report to the Medical and Dental Council, counselling psychology now reports to the Health Professions Council of South Africa (HPCSA), and has its own division within the Psychological Society of South Africa. According to Leach et al. (2003) six out of the 20 universities in South Africa offer training programmes in counselling psychology, three of these combining theoretical teaching relevant to counselling, clinical and educational settings. The profession first emerged in the context of Afrikaner nationalism, reportedly as a contrast to the more English and liberally identified field of clinical psychology, although the psychology profession as a whole was at that time regarded as racist.

Currently, counselling psychologists as a professional group comprise approximately one third of all registered psychologists; the majority of the profession as a whole are white, female and work in private practice. Watson and Fouche (2007) highlight a number of challenges facing the profession in the context of a transformation in South African society, drawing attention to foster more collaborative activities which could meet the needs of the society of which it is a part.

While psychology in India is represented by a number of key professional bodies, including the Indian Association of Clinical Psychologists, there has not been a move to develop a distinct identity for psychologists involved in counselling. A limited number of courses on counselling are on offer, but the quality of training is not monitored for these. There is the need for both western and Indian philosophies and ideas to come together to form theories and approaches that have greater face validity to the Indian population and which therefore might more adequately meet identified needs. For example, Arulmani (2007) draws attention to the fact that traditional Indian psychology, referred to as Mano Vidya, or 'mind knowledge', is recorded in ancient Indian writings documenting the existence of psychological ideas and techniques that 'bear a startling resemblance to ideas put forth by modern Western

psychology and yet predate these efforts by two millennia'. Apparently, there is now some activity in this direction, with the development of psychological inventories that draw on traditional Indian psychology (Wolf, 1998).

While counselling psychology as a specialty in its own right has not flourished in Israel, vocational psychology, as a related field, has been very successful. Activities subsumed under the banner of vocational psychology include career counselling, selection and assessment, and organisational psychology.

Counselling psychology does not exist as a recognised specialty in most of mainland Europe, although there are many psychologists who are working within a practice framework which bears comparisons with what counselling psychologists are doing, for example, in the UK. Although counsellors on the one hand work with the theme of 'accompanying' and 'connection', as a professional group there appears to be no interest in forming professional allegiances or identities. The term 'counselling' does not have a direct equivalent in the French language – the nearest work is 'conseil' which translates as 'advice'. While Rogerian ideas on counselling have found their way into French thinking and practice since the 1970s, the practice is generally regarded as very different from 'psychotherapy.

Although there are postgraduate programmes available for the training of counselling psychologists, there is no professional organisation of the field. Also, there appears to be significant competition from other groups of counsellors who have not come from a psychological background e.g. o career counselling teachers having no specialist training in that field.

The professional title in Germany is 'psychological psychotherapist'. In Germany a four year degree in psychology to masters level is followed by three-years of full-time training in psychotherapy and one full year of practice. The three main modalities covered are described as psychoanalysis, psychotherapy and behaviour therapy although no detail is given as to what is included in the psychotherapy modality.

The Hellenic Psychological Society (HPS) was founded in 1990 in Thessaloniki, with the aim of promoting teaching and research as well as supporting practice across different areas of psychology. HPS has ten divisions including the Division of Counselling Psychology. In Greece the term 'psychologist' and related professional activities are protected by law.

Association of Counselling Psychology was founded in 2006. This association recognises that most European countries do not have a formally recognized specialty in counselling psychology, but that there are many counselling psychologists in different European countries who have trained abroad and returned with that professional identity. The aim of the association is therefore to support the development and application of counselling psychology in Europe, and is likely to provide a forum for professional exchange as well as networking opportunities. The association already has members from Greece, Malta, Ireland, the UK, Italy and Spain.

3.4 COUNSELLING PSYCHOLOGY AND CAREER

Psychology is defined by the American Psychological Association as:

"The study of the mind and behaviour. The discipline embraces all aspects of the human experience — from the functions of the brain to the actions of nations, from child development to care for the aged. In every conceivable setting from scientific

research centers to mental health care services, "the understanding of behavior" is the enterprise of psychologists."

The most recent official definition of counselling is as follows:

Although there are different branches of psychology, counseling psychology and psychotherapy are being used more frequently in person and online by e-mail to address the complex issues that are present in today's world.

'Counselling Psychology is a distinctive profession within psychology with a specialist focus, which links most closely to the allied professions of psychotherapy and counselling. It pays particular attention to the meanings, beliefs, context and processes that are constructed both within and between people and which affect the psychological wellbeing of the person'. (BPS website, 2007)

There is no area where the people are not suffering from any adjustment problems and day to day life stress. The counselling psychologist not only relaxes the person but make the person realise his or her abilities and limitations. Counsellors also train their client to improve the interpersonal relationships through many techniques. They make the client learn the new ways of coping strategies for their problems and growth.The practice of counseling, where one individual seeks guidance from another is an age-old concept and is defined as: "Guidance provided by professional counselors in academic, vocational, and personal matters."

Counselling psychologists, more than clinical psychologists, focus on issues that revolve around family, work and self, such as relationship and development issues, where clinical psychologists focus on mental health issues with more serious implications. A counselling psychologist is in essence a "problem solver." They evaluate role functioning, the possible results and the options available to achieve them. They listen to the problem; analyse it in terms of present events and conscious, rational thinking rather than unconscious motivations.

In the traditional method of counseling, an individual would seek the assistance of a psychologist in person at the office of the therapist. While this method of counseling is still in practice, the advent of the Internet has provided counselling psychologists and other mental health care professionals the means to offer their services online to individuals who may not be able or prefer not to participate in the traditional method of therapy.

To pursue this career, one has to have a genuine interest in people. As a science, it is a systematic approach to the understanding of people and their behaviour. As a profession, it is the application of the understanding of human behaviour to help solve human problems. Since psychology deals with human behaviour, psychologists apply their knowledge and techniques to a wide range of human services, management, education, law and sports. Counseling psychologists do many of the same things that clinical psychologists do. However, counseling psychologists tend to focus more on persons with adjustment problems, rather than on persons suffering from severe psychological disorders. There are some psychologists that hold the opinion that psychotherapy and counselling are not two separate fields of study.('A Guide to Psychology and its Practice' by Raymond Lloyd Richmond).

One can pursue his career by providing on line counselling sessions. Online counselling can help a person cope with life problems that affect men and women of all ages. These can include adjustments to difficult situations such as transitions, changes, loneliness, health conditions, chronic or life threatening illnesses, disability, relationship conflicts, job stresses, mid-life crises, parenting challenges, adoption searches and

reunions, unplanned pregnancies, marital problems, stepfamily or blended family issues, family conflict, weight struggles, anorexia, bulimia, disordered eating, or loss and grief following death, adoption relinquishment, pregnancy loss, separation, or divorce.

