



ALAGAPPA UNIVERSITY

(Accredited with 'A+' Grade by NAAC (with CGPA: 3.64) in the Third Cycle and
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(A State University Established by the Government of Tamilnadu)



KARAIKUDI – 630 003

DIRECTORATE OF DISTANCE EDUCATION

M.Sc. PSYCHOLOGY

Second Year – Third Semester

36332

Counseling Theories and Techniques

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BLOCK I: COUNSELLING – HOLISTIC PERSPECTIVE

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1.1 INTRODUCTION

1.2 OBJECTIVES

After going through the unit you will be able to:

- Understand the meaning and process of counselling
- Understand the purposes and goals of counselling
- Enlist the characteristics that will make the process effective
- Know the do's and don'ts in the process of counseling.

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1.3 COUNSELLING: DEFINITION

Counselling is a one-to-one relationship involving a trained counsellor and focuses on some aspects of a client's adjustment, developmental or decision-making needs. This process provides a relationship and communications base from which the client can develop understanding, explore possibilities and initiate change.

In this setting, it is the counsellors' competence that makes positive outcomes possible. The counsellors' skills and knowledge provide the appropriate framework and direction that maximize the client's potential for positive results.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. Define Counselling

1.4 COUNSELLING AS A PROCESS

Beginning of counselling session (Introduction): As the client enters the room, **greet** the person, call the person by name, welcome the client and make him/her comfortable. Introduce yourself if meeting for the first time and tell the person the purpose of the meeting (to understand the health problem and its best management). Encourage the counselee to talk about themselves.

Active attending and Listening: It is most important step in counselling because the details provided by the client are based on it. Active listening means listening carefully and paying attention to verbal as well as non-verbal signals. Provide in-depth information to relieve fears and worries of the client. Similarly, counsellor's words, expression and posture/gesture (verbal/non-verbal communication) indicate that attention is being paid to what is being said. By demonstrating an attending behaviour the client's self-respect is enhanced, also establishes a safe atmosphere and facilitate free expression of thought by the counselee. Active listening includes reflection of feelings, questioning, paraphrasing and clarification. Similarly, actions of the counselee communicate many unexpressed feeling. Some of these nonverbal activities are counselee entering the room, Voice quality, Breathing, Eyes, Facial expressions, Leg movement & Body posture.

Reflection of content and Feelings: People respond differently to their conditions. They may express their feelings as fear, anger, anxiety or sadness about disease. E.g. depression may be expressed as short temper, Irritable behaviour, less interest in daily routine, inability to sleep, loss of weight and feeling of worthlessness and anxiety. Do not try to stop, let the person express

their feelings, do not stop patient/ family members from crying. Do not take anger personally and try to stay calm.

The counsellor must recognize such feelings in a direct, unemotional way. The focus is kept on the emotions of the client and his/her subjective experiences in coping with the situation. Counsellor reflects the contents and feeling of the other persons by responding back to the client and communicating a message through empathy, questioning or paraphrasing that conveys that counsellor is listening and trying to understand counsellee's circumstances.

Questioning: Always try to use questions and establish communications so that both the problem and the solutions are clear. Asks questions in order to clarify the situation

and make client aware of all the dimensions of the problem and help the clients to understand the core issue underlying his/her fears or concerns. Do not ask too many closed question (closed questions are those questions that can be answered by one word like yes /no). Ask open questions to make communication easier, encourage further discussion and facilitate building of trust and warmth in the relationships.

Use questions containing why with caution as it may easily sound judgmental. If there is a need to use, "why", use it in the middle of a sentence and not in the beginning of a sentence.

Paraphrasing and clarification: Paraphrasing is repetition of the jest of client's feelings by the counsellor in their own words. For example, "You seem to be saying that you are afraid that your family is not going to take care of you". The clients might then agree with the interpretation. If not, the counsellor can seek clarification by saying "will you please explain it with more details?" Utilizing this technique, the counsellor attempts to give feed back to the client; the essence or content of what the client has just said and clarifies understanding of the client's world. Clarification helps the client to come to understand themselves better. When you ask the client to explain something in more details or in a different way; by doing this clients not only explore their own feelings further, but will also feel that you are trying hard to understand their situation. In the process, counsellors also tell the client about the scientific facts not known to them.

Interpretation: Often people avoid focusing on the real problem and talk around the issue. Interpretation goes beyond what is explicitly expressed by the feelings and implied meanings of the client's statements. Even client is unaware of this. Counsellor *redefines* the problem from a different point of view to bring out more clarity to the problem and make client aware to the core problem. The counsellor also helps client to establish what is relevant, emphasising the important points – for example, "Of all the things you talked about today, it seems to me you are most concerned about...."

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Repeating: At times of stress and crisis, clients are in a state of denial or feeling overwhelmed. They may not always understand everything they are told. As a counsellor, do not hesitate and repeat salient points of the discussion, statements of support or necessary facts. It ensures that the clients clearly understand the problem and requisite action. Client would usually convey that they understand and accept the information.

Summarizing: Many people who are stunned by news of the disease may respond by talking quickly and trying to provide more details or ask more questions; than counsellor can absorb or comprehend. It is then helpful for the counsellor to interrupt at times and summarize what has been said. This is like paraphrasing and helps to ensure that each understands the other correctly. Summarizing towards the end of the counselling provides guidance and direction to both counsellor and counselee; to deal with practical matters of the problem and decide plan of action. A summary resembles a combination of reflection of feeling and paraphrasing over a longer period of time.

At the end of each session, the counsellor should summarize the salient points of the discussion, highlight decisions which have been made and need to be acted on.

Confrontation: Many a times clients are so much preoccupied with their fears that cannot see the connection between their behaviour and the responses of the others. Confrontation involves a direct examination of incongruities and discrepancies in the client's thinking, feeling and/or behaviour. The counsellor tells the client that how their thoughts affect their action and behaviour, which in turn affect the behaviour of others towards them. E.g. Because of fear of discrimination, people withdraw themselves and do not speak to friends and relatives. Friends and relatives in turn also respond by not talking to them. Establishment of strong relationship and rapport is essential before commenting on such issues. It is a highly intrusive skill hence timing is very important and advice on confrontation must be delivered in an atmosphere of warmth, care and concern.

Respecting: As a counsellor, try to appreciate that people see their problems in unique personal ways determined by culture, social class and personality. Respect client's views and beliefs and build on them. Show respect, for instance, by asking a client to explain different aspects of the culture or personal beliefs that are strange to you; for example, "you feel strongly about this. I don't know about it. Tell me more about it".

Structuring or Prioritization: Structuring means helping the client to see relationship between facts and feelings. It helps clients to determine the important aspects of their concern that needs immediate attention and other less important aspects that can be put off until later. It is essential part of planning and probably one of the most critical skills in counselling.

Deciding Plan of action: Based on the scientific knowledge, cultural and socio- economic aspect of the client, help the client to explore all the possible solution for the prioritised aspect and choose the most relevant option for action. Encourage client to take their own decision and act accordingly.

Concluding a counselling session: While ending the session summarize the salient points and decision taken, congratulate client for their efforts, wish them luck and fix next visit.

NOTES

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. List a few skills that are used by the counsellor in the process of counseling.

1.5 PURPOSE AND GOALS OF COUNSELLING

The goal of counselling is to help individuals overcome their immediate problems and also to equip them to meet future problems. Counselling, to be meaningful has to be specific for each client since it involves his unique problems and expectations. The goals of counselling may be described as immediate, long-range, and process goals. A statement of goals is not only important but also necessary, for it provides a sense of direction and purpose. Additionally it is necessary for a meaningful evaluation of the usefulness of it.