E-counselling is convenient and time efficient to sit at the home or office computer and compose an email. It is cost effective, at about half the cost of face to face therapy or counselling. Many individuals who choose e-counselling tend to present dilemmas that require brief solution oriented therapy with about 4-6 sessions to fulfil their needs. A smaller number of people seek ongoing sessions as they grapple with longer term issues.

3.5 E-COUNSELLING: AN INTRODUCTION

E-mail counseling is method of providing advice and guidance on a one-to-one basis from a professional counselor, psychologist or mental health practitioner to an individual privately via electronic mail instead of the traditional format of face-to-face consultation. The types of problems addressed cover the full range of the human experience, in relationship to self and others. In many cases e-mail counseling is supported by self-help behaviour modification exercises.

E-counseling just be a one time consultation or a series of e-mail sessions. It is convenient and time efficient to sit at home or office computer and compose an email. It is cost effective, at about half the cost of face to face therapy or counselling.

When many changes happen together in clusters, the result may be emotional overload. One may feel overwhelmed and need some time to reflect and reorganise one's life.

The privacy and anonymity provided by e-mail may be appealing, disinheriting and comfortable. The internet also breaks down obstacles for those who have challenges accessing resources due to physical disabilities or communication challenges such as hearing impairment, speech or language difficulties. One may live in a remote area where there is little access to qualified professionals for counselling. One of the real values of working online is being enabled to say what one might find difficult to say directly to someone

Some of the reasons for using e-mail counselling as follows:

1) E-mail counseling provides personal space, comfort and safety for individuals who have difficulty discussing their personal problems directly with another person. For some individuals, it is easier to express themselves in writing than face-to-face or on the telephone. E-mail counseling offers a level of personal privacy that goes beyond the capabilities of telephone therapy and face-to-face treatment provides.
2) With e-mail counseling, one can take as much time as he wants to compose his thoughts, reflect on his responses and those of the counselor, responding to them when he is ready. Counselling by e-mail provides an excellent way to track his progress and review past session notes.
3) E-mail or online counseling guidelines are set by professional organisations. The California Board of Behavioural Sciences sets stringent guidelines for licensed professionals and provides information to consumers at their website. (The California Board of Behavioral Sciences)

4) Online or e-mail counselling provides access to individuals who are physically handicapped, or those who will not or cannot access local treatment. People with speaking or hearing disabilities, those with concerns about the opinions of others can avail themselves of therapy.

5) Many misunderstandings and misinterpretations that occur in face-to-face therapy may be minimised using e-mail counseling. (Paul J. Hannig, PH.D. MFCC – Psychotherapy HELP)

Online counselling can be divided into five major categories:

1) Behavioural modification counselling provided by psychologists, psychiatrists and other mental health professionals via video conferencing systems.

2) Mental health advice or information, via e-mail to give specific requested information.

3) Online counselling used in conjunction to face-to-face services.

4) E-therapy: Regular counselling sessions provided online via chat applications or e-mail.

5) Full service counseling and mental health advice online.

The primary benefit of online counselling or e-mail counselling is the fact that the sessions are conducted in the privacy of the individuals' home or office. In addition to e-mail as the medium for counselling, some therapists also use telephone and video conferencing services.

E-mail counselling facilitates personal and interpersonal functioning in different phases of life span with a special emphasis on personal, emotional, social, vocational, educational, health-related and developmental issues

How to start E-Counselling Session

The process of counselling is one of self-discovery and interactive evaluation methods, such as an online relationship quiz and love test (Relationship Quiz and Love Test, by Alina Ruigrok) provide support to their one-on-one counselling by e-mail. Assessment tools such as this test help individuals to gain insight into how their behaviour translates into actions. There are many online therapists and counselors who provide other types of self-help tools in the form of CD ROMs, books and audiovisual exercises. Many therapists provide offline sessions in different formats as an adjunct to e-mail counselling.

The service administrator will ask the client to complete a registration and agreement form, which he can then e-mail back to the counselor. This will include information about the keeping of records and confidentiality arrangements of the Counselling Service. The client will then be informed about when to expect his first e-mail contact with the counselor.

If he feels comfortable to go ahead, a number of e-appointments (e-mail exchanges) will be agreed. Initially this would be up to 5 e-mail exchanges, and these will be at weekly intervals. Extended counseling of up to 10 further e-appointments is possible in some cases, and this will usually involve a waiting period.

Whilst e-mail counselling (e-counselling) can help with a wide range of difficulties, this is not a service for immediate crisis, for people feeling suicidal or with diagnosed mental illness.

There are many online or e-mail counselling services, however as with any medical service, it is important to check the references and be certain of one's payment responsibilities for online or e-mail counseling services.

Face-to-face consultations as video conferencing over the internet via webcams may be available. Some family therapy, couple or parental counselling sessions may take place in the home.

Many, however, were still uncomfortable with videoconferencing, with around 20-30% of participants rating it as not at all or a little helpful compared with face-to-face therapy.

Self Assessment Questions

1) In 1946 the APA give recognition to which branch of psychology?
   a) Personnel and Guidance
   b) Guidance and counselling
   c) Counseling and clinical
   d) None of the above

2) In which year the National Register of Health Service Providers in Psychology focused on the training and accreditation of counselling psychologists in the USA .
   a) In 1994
   b) 1974
   c) 1984
   d) 1966

3) Which is the most recent domain included in four professional divisions of the Hong Kong Psychological Society (HKPS) in 2006?
   a) Clinica
   b) Counselling
   c) Industrial/organisational
   d) Educational

4) The Chinese Association for Mental Health (CAMH), established in 1985, was composed mainly of which professionals.
   a) Medical practitioners
   b) Psychologists
   c) Professional Counselors
   d) Psychotherapists

5) Indian psychology is recorded in ancient Indian writings and documented as what?
   a) Mano Vidya
   b) Manovijyan
   c) Mansik Vikas
   d) None

6) A method of providing advice and guidance on a one-to-one basis from a professional counselor, psychologist or mental health practitioner to an individual privately via electronic mail, is best known as
   a) Face to face video conferencing
   b) E-counselling
   c) Online counselling
   d) Face to face counselling

7) E-counselling is not beneficial for the following.
   a) Computer illiterate
   b) For non verabal cues
   c) Visual cues
   d) All of the above

8) Especifcally Who listens to the problem; analyse it in terms of present events and conscious, rational thinking rather than unconscious motivations?
   a) Any mental health professional
   b) A psychiatrist
   c) A clinical psychologist
   d) A professional counsellor

9) In on line counselling behavioural modification, counselling is provided mostly by which system?
   a) Online individual counselling
   b) Online parental counselling
   c) Role modeling
   d) Video conferencing system

10) Regarding the ethical issue control which statement is not true?
   a) Less stringent ethical guidelines in E-counselling.
   b) Ethical issues can be more contrlled in face to face individual counselling.
   c) There is a more controll of ethical issues in e-counselling.
   d) In terms of takng of consent form and crisis management the e-counselling has brestricted boundaries.