The counsellor has the goal of understanding the behaviour, motivations, and feelings of the counselee/client. The counsellor's goals are not limited to understanding his clients. He has different goals at different levels of functioning. The immediate goal is to obtain relief for the client and the long-range goal is to make him 'a fully functioning person'. Both the immediate and long- term goals are secured through what are known as mediate or process goals.

Specific counselling goals are unique to each client and involve a consideration of the client's expectations as well as the environmental aspects. Apart from the specific goals, there are two categories of goals which are common to most counselling situations. These are identified as long-range and process goals. The latter have great significance. They shape the counselee and counsellors' interrelations and behaviour. The process goals comprise facilitating procedures for enhancing the effectiveness of counselling.

The long range –goals are those that reflect the counsellor’s philosophy of life and could be stated as –

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- i. To help the counselee become self-actualizing
- ii. To help the counselee attain self-realization
- iii. To help the counselee become a fully –functioning person.

The immediate goals of counselling refer to the problems for which the client is seeking solutions here and now. The counselee could be helped to gain fuller self- understanding through self – exploration and to appreciate his strengths and weaknesses. The counsellor could provide necessary information but however exhaustive, may not be useful to the client unless he has an integrative understanding of himself, his personal resources and environmental constraints and resources.

There is an inter relation between the long-range and immediate goals as both depend on the process goals for their realization. The process goals are the basic counselling dimensions which are essential conditions for counselling to take place. They comprise empathic understanding, warmth and friendliness which provide for inter personal exploration which in turn helps the client in his self-exploration and self-understanding and eventually lead to the long range goals namely self-actualization, self- realization and self enhancement.

Discussing the goals of counselling, Parloff (1961) distinguishes between immediate and ultimate goals according to him the former refers to the steps and stages in the counselling process which lead to the realization of the ultimate goals. Patterson (1970) suggests a third level of goals namely intermediate goals in addition to mediating and ultimate goals. Ultimate goals refer to the broad and general long term outcomes like positive mental health. Intermediate goals are explained by the reasons for seeking a counsellor’s help and immediate goals as those that refer to the present intentions of the counselee. A major criticism raised is that goals such as self- actualization, actualizing potentialities, etc., are too general and amorphous and hence not useful in actual practice. Krumboltz (1966) holds that an operational definition of terms would be a more useful approach. He suggests that a general concept could be reduced to specific objective and measurable variables. Mediate goals (Parloff, 1967) may be considered as specific steps contributing to the realization of general goals. Behaviourists play much emphasis on mediate goals like reduction of anxiety, acquisition of adaptive habits, etc. The immediate goal of counselling is to motivate a potential counselee to make an appointment with a counsellor and go through the counselling process till the mediate goals are realized. It is through the realization of mediate goals that the ultimate goals of self – understanding, self – realization and self – actualization can be reached. The process of self – exploration is perhaps a kind of immediate goal which sets the counselling process in motion. Areas in which change is considered desirable are relations with other individuals,

academic achievement, job satisfaction, etc. Some of the major goals of counselling generally accepted by the counsellors are given below:-

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1. Achievement of positive mental health

It is identified as an important goal of counselling by some individuals who claim that when one reaches positive mental health one learns to adjust and response more positively to people and situations. Kell and Mueller (1962) hold that the “promotion and development of feelings of being liked, sharing with, and receiving and giving interaction rewards from other human beings is the legitimate goal of counselling”

2. Resolution of Problems

Another goal of counselling is the resolving of the problem brought to the counsellor. This, in essence, is an outcome of the former goal and implies positive mental health. In behavioural terms three categories of behavioural goals can be identified, namely, altering maladaptive behaviour, learning the decision – making process and preventing problems (Krumboltz, 1966).

3. Improving Personal Effectiveness

Yet another goal of counselling is that of improving personal effectiveness. This is closely related to the preservation of good mental health and securing desirable behavioural change(s).

4. Counselling to Help Change

Blocher (1966) adds two other goals. The first, according to him, is that counselling should maximize individual freedom to choose and act within the conditions imposed by the environment. The other goal is that counselling should increase the effectiveness of the individual responses evolved by the environment. Tiedeman (1964) holds that the goal of counselling is to focus on the mechanism of change and that the counselee should be helped in the process of ‘becoming’ – the change which pervades the period of adolescence through early adulthood during which the individual is assisted to actualize his potential. Shoben (1965) also views the goal of counselling as personal development.

5. Decision – Making as a Goal of Counselling

Some counsellors hold the view that counselling should enable the counselee to make decisions. Counselling Goals

The goal of counselling is to help individuals overcome their immediate problems and also to equip them to meet future problems. Counselling, to be meaningful has to be specific for each client since it involves his unique problems and expectations. The goals of counselling may be described as immediate, long-range, and process goals. A statement of goals is not only

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1. To help the counselee become self-actualizing.
2. To help the counselee attain self-realization.
3. To help the counselee become a fully –functioning person.

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There is an inter relation between the long-range and immediate goals as both depend on the process goals for their realization. The process goals are the basic counselling dimensions which are essential conditions for counselling to take place. They comprise empathic understanding, warmth and friendliness which provide for inter personal exploration which in turn helps the client in his self-exploration and self-understanding and eventually lead to the long range goals namely self-actualization, self- realization and self enhancement.

Discussing the goals of counselling, Parloff (1961) distinguishes between immediate and ultimate goals according to him the former refers to the steps and stages in the counselling process which lead to the realization of the ultimate goals. Patterson (1970) suggests a third level of goals namely intermediate goals in addition to mediating and ultimate goals. Ultimate goals refer to the broad and general long term outcomes like positive mental health. Intermediate goals are explained by the reasons for seeking a counsellor's help

and immediate goals as those that refer to the present intentions of the counselee. A major criticism levelled is that goals such as self-actualization, actualizing potentialities, etc., are too general and amorphous and hence not useful in actual practice. Krumboltz (1966) holds that an operational definition of terms would be a more useful approach. He suggests that a general concept could be reduced to specific objective and measurable variables. Mediate goals (Parloff, 1967) may be considered as specific steps contributing to the realization of general goals. Behaviourists place much emphasis on mediate goals like reduction of anxiety, acquisition of adaptive habits, etc. The immediate goal of counselling is to motivate a potential counselee to make an appointment with a counsellor and go through the counselling process till the mediate goals are realized. It is through the realization of mediate goals that the ultimate goals of self – understanding, self – realization and self – actualization can be reached. The process of self – exploration is perhaps a kind of immediate goal which sets the counselling process in motion. Areas in which change is considered desirable are relations with other individuals, academic achievement, job satisfaction, etc. Some of the major goals of counselling generally accepted by the counsellors are given below:-

1. Achievement of positive mental health

It is identified as an important goal of counselling by some individuals who claim that when one reaches positive mental health one learns to adjust and respond more positively to people and situations. Kell and Mueller (1962) hold that the “promotion and development of feelings of being liked, sharing with, and receiving and giving interaction rewards from other human beings is the legitimate goal of counselling”

2. Resolution of Problems

Another goal of counselling is the resolving of the problem brought to the counsellor. This, in essence, is an outcome of the former goal and implies positive mental health. In behavioural terms three categories of behavioural goals can be identified, namely, altering maladaptive behaviour, learning the decision – making process and preventing problems (Krumboltz, 1966).

3. Improving Personal Effectiveness

Yet another goal of counselling is that of improving personal effectiveness. This is closely related to the preservation of good mental health and securing desirable behavioural change(s).

4. Counselling to Help Change

Blocher (1966) adds two other goals. The first, according to him, is that counselling should maximize individual freedom to choose and act within the conditions imposed by the environment. The other goal is that counselling should increase the effectiveness of the individual responses evolved by the environment. Tiedeman (1964) holds that the goal of counselling is to focus on the mechanism of change and that the counselee should be helped in the

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process of 'becoming' – the change which pervades the period of adolescence through early adulthood during which the individual is assisted to actualize his potential. Shoben (1965) also views the goal of counselling as personal development.

5. Decision – Making as a Goal of Counselling

Some counsellors hold the view that counselling should enable the counselee to make decisions. It is through the process of making critical decisions that personal growth is fostered. Reaves and Reaves (1965) point out that "the primary objective of counselling is that of stimulating the individuals to evaluate, make, accept and act upon his choice".

Sometimes the counselees have goals which are vague and their implications are not fully appreciated. It is perhaps one of the primary functions of a counsellor to help clarify a counselee's goal.

6. Modification of Behaviour as a Goal

Behaviourally-oriented counsellors stress the need for modification of behaviour, for example, removal of undesirable behaviour or action or reduction of an irritating symptom such that the individual attains satisfaction and effectiveness. Growth-oriented counsellors stress on the development of potentialities within the individual. Existentially-oriented counsellors stress self-enhancement and self-fulfillment. Obviously the latter cannot be realized without first securing the former, namely, symptom removal or reduction as a necessary pre-condition for personal effectiveness.

The general public tends to view counselling as a remedial function and emphasizes immediate goals, such as problem resolution, tension reduction, and the like. Counselee may refer to the resolution of a particular conflict or problem situation. However, the goals of counselling are appropriately concerned with such fundamental and basic aspects such as self-understanding and self-actualization. These help provide the counselee with self-direction and self-motivation. Counselling in its spirit and essence is generative. It aims at assisting the individual to develop such that he becomes psychologically mature and is capable of realizing his potentialities optimally.

Counselling has no magical solutions. The only meaningful, sensible and realistic view of counselling is that it is not and cannot be everything to everybody. It is concerned with helping individuals find realistic and workable solutions to their problems by helping them gain an insight into themselves so that they are able to utilize their own potentialities and opportunities and thus become self-sufficient, self-directed and self-actualized. It is through the process of making critical decisions that personal growth is fostered. Reaves and Reaves (1965) point out that "the primary objective of counselling is that of stimulating the individuals to evaluate, make, accept and act upon his choice".

Sometimes the counselees have goals which are vague and their implications are not fully appreciated. It is perhaps one of the primary functions of a counsellor to help clarify a counselee's goal.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. Discuss the outcomes of counselling.

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1.6 OVERVIEW STAGES OF COUNSELLING

Hackney and Cormier (1996) identified the stages of counselling as follows:

- 2 Relationship establishment
- 3 Problem identification and exploration
- 4 Planning for problem solving
- 5 Solution, application and termination

1.6.1 Relationship establishment

Counselling is a helping relationship. The counsellor must take the initiative in the initial interview to establish a climate conducive to mutual respect, trust, free and open communication, and understanding in general of what the counselling process involves.

Although responsibility will later shift increasing to the client, at this stage the responsibility for the counselling process rests primarily with the counsellor. Among the techniques the counsellor may use are those designed to relieve tensions and open communication. Both the counsellor's attitude and verbal communication are important to the development of a satisfactory relationship. In the latter instance, all of the counsellor's communication skills such as attentive listening, understanding and feeling with the client are brought into play.

Conditions such as a positive regard and respect, accurate empathy and genuineness imply counsellor openness, an ability to understand and feel with the client, and valuing the client. Counsellor-client relationship not only increase the opportunity for clients to attain their goals but also is a potential model of a good interpersonal relationship, one that clients can use to improve the quality of their relationships outside the therapy setting.

The counselling process within this relationship seeks to assist the client in assuming the responsibilities for his or her problem and its solution. This will be facilitated by the counsellor's communication skills, the ability to identify and reflect client's feelings, and the ability to identify and gain insights into

the clients concerns and needs. Suggested goals for the initial counselling interviews might include:

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Counsellor's goals

- Establish a comfortable and positive relationship
- Explain the counselling process and mutual responsibilities to the client
- Facilitate communication
- Identify and verify the client's concerns that brought him or her to seek counselling assistance
- Plan, with the client, to obtain assessment data needed to proceed with the counselling process

Client's goals

- Understand the counselling process and his or her responsibilities in this process
- Share and amplify reasons for seeking counselling
- Cooperate in the assessment of both the problem and self

1.6.2 Problem Identification and Exploration

Once an adequate relationship has been established, clients will be more receptive to the in-depth discussion and exploration of their concerns. At this stage, clients assume more responsibility because it is their problem and it is their willingness to communicate as much of the nature of the problem to the counsellor as possible that will determine to a large extent the assistance the counsellor can give.

During this phase, the counsellor continues to exhibit attending behaviour and may place particular emphasis on such communication skills as paraphrasing, clarification, perception checking or feedback. The counsellor may question the client, but the questions are stated in such a way as to facilitate the continued exploration of the client's concern. Questions that would embarrass, challenge, or threaten the client are avoided. Throughout this phase, the counsellor will recognize cultural differences and their implications in terms of how techniques should be modified to be culturally appropriate.

Now the counsellor is seeking to distinguish between what might be called surface problems and those that are more complex. The counsellor also strives to determine whether the stated problem is, in fact, the concern that has brought the client to the counsellor. This may be a time for information gathering. The more usable information the counsellor has the greater will be the prospects for accurate assessment of client's needs. It is therefore helpful for counsellors to recognize the various areas of information that must be tapped.

Information may be grouped under these three headings:

1. The time dimension includes the client's experiences, especially those he or she may view as influencing experiences. The present dimension would cover how well the person is functioning presently, especially those current experiences that may have influenced the client to seek counselling. The future time dimension would include future hopes, plans, and goals, and also how the client plans to achieve these.

2. The feeling dimension includes the emotions and feelings of the client toward himself or herself as well as toward significant others. Included are feelings about groups, attitudes, values and self-concept. All are a part of the feeling dimension.

3. The cognitive dimension includes how the client solves problems, the coping styles she or he employs, rationality in making daily decisions, and capacity and readiness for learning.

At this point, some counsellors may use appraisal techniques such as standardized tests for problem diagnosis. Subproblems of the problem may also be identified. During this stage, the client not only explores experiences and behaviours but also may reveal feelings and the relationship of concern to the way he or she is living life in general. The counsellor is seeking to secure as much relevant data as possible and to integrate it into an overall picture of the client and his or her concern. The counsellor also shares these perceptions with the client. A goal of this stage is for both the counsellor and the client to perceive the problem and its effects similarly. One of the counsellor's goals during this stage is to help the client develop a self-understanding that recognizes the need for dealing with a concern – the need for change and action.

The steps or stages in problem identification and exploration are these:

1. Define the problem – The counsellor, with the cooperation of the client, is seeking to describe or identify the problem as specifically and objectively as possible. It is important that the counsellor and client have the same understanding of the problem. In addition to the accuracy desired in defining the problem, it is important for the client to identify the components or contributing factors and the severity of the problem as to its recency and longevity.
2. Explore the problem – The kinds of information needed to fully understand the problem and its background are gathered at this point. Once the kinds of needed information have been identified, counsellor and client must determine how this information can be obtained, who will have responsibility for gathering it, and what the timelines for gathering the data will be. Within this context, decisions may be made regarding the administering, for example, of standardized psychological measures. To test or not to test is a decision in which the client must have a major voice. Regardless of how desirable it may be to obtain data through standardized psychological measures, the effect on the client and his or her willingness to participate fully in the

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counselling process may be threatened by this data-gathering technique. In some situations, the counsellor may wish to complete a detailed case study. This is a decision that will depend on the seriousness of the situation, the amount of data needed, and the amount of time available to both counsellor and client for this purpose. In this process, it is obviously important that the counsellor continue to employ facilitative behaviour.