3.6 E-COUNSELLING: BENEFITS AND CHALLENGES

There has been no shortage of benefits and challenges associated with online therapy identified in the literature to date. While limited empirical evidence exists regarding the perceptions of and/or the effects of these benefits and challenges in practice [Abbott, Klein, & Ciechomski (2008); Bischoff (2004); Casey & Halford ; Cavanagh & Shapiro (2004); Griffiths, Farrer, & Christensen (2007); Hunt, Shochet, & King (2005); Pollock (2006); Recupero (2005); Rochlen, Zack, & Speyer (2004); Syme (2004) from www.aifs.gov.au/afrc/pubs]

Benefits

1) Increased accessibility, for example, for rural and remote persons (although limited by bandwidth and availability of carriers), single or at-home parents, people with a disability, in cases of fear of violence or intimidation, people with agoraphobia, people who are relocating but want to work with the same therapist, fast-pace lifestyles, unusual employment hours.
2) Offers solution to shortfall in psychotherapy services.
3) When email is used, the written word may be expressive for some, can think through and reflect on content before sending.
4) Anonymity, privacy, convenience, often in comfort of own home.
5) Disinhibition and internalisation, that is, core issues addressed more quickly, matters expressed more freely.
6) Enhanced self-reflection, in the case of asynchronous communication. Can revisit treatment communications from therapists in own time.
7) Therapists can respond to specialist areas of concern, regardless of geographical location.
8) Available any time of day (where service models permit).
9) May be particularly viable for computer-savy young people and children.
10) Allows clinician time to be freed up for others and reduces the number of face-to-face sessions.
11) Increased flexibility of services.
12) Affordability.

Challenges

1) Practical and technical concerns, for example, skills deficiencies, computer illiteracy. Older people and those from a different cultural background may feel less comfortable.
2) Lack of visual cues, non-verbal cues, and misunderstandings arising from this. Not able to observe how couples or family members interact.
3) Time delays between contact and response in asynchronous communication.
4) Diminished capacity to deal with any crises.
5) Verifying credentials of therapist, verifying that therapist and/or client is the person online.
6) Technical failures, limited access to communications infrastructure, unreliable bandwidth connections.
7) Security risks - email misdirected through error in address, intercepted by hackers, computer programming errors.
8) Client may expect services to be free.
9) Legal and ethical issues, including confidentiality, privacy.
10) Lack of therapist training.

3.7 ETHICAL ISSUES IN E-COUNSELLING

Many ethical issues associated with the delivery of online therapy are noted in the literature. Issues are often similar to face-to-face therapy, but may be considered more difficult to address due to the nature of the online environment. Some authors, however, draw attention to the specific characteristics of the online environment that make it a safer alternative than face-to-face.

There is some concern that the unrestricted nature of the online environment is allowing therapists to operate under less stringent ethical guidelines than face-to-face therapy. For example, in the review of e-therapy websites conducted (Santhiveeran, 2009), few websites discussed limits to confidentiality, and only 12% of sites promoted how treatment records are maintained.

It is considered vital to give enough information so that consumers can provide informed consent to take part in online therapy (Abbott et al., 2008), including a standardised list of risks and benefits included in consent forms (Ybarra & Eaton, 2005)

Shearsby (2009) pointed out that mediums such as Facebook, with the ability to search for and invite other users to be “friends”, are uncharted territory for health professionals and may have implications for clients, for example, those who are marginalised or isolated.

Families experiencing difficult communication between members may also find Internet or e-mail communication a less threatening way to reconnect than telephone or face-to-face meetings (King et al., 1998).

Online dispute resolution is used to resolve varying disputes, such as family, workplace, e-commerce, insurance and political conflict (Conley Tyler & Raines, 2006), yet very little research has occurred so far which has examined its efficacy, and less still that is specific to its application to family dispute resolution (Raines, 2006).

May 2007. Katherine Graham, director of Resolution Online, reported that as yet no evaluation has occurred, but the business has grown considerably. Once couples are engaged and on board with the process, the sessions work as effectively as face-to-face and are particularly suitable for removing the emotion from a situation, and for relationships with a history of violence. The differing locations of parties is the main reason given for engaging with Resolution Online, and assessing parties' ability to use the online medium is considered important. A formal evaluation is planned for the future (K. Graham, personal communication, 17 March 2009).

3.8 LET US SUM UP

It is difficult to say that online counselling is more beneficial than face to face individual counselling. But as in today's world every person is busy and can not take time to resolve the emotional issues, e-counselling would be a demand after some time. But whether there is individual face to face counselling or e-counselling it should be taken by the trained professionals. The client should get benefited by it and in all counselling session ethical issues should also be taken care of.

3.9 UNIT END QUETIONS

1) Write down in short the development of counselling psychology in different countries?
2) Highlight the various scopes to make career in Counselling Psychology field.
3) What are the application of counselling psychology in different aspects of life and why?
4) What do you understand by E-counselling? What are the benefits and challenges of it?
5) What could be the ethical issues related to E-counselling and how it is different from face to face individual counselling?

3.10 SUGGESTED READINGS

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3.11 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) a), 2) b), 3) b), 4) a), 5) a), 6) b), 7) d), 8) d), 9) d), 10) c).

UNIT 4 RESEARCH FINDINGS

Structure

4.0 INTRODUCTION

According to John McLeod, 2003 research is a systematic process of critical inquiry leading to valid propositions and conclusions that are communicated to interested others.

In counselling research very few researches are empirical or based on scientific facts. Actually counselling is an art to deal with the individuals on one hand. On other hand it is a science also as counselor applies techniques in a controlled way and he is much trained to control and modulate a person's emotion, thought and behaviour. Although tools are not like parameters of medical science, but they are standardised and findings are inferred according to the norms. The criteria of emotional and mental problems are universally established, valid and reliable. This field looks very much subjective but the approach, the way by which the counselor deals with the client is every minute exploratory and challenging. It is hard to make the person change his own thoughts, behaviour or personality or way of dealing with interpersonal relationships. A professional counselor needs lots of training to deal effectively with the problems of the client.