3. Integrate the information – In this step all the information collected is systematically organized and integrated into a meaningful profile of the client and the client's problem. At this point it would be appropriate to begin the exploration of changes that may be needed and barriers that may exist to these changes.

1.6.3 Planning for Problem solving

Once the counsellor has determined that all relevant information regarding the client's concern is available and understood and once the client has accepted the need for doing something about a specific problem, it is time to develop a plan to solve or remediate the concern of the client.

At this point, effect goal setting becomes the focus of the counselling activity. Mistakes in goal setting can lead to non-productive procedures and the client's loss of confidence in the counselling process.

1. Define the problem – It is important that both the counsellor and the client view the problem from a similar perspective and have the same understanding of its consequences.
2. Identify and list all possible solutions – At this point, it is appropriate to brainstorm all possibilities. Both the client and counsellor participate, but the client should be given the opportunity to list as many possibilities as may come to her or his mind. If there are some obvious solutions that are overlooked, the counsellor may suggest to the client, "Have you also thought of __?" When listing solutions, none should be eliminated simply because at first glance they appear to be impossible to implement.
3. Explore the consequences of the suggested solutions – Here the client with encouragement and occasional suggestion from the counsellor will identify the procedures needed to implement each of the suggested solutions. As she or he does so, some procedures will appear too complex or for other reasons impossible to apply. Other solutions may produce more problems or more serious consequences than the problem that is the focus in this counselling sequence. In any event, the projected outcomes for each solution must be explored thoroughly.
4. Prioritize the solutions – Following the exploratory stage, the client again with the counsellor's encouragement, will prioritize the solutions from best possibility down to least likely to produce the desired results. Once the decision had been made and the best solution selected, the client is now ready to move on to the application and implementation.

In the further development of this plan, the counsellor recognizes that the client will frequently not arrive at basic insights, implications, or probabilities as fast as the counsellor will. However, most counsellors will agree that it is better to guide the client toward realizing these understandings himself or herself. To facilitate the client's understanding, the counsellor may use techniques of repetition, mild confrontation, interpretation, information and encouragement.

1.6.4 Solution, Application and Termination

In this final stage, the responsibilities are clear-cut. The client has the responsibility for applying the determined solution, and the counsellor, for determining the point of termination. In the first instance, the counsellor has a responsibility to encourage the client's acting on his or her determined problem solution. During the time the client is actively engaged in applying the problem solution, the counsellor will often maintain contact as a source of follow-up, support and encouragement. The client may also need the counsellor's assistance in the event things do not go according to the plan.

The responsibility of termination is primarily that of the counsellors although the client had the right to terminate at any time. The counsellor usually gives some indication that the next interview should just about wrap it up and may conclude by summarizing the main points of the counselling process. Usually, the counsellor will be open for the client's possible return if additional assistance is required

The counsellor hopes that the client has not only learned to deal with this particular problem but has also learned problem-solving skills that will decrease the probability of the client's need for further counselling in future.

It should be remembered that problems are not always based on perceived inadequacies or failures requiring remediation and restorative therapy, clients can have equally pressing needs resulting from concerns for developing their human potential – for capitalizing on their strengths. In these instances, emphasis is on development, growth or enhancement rather than remediation.

1.6 CHARACTERISTICS OF AN EFFECTIVE COUNSELLOR

The following are the personal qualities and characteristics that are essential for an effective counsellor:

- *They have an identity.* They know who they are, what they are capable of becoming, what they want out of life, and what is essential.
- *Respect and appreciate themselves.* They can give and receive help and love out of their own sense of self-worth and strength. They feel adequate with others and allow others to feel powerful with them.
- *Are open to change.*

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They make decisions about how they would like to change, and they work toward becoming the person they want to become.

- *Make choices that are life oriented.* They are aware of early decisions they made about themselves, others, and the world. They are not the victims of these early decisions, and they are willing to revise them if necessary.
- *Are authentic, sincere, and honest.* They do not hide behind masks, defenses. They are genuine.
- *Have a sense of humor.* They have not forgotten how to laugh, especially at their own weaknesses and contradictions.
- *Make mistakes and are willing to admit them.* They do not dismiss their errors lightly, yet they do not choose to worry about them forever.
- *Live in the present.* They are not fixed to the past, nor are they fixated on the future. They are able to experience and be present with others in the “now.”
- *Appreciate the influence of culture.* They are aware of the ways in which their own culture affects them, and they respect the diversity of values of other cultures. They are also sensitive to the unique differences arising out of social class, race, sexual orientation, and gender.
- *Have a sincere interest in the welfare of others.* This concern is based on respect, care, trust, and a real valuing of others.
- *Possess effective interpersonal skills.* They are capable of entering the world of others without getting lost in this world, and they strive to create collaborative relationships with others.
- *Become deeply involved in their work and derive meaning from it.* They can accept the rewards flowing from their work, yet they are not slaves to their work.
- *Effective Counsellors are passionate.* They have the courage to pursue their passions, and they are passionate about life and their work (Skovholt & Jennings, 2004).
- *Are able to maintain healthy boundaries.* Although they strive to be fully present for their clients, they don't carry the problems of their clients around with them during leisure hours. They know how to say no, which enables them to maintain balance in their lives.

Combs (1989) reviewing 13 studies about effective and ineffective helping relationships, concluded that there are some shared beliefs among helpers in the major helping professions, such as:

1. Attitude toward other people: The effective helper views people as being able rather than unable, worthy rather than unworthy, dependable rather than undependable, helpful and friendly rather than hindering and alienating, optimistic about others rather than negative.

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2. Self-concept: Effective helpers feel personally adequate rather than inadequate, identify with others rather than feel isolated, feel trustworthy rather than untrustworthy, feel wanted rather than unwanted, feel worthy rather than unworthy.
3. Approaches to helping: Effective helpers are more directed toward people than things and are more likely to approach clients subjectively or phenomenologically – that is, from the client’s vantage point and perspective rather than from their own. The strategies that they use are implemented empathically and are congruent with their own values.

Rogers (1958) believes that counsellors must be open and that the following conditions are necessary for client development in a helping relationship:

1. Unconditional Positive Regard: Counsellors should communicate acceptance of clients as worthwhile persons, regardless of who they are or what they say or do.
2. Genuineness and congruence: Counsellors should be real and sincere, honest and clear. They should speak and act congruently. They should practice what they preach.
3. Empathy: Counsellors should be able to communicate empathic understanding of clients frames of reference and should let them know they feel and understand clients’ concerns from their point of view.

Carkhuff and Berenson (1967) identified four basic traits that facilitate effective helping relationships if communicated skilfully.

1. Empathy: Effective counsellors are able to communicate to the client their own self-awareness and understanding, providing the client with an experiential base for change.
2. Respect and positive regard: Effective counsellors can communicate warmth and caring.
3. Genuineness: Effective counsellors are honest with themselves and their clients.
4. Concreteness: Effective counsellors respond accurately, clearly, specifically and immediately to clients.

Corey (2001) implores counsellors to learn about themselves as persons in the helping relationship. He stresses the following conditions:

1. Self-awareness: Counsellors should continuously develop their awareness of their own values and feelings in order to grow, be open to change, and model congruent behaviour and high-risk activity. Self-awareness leads to greater authenticity.
2. Interest: Counsellors should show interest in and involvement with the welfare of others and the influence of culture on all people.
3. Knowledge and skills: In order to be professionally effective, practitioners need to be able to integrate psychological theory and practice into their personal meaning. They must integrate multicultural competencies into their knowledge and skills.

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Sue and Sue (1999) summarized the following important characteristics of multiculturally competent counsellors:

1. Self-awareness: Counsellors should be aware of their own standards, values and assumptions.
2. Knowledge: They need to be knowledgeable of the socio-political factors operating in their clients' worlds and know that they may inadvertently discriminate if they treat all clients alike.
3. Understanding: Counsellors need to be able to understand the worldview of each client.

Egan (1998) refines the concept of empathy by defining two types: primary empathy, in which counsellors attend, listen and reflect to communicate accurate perception of the client's message; and advanced accurate empathy, in which, in addition to communicating primary empathy, the counsellor influences the client through self-disclosure, directives or interpretation.

Brammer believes that the following conditions are necessary to the effective helping relationship:

1. Self-awareness: Counsellors should be aware of their own values and feelings, of the use (and power) of their ability to function as model for the clients.
2. Interest: Counsellors should show interest in and involvement with people and social change
3. Ethical behaviour: Counsellors should demonstrate commitment to behaviours that are reflections of their own moral standards, of society's codes, and of the norms of helping profession.

Ivey, Ivey, and Simek-Downing (1997) and Ivey and Ivey (1999) have summarized the findings into what they consider to be the qualitative communication components necessary for effective helping.

1. Empathy (primary and advanced accurate)
2. Positive Regard – selectively attending to positive aspects of client's verbalizations and behaviour
3. Respect – stating positive opinions of the client and openly and honestly acknowledging, appreciating and tolerating differences
4. Warmth – showing concern for the client through nonverbal expression
5. Concreteness – clarifying facts and feelings specifically
6. Immediacy – speaking in the present instead of the past or future tense
7. Confrontation – Discussing differences, mixed messages, incongruities, and discrepancies between verbal and nonverbal behaviours.
8. Genuineness – Being authentic, spontaneous and sensitive to the needs of the client.

1.7 ETHICS IN COUNSELLING.

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Code of ethics is meant to protect counsellors from the public and vice versa and professional organizations such as American Counselling Organization, American Psychological Organization and may other Indian professional organizations continue to update their code of ethics. Most ethical codes are based on five fundamental ethical principles: (1) respect autonomy (2) do not harm (3) benefit others (4) be fair and (5) be faithful (Kitchener, 1988).

Ethical problems are increasingly complicated and complex, and it is impossible for helpers to avoid them. Those whose behaviour is consistent with their definition of helping and who are committed to questioning their own behaviours and motives and seeking consultation from others are less likely to function unethically than those who are closed to such reflections.

The ethical issues that appear to be particularly relevant in the present times are (1) privileged communication and sharing of confidential information, particularly in this era of managed care and high technology, (2) conflicts of interest (3) record keeping (4) use of tests and computerized programs (5) dual relationships and (6) misrepresentation.

Privileged Communication and Confidentiality

Some counsellors have privileged communication, which means that they can be called on to testify in a court of law about the nature of their discussion with clients and their records can be summoned. There are two kinds of confidentiality: legal and personal. The former depends on the laws of the particular state/country. The latter is of your own making. In other words, if because of your setting (such as a school or a correctional institution) you are unable to treat information obtained in a helping session confidentially, you must make this clear to the client in advance of his or her sharing concern with you.

If you are able to promise personal confidentiality, you must maintain it in any circumstances. Recent court cases indicate that professional helpers can be held accountable if they do not warn potential victims of violence.

The best way for counsellors and clients to be protected is for clients to sign an informed consent form and for the counsellors and clients to discuss openly what diagnosis will be used. Counsellors are also ethically responsible for ensuring that their employer organization's policies are congruent with their own professional and personal ethical codes.

Conflict of Interest

There are times when the counsellor may experience a conflict of interest between their obligations to their organization and their obligations to their clients. There are no blanket solutions for such cases. Each person must find an answer that he or she can live with.

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It is important for the counsellors to remember that their primary responsibility during the helping process is to the client, not to any other individual or group. Thus, if a conflict of interest arises, counsellors must make sure that they do not breach a client's confidentiality because of their own ignorance, insecurity or ineptness, or for the good of some organization or group. The only justification for a breach of confidentiality is that the welfare of the client or some other human being is at stake.

Record Keeping

With regard to records, it may be a good idea to write down only objective, behavioural information and to exclude subjective material / interpretations. If tape recordings are used, it should be with the full knowledge of the client, a full explanation of the intentions and purposes of the recordings and the counsellors' guarantee that the tapes will be destroyed after they fulfil their purposes. If third-party payments are involved, discuss what specific information is provided to that party. Storing the information of the client on the computers should also be done cautiously to ensure confidentiality of the client.

The purpose of record keeping is to provide documentation of a client's progress and continuity of treatment. The overriding objective is the client's welfare.

Testing

It is ethical for counsellors to administer tests only if they have had sufficient training and supervision in the administration of the particular test. Counsellors are also ethically bound to determine and explain clearly to clients the rationale for and purposes of the testing process. They must discuss culture fairness of the instruments and also known limitations. A related issue concerns the use of test data – who receives these data and what use will be made of them. Without client's specific verbal permission his/her case should not be discussed to anyone. This is necessary to ensure trust and to communicate the counsellor's interest in the client welfare.

Dual-role Relationships

Different roles involve different expectations of behaviour, power and obligations. There is likely to be conflict between these role expectations if the counsellor engages in any role other than that of the professional helper. Example, forming a social or sexual relationship with the counsellor, becoming a student or supervisee's therapist or entering into a professional helping relationship with a friend or family member.

Clear boundaries and clarification of the nature and process of the helping relationship, will reduce against possible abuses of power. Dual relationships have a high potential for exploiting the client, who is in a less powerful position than the counsellor regardless of the circumstances. If this power

differential is not acknowledged and both parties consent to another kind of relationship, the damage may be more.

Misrepresentation

Misrepresentation can occur when a counsellor directly claims or indirectly infers knowledge, training, experience and or expertise with a particular type of client or a particular type of problem. Professional code of ethics specifically requires counsellors to acknowledge their limitations. They can work in such situations with supervision/ consultation from an outside expert, refer to an expert, or use co-therapy with an expert.

Failing to consider other forms of assessment and treatment, such as physical examination, psychopharmacology, or testing is another ethical issue. For example, many clients experience distress that turns out to be related to underlying medical conditions. A pluralistic approach is needed as psychological and sociocultural variables compound symptoms.

No code of ethics can cover all situations and circumstances. Ethical issues involving the use of computers for assessment as well as record keeping are now being addressed.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What are the fundamental ethical principles that have to be taken care of in counselling?

1.9 LET US SUM UP

In this unit, you have been introduced to the meaning of counselling, the process, stages, purpose and goals. The unit also outlined the characteristics that are essential for a counsellor that would make the process effective. The ethical issues had also been discussed so that the client's rights and safety would be ensured in the process.

1.10 UNIT-END EXERCISES

1. List the characteristics of an effective counsellor.
2. Describe the stages of counselling.
3. Confidentiality in the process of counselling – Discuss.

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1.11 ANSWER TO CHECK YOUR PROGRESS

1. Counselling is a process that provides a one-to-one relationship and communications base from which the client can develop understanding, explore possibilities and initiate change.