4.1 OBJECTIVES

After reading this unit you will be able to:

- Describe the association of basic researches done earlier with the recent researches in the field of counselling;
- Discuss counselling researches as basically based on single case based follow up researches;
- Explain the pre and post evaluation experiment researches, outcome researches have also been done in this area;
- Define e-counselling is the leading area of research; and
- Elucidate the ethical issues related to the counselling researches to be taken care in future.

4.2 THE LEADING COUNSELLING RESEARCH APPROACH

In some way or other there is found connections between recent researches and the earlier researches.

The recent researches based on the experience of the client (e.g. Rennie, 1990) have similar approach to client-centered research carried out in the 1940s (e.g. Lipkin 1948). Similarly, current research into 'non-specific' or general characteristics (Grencavage and Norcross, 1990) can be traced back to Fiedler (1950) and Watson (1940). The explosion of studies of outcome and effectiveness that occurred in the 1960s and 1970s had its precursor in the 1940s (Eysenck 1952). Contemporary attention to the problems of intensive case-study methodology (Hilliard, 1993; Jones, 1993) represents a fascinating recapitulation of the dilemmas and challenges confronted by Henry Murray and his colleagues in the 1920s and 1930s (Murray, 1938).

The concept of 'non-defectiveness' that informed much of the early client-centered research has become replaced by ideas such as therapist 'reflection' in more recent studies. Research into the Rogerian 'necessary and sufficient' conditions of empathy, acceptance and congruence has for the most part been recast as the study of the 'therapeutic alliance'.

Malan (1973) surveys the history of psychodynamic research. Lietaer (1990) examines the history of c1ientcentred research. Treacher (1983) looks at the field from a politically informed radical perspective. Hill and Corbett (1993) approach the evolution of therapy.

The core assumptions and techniques characteristic of psychoanalysis were described by Freud in cases such as Dora (Freud, 1901/1979), the Rat Man (Freud, 1909/1979) and Schreber (Freud, 1910/1970). The founder of behaviourism, J.B. Watson, illustrated the applicability of behavioural concepts to problems of emotional disturbance through his famous study of Little Albert. Carl Rogers (1942, 1951) included several cases in *Counselling and Psychotherapy* and *Client-Centered Therapy*, the key books that defined the nature of the client-centred approach to counselling. The tradition of using case studies as a teaching tool is also apparent in the collections of cases brought together by Wedding and Corsini (1979), Kutash and Wolf (1986) and Dryden (1987) and in the widespread use of filmed sessions such as the famous 'Gloria' tapes.

4.3 SYSTEMATIC CASE STUDY RESEARCH

A key stage in the acceptance of case study methods was the publication in 1980 of a series of case studies by Hans Strupp (1980). Then a detailed analysis of a single case carried out by Hill, Carter and O'Farrell (1983a) was done. This was the first case study to be published in the *Journal of Counselling Psychology,* together with commentary pieces (Hill et al., 1983b; Howard, 1983; Lambert, 1983). The appearance of the Hill et al. (1983a) paper in a journal that had previously specialised in large-scale, 'extensive' rather than 'intensive' studies represented a breakthrough in legitimacy for this approach. The special section of the *Journal of Consulting and Clinical Psychology* devoted to single-case research in psychotherapy (Jones, 1993). More recently, the development of the 'assimilation model' of client change has largely relied on testing and elaboration of the model in the context of a series of case studies (e.g. Honos-Webb et aI., 1998, 1999).

Systematic case study research represents the best way of constructing a knowledge base that is relevant to practice. The issues involved in developing an appropriate methodology for single-case research in counselling and psychotherapy have been explored by Edwards (1998), Elliott (2001, 2002) and Schneider (1999).

4.3.1 Qualitative Single Case Study Research in Counselling

A qualitative research in this area is based on the experiences of the clients and these are descriptive by nature. Some of the procedures used for gathering this kind of material include recording therapy sessions, stimulated recall of sessions, interviews, diaries or journals, open-ended questionnaires, projective techniques, and observation of meetings. A set of narrative case studies that has been widely read is the *Love's Executioner* collection by Irvin Valom (1989). These case studies are characteristic of the case report written by a counsellor or therapist based on work with one of his or her own clients. Bolgar (1965) reviews the history and use of this type of clinical case study in therapy research. There is some research evidence to support the idea that counsellors and clients can sometimes diverge greatly in their interpretation of events (Kaschak, 1978; Mintz et al.).

Mearns and Thorne (1988), Dryden and Yankura (1992) and Yalom and Elkin (1974) have each produced case studies that are collaborations between counsellor and client. Dryden and Yankura (1992) and Mearns and Thorne (1988) both taped counselling sessions, and reviewed these tapes with the clients some months after the end of counselling. The participants in Yalom and Elkin (1974) kept diaries, and used these to stimulate their memories of the therapy process. However no systematic methods of qualitative analysis to interpret or check the data have been applied in these researches.

A more systematic narrative case study is the investigation by Etherington (2000) into the experiences of two male clients who had been sexually abused. This case report draws on a range of analytic strategies drawn from contemporary qualitative research. Other examples of narrative case studies can be found in McLeod and Lynch (2000) and McLeod and Balamoutsou (2000, 2001).

One of the central methodological issues in narrative case study research arises from the realisation that it is always possible to generate alternative interpretations of a life or case. The debate over the case of Schreber (Freud, 1910/ 1979) presents a dramatic example of the radically different interpretations of a case, Schreber, an

eminent German judge developed paranoid schizophrenia in later life. Freud used the evidence of this case in the construction of his theory of the origins of paranoia in repressed homosexuality.

Schatzman (1973), drawing on historical work by Niederland (1959), presented an alternative interpretation of the case, viewing the apparent delusions of Schreber as frustrated attempts to communicate about the extreme abuse he had received in early childhood. Another example can be found in the analysis by Runyan (1981) of 'Why did Van Gogh cut off his ear?' In a review of biographical writing on Van Gogh, Runyan (1981) found 13 competing, but plausible, psychological explanations for this *event* in the life of the artist.