2. Active attending and Listening, Reflection of content and Feelings, Questioning, Paraphrasing and clarification, Interpretation, Repeating, Summarizing, Confrontation, Respecting, Structuring or Prioritization.

3. Achievement of Immediate goals – helping clients to find solution “here and now” and Long-term goals to develop the client into a “fully functioning person”.

4. Respect autonomy, not harming the client in anyway, benefit them, being fair and being faithful.

1.12 SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper’s Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D. John Antony, Skills of Counselling, 2003, Anugraha Publications.

UNIT 2: Meaning and Nature

Meaning and Nature

Structure

- 2.1 Introduction
- 2.2 Objectives
- 2.3 Definition
- 2.4 Aims and Scope of Counselling
- 2.5 Characteristics of effective Counselling
- 2.6 Application of Counselling in various areas
- 2.7 Diversity in Counselling
- 2.8 Attitude of a Professional Counsellor
- 2.9 Personality of effective Counsellors
- 2.10 Values in Counselling
- 2.11 Ethical Considerations for a Counsellor
- 2.12 Characteristics of a Successful Counsellee
- 2.13 Counsellee Expectations
- 2.14 Let us sum up
- 2.15 Unit-End Exercises
- 2.16 Answer to Check your Progress
- 2.17 Suggested Readings

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2.1 INTRODUCTION

2.2 OBJECTIVES

After going through this unit, you will be able to

- Understand the significance of counsellor as a person in therapeutic relationship
- Be aware of the ethical issue that may arise in the process and the right practice to adopt to

- Identify the areas in which a counsellor can specialize in and the scope of counselling

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2.3 DEFINITION

Counselling psychology is a psychological specialty that facilitates personal and interpersonal functioning across the life span with a focus on emotional, social, vocational, educational, health-related, developmental, and organizational concerns. Through the integration of theory, research, and practice, and with sensitivity to multicultural issues, this specialty encompasses a broad range of practices that help people improve their well-being, alleviate distress and maladjustment, resolve crises, and increase their ability to live more highly functioning lives. Counselling psychology deals with both normal developmental issues and to problems associated with physical, emotional, and mental disorders.

2.4 AIMS AND SCOPE OF COUNSELLING

Counselling psychology is an applied area of psychology. It is based on clear psychological principles or methods. Counselling psychologists work with a range of human needs and issues which occur within the course of the human life-span. They include family and marital matters, gender identity, bereavement, divorce and depression, phobias, sexual abuse, retirement, etc

Some counselling psychologists specialize in particular groups or issues. People of all ages and backgrounds can be benefitted by counselling. On the whole, counselling psychologist works with the less disturbed client. The emphasis of their practice is on well-being and self-actualization and less upon sickness and maladjustment. Counsellors seek to establish and develop relationships within which clients will feel safe and free to explore the issues they bring.

As a therapist, the counsellors' concern is to provide a therapeutic relationship which would facilitate personal growth. It is the psychological exploration and elaboration of the client-counsellor relationship. The skills of the counselling psychologist are centered on the development and maintenance of client-counsellor relationship. Fundamental is the ability to truly listen to the clients, to be able to empathize with their perspective, to hear their story. Just as important is the ability to stand back in order to evaluate, make judgements, interpret and observe outcomes.

Counselling psychologists have to learn to deal with stress and emotions. In some circumstances it may be appropriate to employ psychological tests for which training is necessary and there are important administrative tasks, in particular the writing of client reports. Good counselling practice is nourished by the counsellor's reflection upon practice and by the insights of counselling theory and research. The counselling psychologist needs to know when to refer a client to another professional, when to terminate a counselling relationship,

as well as be able to recognize the limits of his or her professional competence.

Counselling psychologists perform so many different functions that it is hard to enlist all of them. A counselling psychologist can consult with a variety of agencies (eg., Schools, government, private organizations), teach, do research, administer therapy, hold administrative positions, among others.

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Counselling psychologists study and work in a variety of settings. Some areas that counselling psychologists work in and study are as follows:

- Vocational psychology
- Child development
- Adolescent development
- Adult development/aging
- Health psychology
- Mental illness
- Forensic psychology
- Sport psychology
- Neuropsychology
- Interpersonal relationships
- Assessment
- Rehabilitation
- Community psychology
- Crisis intervention
- Developmental disabilities
- Eating disorders
- Suicidal and homicidal tendencies
- Multiculturalism

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. Enlist the various settings in which a counsellor can work.

2.5 CHARACTERISTICS OF EFFECTIVE COUNSELLING

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

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What the client expect to achieve with the counsellor should be clearly defined in the initial stage of your counselling. The client and the counsellor should discuss realistic time frames for reaching the goals and agree on how the progress will be measured.

It's important that the client and the counsellor establish a good relationship in which both feel comfortable, particularly the client should feel comfortable with the counsellor's personality, approach and style. An effective counsellor can help pinpoint the obstacles in the way of the client's efforts to make changes in his/her life. The counsellor can suggest behavioral changes to help the client to overcome obstacles. If these obstacles involve factors outside of the client's control, the counsellor can teach coping mechanisms that will foster the clients' well-being in trying circumstances.

An effective counsellor can identify negative thinking patterns that may be feeding feelings of sadness, depression or anxiety. By encouraging the client to build upon personal strengths and suggesting skills that can overcome self-inflicted feelings of hopelessness, a counsellor can help the person to develop a more positive attitude.

A good counsellor can assist the client in making positive changes in his/her relationships with others, helping them to recognize behaviors that may be contributing to a troublesome relationship. Counsellors also can teach effective ways of communicating, clearing the way for honest exchanges with people in the client's life who may be causing emotional pain.

The effectiveness of counselling may be determined if the client begin to obtain insights about his/her thoughts and behaviors that may have eluded them before. Over time, they should be able to recognize patterns in the way they act, trace their sources and identify stumbling blocks to happiness and well-being. The end result is personal growth that empowers the client to control their lives and enjoy positive, life-affirming relationships with others.

2.6 APPLICATION OF COUNSELLING IN VARIOUS AREAS

A counsellor can to choose to specialize in various areas according to his or her interest and aptitude. Presented below are a few areas of application, among the many.

Relationship counselling

Relationship counselling is the process of counselling the parties of a relationship in order to try and reconcile differences. The relationship involved may be people in a family, between employees in a workplace, or between a professional and a client. Relationship counsellors are extremely helpful at any stage/type of a relationship. There are counsellors specializing in premarital counselling as well as those working with married couples experiencing

difficulties of many years' duration. Relationship counselling aims to help recognize and to better manage or reconcile troublesome differences and repeating patterns of distress. The goal of relationship counselling is to help couples improve communication skills, learn to handle conflicts constructively, and help to resolve old childhood issues that may be hindering the growth of a healthy relationship.

Rehabilitation counselling

Rehabilitation counselling, aims to assist individuals with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in a systematic manner. The counselling process is like any other, involving communication, goal-setting, and initiating and augmenting beneficial growth or change through self-advocacy, psychological, vocational, social and behavioural interventions. The specific techniques and modalities utilized in the rehabilitation counselling process may include, but are not restricted to the following:

- Assessment and appraisal
- Diagnosis and treatment planning
- Career (vocational) planning; job analysis and job development
- Provide placement services, including assistance with reasonable accommodations
- Case management, referral, and service coordination
- Advocacy and interventions to remove environmental, employment and attitudinal barrier
- Provision of consultation about and access to rehabilitation technology

Addiction Counselling

When an individual persists in use of alcohol or other drugs despite problems related to use of the substance, substance dependence may be diagnosed. Addiction is both a physiological and a psychosocial phenomenon. It can affect anyone from all walks of life. Counselling approaches generally integrate psychotherapeutic and coping skills-training techniques. The primary goal is to enhance and sustain patient motivation for change, establish and maintain abstinence from all psychoactive drugs, and foster development of coping and problem solving skills to thwart and ultimately eliminate impulses to "self-medicate" with psychoactive drugs.