Bromley (1981, 1986) suggests that researchers carrying out case studies should apply a 'quasi judicial' approach, for example seeking out alternative views on the data, or appointing an 'adversary' to the research team. Murray (1938) used a 'diagnostic council' (McLeod, 1992) of five or six researchers who met to consider different perspectives on a case. DeWaele and Harri (1976) have described a model for research in which two research teams study each case in parallel, coming together at regular intervals to compare findings. Bromley (1986) takes the *view* that the field of case study research must create a set of rules and 'case law' that can be applied in deciding the validity of competing explanations of a case. Murray and Morgan (1945) and DeWaele and Harri (1976) propose that competing interpretations can be used in generating hypotheses that guide a further cycle of inquiry and data-gathering. Mearns and McLeod (1984) argue that in some instances alternative interpretations represent different 'realities' that cannot be reconciled, and that these different viewpoints should all be respected in a research report. Within social psychology and psychoanalysis, there have been psychobiographical or psycho historical studies of famous people such as Luther, Gandhi, Lincoln, Shakespeare and many others. The book by Runyan (1981b) represents an excellent review of this field of study. The Narrative Study of Lives series, edited by Lieblich and Josselson (1997) and McAdams, Josselson and Lieblich (2001) provide excellent examples of the type of narrative case study research which has the potential to be highly relevant in the domain of counselling and psychotherapy.

4.3.2 Single Case Experiments

The method known as the 'n = l' or 'single-subject' study represents an application of the case study approach to evaluating therapeutic change in individual cases. Hilliard (1993) uses the term 'single-case experiment' to describe this type of research, since it employs the classic experimental principle of testing a hypothesis. This type of case study is usually based on the administration of a standard test or behavioural assessment on a number of occasions: before, during and after the treatment. The pre-treatment assessments constitute a 'baseline' measure of the target behaviour which it is wished to change. The on-going assessments carried out during treatment display the actual effect of the intervention, while the post-therapy or follow-up assessments give a measure of the stability or permanence of change. This kind of research design is known as 'time-series' analysis, and its simplest form is the 'AB' time series, where A is the pre-treatment baseline and B is the treatment period.

An example of an AB time-series case study is the report by Viens and Hranchuk (1992) on their work with a client with a severe eating disorder. The client was a woman of 35 who presented with a problem of vomiting after eating most types of food. In the past she had been severely obese, and had undergone two surgical

operations to remove part of her stomach and abdominal fatty tissue. After these operations her weight dropped considerably, but her pattern of binge eating continued. To maintain her weight, the client began to voluntarily vomit her food. Over time, this vomiting became an involuntary response over which the client had no control. On being accepted for treatment, the client was instructed to self-monitor her behaviour for a period of three weeks. She was required to write down what she ate, how many mouthfuls she took per meal, and how many times she vomited her food during or after each meal. On the basis of this baseline information, a behavioural programme was initiated which included continuing to record eating behaviour, beginning a physical activity schedule, regular weighing, practising pacing and relaxation techniques while eating, and reporting progress at weekly therapy sessions.

The Viens and Hranchuk (1992) paper also includes a descriptive account of the progress of therapy with this client, and this combination of quantitative and qualitative information can allow a broader consideration of the meaning of the results. For example, Viens and Hranchuk (1992) observed that the increase in vomiting between weeks 13 and 17 coincided with the absence of the therapist, while the sudden improvement around week 3 coincided with the introduction of some adjustments to the behavioural programme.

Houghton (1991), for example, has published a case study of a cognitive intervention carried out with an Olympic archer who experienced performance related anxiety in competitive situations. Houghton (1991) was able to graph the actual tournament scores achieved by the client before and after treatment. This type of objective data can provide highly convincing evidence for the effectiveness of a therapeutic technique.

McCann (1992) describes the use of the behavioural technique of eye movement desensitisation (EMO) in a case of Post-Traumatic Stress Disorder (PTSD). The client in this case was a man who had, eight years previously, survived burn injuries at work which had left him seriously disabled. The client reported that he 'still lived daily with the traumatic experience of being burned', through nightmares, flashbacks, insomnia, startle responses and avoidance behaviour. During one session, the use of eye movement desensitisation enabled the client to release these intrusive memories and images. At one-year follow-up, the PTSD symptoms had not returned.

Herbert and Mueser (1992), however, have pointed out that absence of standardised assessments and measures in studies of EMD make it difficult to evaluate its overall effectiveness. 1.

N = 1 researchers have devised some important adaptations of this method. The first is the ABAB design, in which there is a baseline period (A), followed by intervention (B), followed by another baseline period produced by withdrawal of the intervention (A), and finally a re-introduction of the intervention (B). In practice, most ABAB studies have been carried out in institutional rather than counselling settings (Heppner et aI., 1999; Peck, 1989), with clients

Some researchers have advocated the use of 'randomized' AB designs, in which an intervention is applied or not in different sessions at random (Heppner et al.,1999). Another variant on the time series method is known as the 'multiple baseline' study. In this form of n = 1 case study, the impact of an intervention is traced through its application to a series of problems reported by one client.

4.3.3 Single-Case Quantitative Studies

In single-case quantitative analysis (Hilliard, 1993) the aim is to use quantitative techniques to trace the unfolding over time of variables, but without, as in n = 1

single-case experiments, introducing any experimental manipulation or control of these variables.

An example of this type of research is the Hill et al. (1983) study of process and outcome in a client who received 12 sessions of time-limited insight-oriented psychological counselling. The outcome was assessed by a set of standard measures. The client and a significant other (her mother) both wrote summaries of their perceptions of the value of the counselling. Process measures included ratings of counselor and client verbal response modes, anxiety as expressed in client and counselor speech patterns, activity levels (number of speech acts) of both participants, counselor intentions, and counselor and client perceptions of session effectiveness and significant events. Best versus worst sessions were compared.

4.3.4 Combined Quantitative and Qualitative Case Studies

The final approach to case study method identified by Hilliard (1993) refers to studies combining quantitative and qualitative techniques of data-gathering and analysis within one study.

The originator of this approach to case study methodology was Henry Murray, whose 1938 book Explorations in Personality remains a landmark in the field of personality research.

Murray (1938) developed a process by which the key researchers working on a case would meet as a 'diagnostic council' (McLeod, 1992) to arrive at an agreed formulation of a case. The general approach to case study methodology pioneered by Murray is also reflected in the work of DeWaele and Harri (1976) and Bromley (1981, 1986).

It is often difficult to gather together a team of researchers all interested in collaborating on the same case. There can also be difficulties in finding research subjects or participants who are willing to spend many hours providing information about themselves.

Qualitative/Hermeneutic Single-Case Efficacy Studies

The approaches to case study research have been integrated into a coherent qualitative/hermeneutic single-case methodology by Bohart (2000), Elliott (2001, 2002) and Partyka et al. (2002). The primary aim of this type of case study is to investigate the effectiveness of therapy through analysis of a series of case studies.

Bohart (2000) and Elliott (2001, 2002) recommend the use of a research team. Once the data set is gathered together, members of the team analyse it in the light of a set of 'plausibility criteria'. These criteria operate as a kind of 'case law', by giving explicit rules for arriving at an agreed interpretation of evidence. One group of researchers seeks to assemble all the information that it can in support of the case that therapy has been effective and other speaks against it. The two teams then go through the arguments until a consensus can be reached.

This methodology is similar both to the approach developed by Henry Murray in the 1930s and to the method of consensual qualitative research used by Clara Hill and her associates (Hill et al., 1997).

Several strategies can be employed to address the issue of *generalisability* in case studies (Kazdin, 1981; Vin, 1994). No single experiment or survey provides conclusive evidence taken alone. It is only when a number of studies produce similar results. The concept of *replication* implies that each case must be seen as equivalent to a separate experiment or survey.

The logic of sampling is virtually impossible to achieve in case study research, because of the time and resources required to obtain case data of sufficient quality. The logic of replication, on the other hand, is central to systematic case study research. Ideally, the conceptual model generated in the first case study is tested in the second and subsequent studies. The series of case studies carried out by Strupp (1980) illustrate the use of the theoretically important concepts of success and failure to guide the selection of cases for replication. Yin (1994) gives other examples of this approach. The most ambitious attempt to carry out theoretical replication is the study by Murray (1938), in which a series of 50 cases was used in the development of an influential theory of personality.

Logically, a single instance or event can be enough to refute a general theory. For example, a theory such as 'all crows are black' will be refuted by a sighting of only one white crow.

A further critical issue in case study research arises from the communicability of case material. Often, researchers gather more case material than they know how to handle, and produce reports that are lengthy and impenetratable.

Case study research produces detailed accounts of individual cases that can be useful for practitioners. It is also a mode of research that enables practitioners to make a contribution to the research literature. It would seem reasonable to suggest that counselling and psychotherapy research is about to see a period of innovation and discovery in relation to the utilisation of systematic case study methods.

4.4 OUTCOME STUDIES

4.4.1 Types of Outcome Studies

1) **Client satisfaction studies:** A client satisfaction study *evaluates* the benefits of counselling by asking clients to complete a short, simple questionnaire once they have finished seeing their counsellor. The influential paper by Seligman (1995) illustrates an interesting application of satisfaction research methods, in the form of a client survey carried out by a consumer organisation in the USA. More detailed accounts can be found in Attkisson and Greenfield (1994), Berger (1983), Lebow (1982) and Webb (1993).

2) **Randomised controlled trials:** A randomised trial involves first of all finding a pool of people who are all seeking help and who have a similar problem (e.g. as diagnosed through a psychiatric interview or through their scores on a questionnaire). These clients are then randomly assigned to different 'treatment conditions' (as in the Sloane et aI., 1975 study). These conditions may comprise two or three different kinds of therapy, or a therapy compared with a control condition (e.g. remaining on a waiting list for six months) or a comparison with a placebo condition (e.g. being given regular meetings with a helper who does not use actual therapeutic skills or interventions). The client's level of anxiety, depression, phobias or other problems are assessed before therapy, at the end of therapy and then again at a follow-up period. Randomised controlled trials are widely used in medicine, for example in trials of the effectiveness of new drug treatments.

3) **Naturalistic outcome studies:** This kind of study is similar to a client satisfaction study in so far as it involves collecting data on every client who is seen in a clinic or counselling agency. In it before and after measures of change are taken, rather than relying on a one-shot questionnaire completed only at the end of counselling. Naturalistic outcomes are basically built around routine

administration of questionnaires or other data collection methods (e.g. target complaint forms) by the staff of counselling agencies. Naturalistic studies cost a lot less to set up and provide a picture of therapy as it is practised in real-life conditions, rather than in the somewhat artifical conditions of a 'trial'.

4) **Qualitative outcome studies:** Another way of evaluating outcome is to carry out qualitative, open-ended interviews with clients. Perhaps it has not been used any great extent in counselling research, probably due to the domination of quantitative, statistical methods in the outcomes literature. The use of qualitative methods in outcome research is explored in McLeod (2000, 2001).

4.4.2 Use of Tools

A completely different approach to demonstrating change in outcome studies involves using well-validated standardised scales, and arguing that the therapy being evaluated can be shown to be effective if the test scores recorded by clients move from the symptomatic range before therapy into the normal, asymptomatic range following treatment. An example of this type of study is the Barkham and Shapiro (1990) investigation of the outcome of very brief (threesession) therapy with moderately depressed white-collar workers. In this study, the criterion for success was that, over the course of treatment, a client would improve at least one standard deviation below the mean of scores obtained in pre-therapy administration of the test (in this case the Beck Depression Inventory or BDl). Being able to show that clients move from 'distressed' to 'normal' is a powerful demonstration of the effectiveness of a form of counselling or psychotherapy.

Tests such as the CORE, the Outcome Questionnaire (OQ), Beck Depression Inventory (BDI), Hopkins Symptom Checklist (SCL-90) and Minnesota Multiphasic Personality Inventory (MMPI) have been widely employed in outcome studies to provide an assessment of personality functioning and adjustment before and after therapy, and at follow-up.

An alternative approach, developed by Cheyne and Kinn (2001a, 2001b), has been to train the counsellor to administer a specially designed 'quality of life' tool within actual counselling sessions.

4.4.3 Control Groups

The control group formats has its distinctive advantages and disadvantages. DiMascio et al. (1979), for example, wished to study the effects of psychotherapy with acutely depressed clients, but were concerned about the ethical implications of denying help to research participants allocated to a control condition. They described it as non-scheduled treatment control, in which control group clients were told that many people spontaneously recovered from depression that they could enter therapy whenever they wished, and that they would be regularly re-assessed by an independent clinical evaluator to see if they needed immediate treatment. Under these very carefully planned conditions, only 33 per cent of the control clients remained in the control group at the end of the planned 16-week waiting period. It was highly respectful and caring in terms of responding ethically to the needs of clients, although not much scientific.

4.5 E-COUNSELLING RESEARCHES

Barak et al. (2008) concluded that online therapy was particularly effective for treating anxiety and stress, with lasting effects, and on average is as effective as face-to-face interventions. Individual online treatment was found to be more effective than group

therapy, chat or email more effective than forums or webcam, and there were no significant differences found between synchronous and asynchronous forms of communication. Closed access websites (require screening and personal authorization to enter the site) were more effective than open sites (anyone can use), which again highlights the importance of screening and assessment.