Issues relevant to mental and physical well-being of women

Rape is when one person wants and pursues a sexual act on, to or inside another person who does not want to participate, and who does not fully and freely consent to take part in that act. Victims of rape can be severely traumatized by the assault and may have difficulty functioning as well as they had been used to prior to the assault, with disruption of concentration, sleeping patterns and eating habits. It is common for the victim to experience Acute Stress Disorder, including symptoms similar to those of posttraumatic stress

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disorder, such as intense, sometimes unpredictable, emotions, and they may find it hard to deal with their memories of the event. It is important that the rape and assault survivors have a supportive network of family and friends along with professional help.

Counselling women may cover preventive aspects such as providing necessary education regarding the physical and psychological changes relating to puberty, pregnancy and menopause. It may involve educating family members also to provide necessary support at these phases of a women's life. Women may also require help in making career choices, improving their careers, and handling various difficulties at work.

Educational setting

A counsellor can work in school or college setting. Counsellors are today vital members of education team. They help students in the areas of academic achievement, personal/social development, and career development, ensuring today's students become the productive, well-adjusted adults of tomorrow. The counsellor is required to possess the following skills: ability to work with parents, students, faculty, college educational representatives, as well as community groups, understanding student maturity levels and the process of goal selection, ability to motivate students and provide academic incentive for success, ability to use culturally relevant and responsive strategies when planning programs and making presentations.

Career Counselling

Career counselling may include provision of occupational information, modeling skills, written exercises, and exploration of career goals and plans. It also involves use of personality or career interest assessments. When people seek out a career counsellor or are referred to one, they may work with the counsellor to evaluate skills, learn how to improve skills, learn how to successfully search for jobs, and develop methods for effectively applying and interviewing for work. The career counsellor can also help individuals who have trouble maintaining jobs or who have certain skills that are no longer in demand. A career counsellor can also be extremely helpful in situations where individuals need to change careers and at difficult times such as recession, downsizing, etc. The counsellor assesses the clients' background, skills, and experience and helps identify other career options that may or may not have occurred to the displaced employee.

Counselling the aged

Old age brings about changes in life-styles, activities and relationships. Older people need to be counseled to utilize their earlier skills/ training etc. to stay connected with people. The problems of the elderly generally arise from three sources: Medical, Financial and Social. As people age, health related problems are likely to occur. Vision and mobility are the two most threatening of them. It is important to counsel them, to stay healthy by adopting life-styles that involve diet control, exercise regimen and stress-free living.

Elderly may cope with aging through the following ways:

1. Plan and prepare from early years, particularly middle age
2. Enhance and manage finances well. Focus on savings and investments
3. Pay attention to health.
4. Develop hobbies and sustain interpersonal interactions to the extent possible
5. Orient positively towards the personal concerns of grown up children and their family

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2.7 DIVERSITY IN COUNSELLING

Diversity in the counseling relationship is a two-way street. As a counsellor, you bring your own heritage with you to your work, so you need to recognize the ways in which cultural conditioning has influenced the directions you take with your clients.

Unless the social and cultural context of clients and counselors are taken into consideration, it is difficult to appreciate the nature of clients' struggles. Counselling students often hold values—such as making their own choices, expressing what they are feeling, being open and self-revealing, and striving for independence—that differ from the values of clients from different cultural backgrounds. It is essential that counsellors become aware of how clients from diverse cultures may perceive them as therapists, as well as how clients may perceive the value of formal helping. It is the task of counsellors to determine whether the assumptions they have made about the nature and functioning of therapy are appropriate for culturally diverse clients.

Clearly, effective counseling must take into account the impact of culture on the client's functioning, including the client's degree of acculturation. Culture, is the values and behaviors shared by a group of individuals. Culture refers to more than ethnic or racial heritage; culture also includes factors such as age, gender, religion, sexual orientation, physical and mental ability, and socioeconomic status.

2.8 ATTITUDE OF A PROFESSIONAL COUNSELLOR

Every counsellor should have a conviction that all human beings are worthwhile, valuable and unique in order to relate to them in a positive and constructive manner. This must be felt as an experience and not an abstract philosophical concept. The counsellor should have a genuine interest in the client and respect the counselee as an important, valuable, and worthwhile human being. This is what Carl Rogers called "unconditional positive regard".

The counsellor should believe that the clients are capable of making change. A counsellor has to be optimistic. The belief that all counselees can, at least to

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some extent, modify their feelings, attitudes, cognitive structure and behaviour is imperative.

The counsellor should see the counselee as an individual as well as a member of the society. The unique ways of the individual and his or her functioning in the world outside should be very carefully understood by the counsellors.

Counselling should not only be seen as just a process to alleviate pain but also as a process to enhance growth and prevent pain.

Counsellor should be prepared to commit time and energy to assist the counselee. Commitment of the counsellor can easily influence the client when he/she sees that the counsellor exhibits a deep willingness to become involved in the clients' lives.

Counsellors must have a very good knowledge about themselves. They must be aware of their feelings, thoughts and behaviour and must have understood and processed their own attitudes, values and motivations for working with others, and must be constantly in search of personal growth. Counsellors who have a good sense of self-esteem, adequacy, and self-discipline transcend their own limitations and are free to give the necessary attention to their clients and focus on ways to assist them. These counsellors are warm, understanding, sincere, and generally interested in the counselee's health.

2.9 PERSONALITY OF EFFECTIVE COUNSELLORS

Though this list is not exhaustive and may seem too idealistic, effective counsellors, by and large tend to display the following personality traits and are continuously developing these traits: Effective counsellors:

- *Have an identity.* They know who they are, what they are capable of becoming, what they want out of life, and what is essential.
- *Respect and appreciate themselves.* They can give and receive help and love out of their own sense of self-worth and strength. They feel adequate with others and allow others to feel powerful with them.
- *Are open to change.* They exhibit a willingness and courage to leave the security of the known if they are not satisfied with the way they are. They make decisions about how they would like to change, and they work toward becoming the person they want to become.
- *Make choices that are life oriented.* They are aware of early decisions they made about themselves, others, and the world. They are not the victims of these early decisions, and they are willing to revise them if necessary. They are committed to living fully rather than settling for mere existence.
- *Are authentic, sincere, and honest.* They do not hide behind masks, defenses, sterile roles, or facades.

- *Have a sense of humor.* They are able to put the events of life in perspective. They have not forgotten how to laugh, especially at their own weaknesses and contradictions.
- *Make mistakes and are willing to admit them.* They do not dismiss their errors lightly, yet they do not choose to dwell on misery.
- *Generally live in the present.* They are not fixed in the past or on the future. They are able to experience and be present with others in the “now.”
- *Appreciate the influence of culture.* They are aware of the ways in which their own culture affects them, and they respect the diversity of values espoused by other cultures. They are also sensitive to the unique differences arising out of social class, race, sexual orientation, and gender.
- *Have a sincere interest in the welfare of others.* This concern is based on respect, care, trust, and are a valuing of others.
- *Possess effective interpersonal skills.* They are capable of entering the world of others without getting lost in this world, and they strive to create collaborative relationships with others. They do not present themselves as polished salespersons, yet they have the capacity to take another person’s position and work together toward consensual goals.
- *Become deeply involved in their work and derive meaning from it.* They can accept the rewards flowing from their work, yet they are not slaves to their work.
- *Are passionate.* They have the courage to pursue their passions, and they are passionate about life and their work. *Effective therapists are able to maintain healthy boundaries.* Although they strive to be fully present for their clients, they don’t carry the problems of their clients around with them during leisure hours. They know how to say no, which enables them to maintain balance in their lives.