In a meta-analysis that examined randomized-control trials of Internet-based cognitive-behaviour therapy programs for depression and anxiety, Spek et al. (2006) found that treatment programs were largely effective. They suggested that the type of problem (symptoms of anxiety or depression) was less important than whether or not therapist support was available (e.g., monitoring, feedback or brief weekly phone calls).

Promising Australian research also indicates that online interventions for depression may be effective. Two programs, MoodGym and Blue Pages have been associated with improvements in mental health and knowledge and attitudes towards depression (Griffiths & Christensen, 2007; Mackinnon, Griffiths, & Christensen, 2008). Mackinnon et al. (2008) found that benefits remained for both groups of participants allocated to MoodGym and Blue Pages compared to the control group at a 12-month follow-up. Interventions based on cognitive-behaviour therapy appear to be particularly suited to online delivery, as it is a structured treatment approach (Barak et al., 2008; Spek et al., 2006).

Studies indicate that many clients and therapists hold positive views towards online therapy (Cavanagh & Shapiro, 2004; Skinner & Latchford, 2006) and are willing to contemplate its use (Skinner & Latchford, 2006).

The application of use of telecommunications to marriage and family counselling does exist (Hines, 1994; Pollock, 2006). King et al. (1998) suggested that the asynchronous nature of email allows family members to read and respond at a time that is suitable to them, and they can delay a response while they consider the contents of the communication.

The main challenges raised in the literature that are related to online family therapy or counselling centre on the lack of non-verbal cues (Gilkey et al., 2009; Jencius & Sager, 2001) and an inability to witness interactions (Pollock, 2006). The discouragement of impulsive, hostile or negative comments without a cooling-off period, for example, recognises and draws attention to the permanency of email records (King et al., 1998).

Syme (2004) suggested that the loss of information in telecommunications, in the case of online dispute resolution, may have an impact on issues such as trust. Online dispute resolution, however, may be appropriate where interpersonal dynamics are destructive - for example, where conflict, violence or abuse, confinement or imprisonment are involved (Conley Tyler & McPherson, 2006).Clients have breathing space in high emotional or distressing moments (Conley Tyler & McPherson, 2006).

Gilkey, Carey, and Wade (2009) found that computer literacy was not a consistent factor in reported comfort or ability to benefit from the videoconferencing therapy program under study.

Conferencing facilities have been used in family work. Within their clinical mental health practice, Looi and Raphael (2007) noted that teleconferencing has been a useful and well-received intervention to involve geographically separated family members in care plans. Gilkey et al. (2009) reported on the use of videoconferencing in family therapy for families of children with a traumatic brain injury.

Videoconferencing sessions were well received by participants, with 90% rating the website accompanying the sessions and 88% rating the videoconferencing itself as moderately to extremely helpful.

There are lingering questions regarding the right mix of online programs and face-to-face therapy, how it is best delivered and under what circumstances people will benefit (or not) (Cavanagh & Shapiro, 2004; Griffiths et al., 2007; Mackinnon et al., 2008) and how to effectively integrate online therapy with other models of care (Cavanagh & Shapiro, 2004). In the case of online dispute resolution, these considerations are in their infancy.

Several studies suggest a need for training for staff that is specific to the use of information technology in therapy (Gilkey et al., 2009; Proudfoot, 2004; Rochlen et al., 2004; Santhiveeran, 2009; Ybarra & Eaton, 2005).

Griffiths and Christensen (2007) reported a high level of use by rural users of MoodGym (a cognitive-behavioural therapy Internet intervention) and Blue Pages (a depression information website), Hand, Chung, and Peters (2009) recognised the positive potential of the Internet, if safety procedures are in place, for women who are seeking help regarding domestic violence and feel ashamed or need to find ways that will not alert the perpetrator to their accessing help. Hand et al. (2009) also pointed out the possible use of the Internet as an anonymous and private way for perpetrators of violence to seek help.

Marginalised people may be less likely to use online therapy, for example, refugees, culturally and linguistically diverse people, and those with no access to the Internet (Hand et al., 2009). In discussing online dispute resolution, Primerano (2004) drew attention to the fact that it may be particularly complicated for the culturally and linguistically diverse population, as there may be written language literacy as well as computer literacy issues.

As would be expected, people familiar with the online environment are more likely to use online counselling (Liebert, Archer, Munson, & York 2006). In a comparison of users of face-to-face therapy and Internet support groups by Skinner and Latchford (2006), the users of Internet support groups were more likely to think that computer-based communication with a therapist would have a positive impact on their mental health.

Abbott et al. (2008) reported that in early trials of Panic Online, an online treatment program, some participants lacked IT skills and hence had difficulties. Data from the Australian Bureau of Statistics (ABS, 2006) appears to support this assertion, with 93% of 15-17 year olds and 85% of 18-24 year olds reporting Internet use compared to 54% of 55-64 year olds and only 19% of those aged 65 years and over.

Abbott et al. (2008) in their clinical and research work at Swinburne University of Technology eTherapy Unit, found that therapeutic alliance was not compromised, and in fact proposed that online therapy allows greater contact with the therapist than face-to-face, increasing continuity of care. The absence of a face-to-face therapeutic relationship may be part of the attraction to online therapy for some individuals, for example, those with an avoidant personality (K. Halford, personal communication, 23 July, 2009).

Gilkey et al. (2009) noted that the loss of nonverbal information can be offset by the increased comfort that participants felt due to being in their own homes. In the case of videoconferencing, this comfort may also bring about family patterns of interaction that would not otherwise be seen.

In the e-therapy unit at Swinburne, it is mandatory to have contact details of the client and their general practitioners (Abbott et al., 2008). Pollock (2006) suggested counselors have client contact information as well as an email address, the name of a counselor in the geographical area in case of emergencies, and emergency contact details.

Comparisons of costs associated with online and face-to-face therapy are not clear-cut. Costs may also be shifted, for example, a videoconference can reduce travel costs for clients but increase overhead costs for the practitioner (Syme, 2004).

Therapists potentially serve more clients on a daily basis, reducing overall costs and cutting waiting time due to the decreased demand on therapist time (Proudfoot, 2004).

Self Assessment Questions

1) The the first case study to be published in the Journal of Counselling Psychology by whom?
   a) Treacher (1983) b) Kazdin (1981)
   c) Hill, Carter and O'Farrell (1983) d) None of the above

2) Rogerian 'necessary and sufficient' conditions of empathy, acceptance and congruence has for the most part been recast as the study of what?
   a) Therapeutic condition b) Therapeutic alliance
   c) Direct approach d) Non direct Approch

3) The detailed analysis of individual cases yields information that is immediately applicable to the counselling relationship is known as
   a) Systematic case study b) Single client study
   c) Quantitative case study d) All of the above

4) The method known as the 'n = l' or 'single-subject' study represents an application of the case study approach to evaluating therapeutic change in individual cases, is known as?
   a) Single case experiment b) Follow up study
   c) Single case study d) Qualitative case research

5) Evaluation of therapeutic change in individual cases is also known as?
   a) AB time series case study b) Single case experiment
   c) n = 1 single case study d) All of the above

6) The research which deals with the participants having same problems and getting different treatment strategy, known as:
   a) Randomised control trial b) Naturalistic outcome study
   c) Qualitative out come study d) None of the above

7) To rely on the fact that participants have been fully informed about research procedures and the risks entailed, what is to be taken?
   a) Confidentially b) Agreement
   c) Informed content d) None of the above

8) Which concept emphasises that each case must be seen as equivalent to a separate experiment or survey.
   a) Replication b) Generalisability
   c) Case Law d) Communicability

9) Who concluded that online therapy was particularly effective for treating anxiety and stress?

a) Abbott et al., 2008
b) Mackinnon et al. (2008)
c) Barak et al. (2008)
d) Hand et al. (2009)

10) What was established in the late-1990s, to promote the use of online technologies among mental health professionals?

a) A Society of Online mental health
b) Mental Heath Online
c) The International Society of Mental Health Online
d) None of the above

4.6 ETHICAL ISSUES IN COUNSELLING RESEARCH

In much of the discussion of ethical dimensions of applied disciplines such as medicine, education and counselling, writers have tended to focus on the implications of a small set of basic ethical principles (Beauchamp and Childress, 1979; Kitchener, 1984). These are: *beneficence* (acting to enhance client well-being), non *maleficence* (avoiding doing harm to clients), *autonomy* (respecting the right of the person to take responsibility for himself or herself), and *fidelity* (treating everyone in a fair and just manner).

There is a wide range of ethical issues associated with counselling research. Some of the more frequent dilemmas are: (John McLeod; 2003).

- studying experimental or innovative treatments that may cause harm to clients;
- excluding people from therapy unless they take part in a research study;
- compromising the confidentiality of the client-counselor relationship by making recordings of sessions that may subsequently be heard by several members of a research team;
- research interviews or questionnaires triggering off painful material for clients;
- counsellors in research studies feeling self-conscious or anxious and as a result not functioning at their best for clients;
- using archival information about clients (e.g. case records) without their consent;
- unconsciously manipulating therapy process or content to produce results that conform to a research hypothesis;
- the possibility of coercion arising from asking a current client to take part in a research study conducted by their therapist.

4.6.1 Informed Consent

The most important strategy to deal with ethical dilemmas is to rely on the fact that participants have been fully informed about research procedures, and the risks entailed, and therefore take personal responsibility for any negative consequences of participation. In many research studies participants are required to read and sign a consent form, which would usually include the following: (John McLeod; 2003).

- name, address and contact number of the person carrying out the study (if appropriate, the name of the research supervisor may be included);
- a description of the aims of the study;
- information about procedures, and what will be demanded of the participant;
- description of any potential risks to the participant;
- account of measures that will be taken to ensure confidentiality;
- information about what will be done with the data;
- statement about the right to withdraw from the study at any time;
- the name, address and contact number of the person or professional association to whom the research participant could make a complaint if necessary;
- information about the arrangements for de-briefing at the end of the study.

Participants would routinely be given their own copy of this contract to keep, after it had been signed by both parties.

4.6.2 Ensuring Confidentiality

A basic necessity in all research is to disconnect information about client identity. It is important that research data is identified only by a neutral code number, with the key to the code, along with biographical information about research informants, stored in a secure place. Other techniques for safeguarding confidentiality include:

- Remembering to lock rooms that contain research data;
- Checking that research assistants or technicians understand the importance of confidentiality;
- Destroying notes and tapes after the completion of a study, or offering to return tapes to informants;
- Omitting information from a report if it will compromise the identity of an informant.

If the research participant can see that the researcher is doing everything possible to protect confidentiality, then he or she will be more willing to be open, honest and forthcoming in the information that he or she discloses.

Many studies highlight confidentiality as a major issue related to online therapy (Chester & Glass, 2006; Hunt et al., 2005; Pollock, 2006). Santhiveeran (2004) discussed issues such as validating the identity of clients, the possibility that anyone accessing a computer could access and print messages, and the fact that backup systems are logically inconsistent with the permanent deletion of communication from computers. Chester and Glass (2006), however, pointed out that there is no situation that is risk-free - in face-to-face therapy, filing cabinets may be left unlocked or walls may be thin. In fact, online communication has particular safeguards that can be used, for example, email interception security risks can be virtually eliminated by the use of encryption (Chester & Glass, 2006; Santhiveeran, 2004).

The International Society of Mental Health Online was established in the late-1990s, to promote the use of online technologies among mental health professionals (Chester & Glass, 2006). Around this time, guidelines were also established regarding ethical online counselling, such as those created by the American Psychological Association in 1997, American Counselling Association in 1999 and, in 2005, the British Association of Counselling and Psychotherapy. The Australian Psychological Society published similar guidelines in 2004, which are available for members only.

4.7 LET US SUM UP

Counselling a person is itself difficult and needs lots of training. Doing research in the area of counselling, measuring and recording the behavior of the client is not an easy task. The researcher faces lots of ethical and confidentiality issues. Researcher maintains the objectivity of the study on one hand. On other hand he has to deal with the client in a therapeutic alliance, not technically.

Some practitioners may place high value on face-to-face, interpersonal communication, whereas others, particularly related to online dispute resolution, are anxious about witnessing displays of emotion and prefer the more structured online environment (Conley Tyler & McPherson, 2006; Syme, 2004).

4.8 UNIT END QUESTIONS

1) What do you understand by systematic case research? What are different types of it?
2) What is the difference between a qualitative and quantitative case research? How a combined report can be more scientific?
3) Discuss e-counselling researches in brief?
4) Discuss the different types of outcome researches.
5) Give ethical issues related to counselling researches?

4.9 SUGGESTED READINGS

John McLeod (2003). *Doing Counselling Research*. Sage Publication, New Delhi, 1-9.

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4.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

1) c), 2) b), 3) a), 4) a), 5) d), 6) a), 7) c), 8) a), 9) c), 10) c).