2.10 VALUES IN COUNSELLING

The degree to which counselors’ values should enter into a therapeutic relationship is a matter of debate. Counselors are often taught not to let their values show. Yet they are simply not value-neutral, nor are value-free. Therapeutic interventions rest on core values, even the choice of words they use expresses their value system. It is neither possible nor desirable for counselors to be neutral with respect to values in the counseling relationship. Although counsellors’ values do influence the way they practice, it is possible to maintain a sense of objectivity.

Counselors need to guard against the tendency to assume either of two extreme positions. At one extreme are counselors who hold definite and

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absolute beliefs and see it as their job to exert influence on clients to adopt their values. These counselors tend to direct their clients toward the attitudes and values they judge to be “right.” At the other extreme are counselors who maintain that they should keep their values out of their work and that the ideal is to strive for value-free counseling. Because these counselors are so intent on not influencing their clients, they run the risk of immobilizing themselves.

Research has shown that counselors’ values influence all aspects of the therapeutic process, including assessment strategies, therapy goals, identifying what client problems will be the focus of treatment, choice of techniques, and evaluation of therapeutic outcomes. Clients are influenced by therapists’ values and often adopt some of these values.

Counselor’s role is to create a climate in which clients can examine their thoughts, feelings, and actions and eventually arrive at solutions that are best for them. Counsellors’ task is to assist individuals in finding answers that are most congruent with their own values. Hence, it is critical that they become aware of the nature of their values and how their beliefs and standards operate on the interventions utilized in their professional work. Counsellor’s function is not to convince clients of the proper course to take but to help them evaluate their behavior so that they can determine the degree to which it is working for them. If clients acknowledge that what they are doing is not getting them what they want, it is appropriate to assist them in developing new ways of thinking and behaving to help them move closer to their goals. This is done with full respect to their right to decide which values they will use as a framework for living. Individuals seeking counseling are the ones who need to clarify their own values and goals, make informed decisions, choose a course of action, and assume responsibility and accountability for the decisions they make.

2.11 ETHICAL CONSIDERATIONS FOR A COUNSELLOR

Professional codes of ethics serve a number of purposes. They educate counseling practitioners and the general public about the responsibilities of the profession. They provide a basis for accountability, and through their enforcement, clients are protected from unethical practices. Perhaps most important, ethics codes can provide a basis for reflecting on and improving your professional practice.

Ethics is usually viewed negatively, merely as a list of rules and prohibitions that result in sanctions and malpractice actions if practitioners do not follow them. **Mandatory ethics** is the view of ethical practice that deals with the minimum level of professional practice, whereas **aspirational ethics** is a higher level of ethical practice that addresses doing what is in the best interests of clients. Ethics is more than a list of things to avoid for fear of being punished. Ethics is a way of thinking about becoming the best practitioner possible. **Positive ethics** is an approach taken by practitioners who want to do their best

for clients rather than simply meet minimum standards to stay out of trouble.

Knowing and following the profession's code of ethics is part of being an ethical practitioner, but these codes do not make decisions for the counsellor. Interpreting the ethical guidelines of professional organizations and applying them to particular situations demand the utmost ethical sensitivity. Even responsible practitioners differ over how to apply established ethical principles to specific situations. In your professional work you will be challenged to deal with questions that do not always have obvious answers. You will have to assume responsibility for deciding how to act in ways that will further the best interests of your clients.

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Putting Clients' Needs Before Your Own

As counselors we cannot always keep our personal needs completely separate from our relationships with clients. Ethically, it is essential that we become aware of our own needs and realize how such factors could interfere with effectively and ethically serving our clients. Our professional relationships with our clients exist for their benefit. A useful question to frequently ask yourself is this: "Whose needs are being met in this relationship, my client's or my own?" It takes considerable professional maturity to make an honest appraisal of how your behavior affects your clients. It is not unethical for us to meet our personal needs through our professional work, but it is essential that these needs be kept in perspective. An ethical problem exists when we meet our needs, in either obvious or subtle ways, at the expense of our clients' needs. It is crucial that we avoid exploiting or harming clients.

The Right of Informed Consent

Regardless of the counsellors' theoretical framework, informed consent is an ethical and legal requirement that is an integral part of the therapeutic process. It also establishes a basic foundation for creating a working alliance and a collaborative partnership between the client and the therapist. **Informed consent** involves the right of clients to be informed about their therapy and to make autonomous decisions pertaining to it. Providing clients with information they need to make informed choices tends to promote the active cooperation of clients in their counseling plan. By educating your clients about their rights and responsibilities, you are both empowering them and building a trusting relationship with them.

Confidentiality

Confidentiality and privileged communication are two related but somewhat different concepts. Both of these concepts are rooted in a client's right to privacy. **Confidentiality** is an ethical concept, and in most states the legal duty of therapists to not disclose information about a client. **Privileged communication** is a legal concept that generally bars the disclosure of confidential communications in a legal proceeding.

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Confidentiality is central to developing a trusting and productive client–therapist relationship. Because no genuine therapy can occur unless clients trust in the privacy of their revelations to their therapists, professionals have the responsibility to define the degree of confidentiality that can be promised. Counselors have an ethical and legal responsibility to discuss the nature and purpose of confidentiality with their clients early in the counseling process. In addition, clients have a right to know that their therapist may be discussing certain details of the relationship with a supervisor or a colleague.

Although most counselors agree on the essential value of confidentiality, they realize that it cannot be considered an absolute. There are times when confidential information must be revealed, and there are many instances in which keeping or breaking confidentiality becomes a hazy issue. In determining when to breach confidentiality, therapists must consider the requirements of the law, the institution in which they work, and the clientele they serve. Because these circumstances are frequently not clearly defined by accepted ethics codes, counselors must exercise professional judgment.

There is a legal requirement to break confidentiality in cases involving child abuse, abuse of the elderly, abuse of dependent adults, and danger to self or others. All mental health practitioners and interns need to be aware of their duty to report in these situations and to know the limitations of confidentiality. Here are some other circumstances in which information must legally be reported by counselors:

- When the therapist believes a client under the age of 16 is the victim of incest, rape, child abuse, or some other crime
- When the therapist determines that the client needs hospitalization
- When information is made an issue in a court action

In general, the counselor’s primary obligation is to protect client disclosures as a vital part of the therapeutic relationship. Informing clients about the limits of confidentiality does not necessarily inhibit successful counseling.

Ethical Dilemmas in Assessment and Diagnosis

Assessment and diagnosis are integrally related to the practice of counseling and psychotherapy, and both are often viewed as essential for planning treatment. Regardless of their theoretical orientation, therapists need to engage in assessment, which is generally an ongoing part of the therapeutic process. Assessment should not precede and dictate intervention; rather, it is woven in and out of the therapeutic process as a pivotal component of therapy itself. This assessment may be subject to revision as the clinician gathers further data during therapy sessions. Some practitioners consider *assessment* as a part of the process that leads to a *formal diagnosis*.

Assessment consists of evaluating the relevant factors in a client's life to identify themes for further exploration in the counseling process. **Diagnosis**, which is sometimes part of the assessment process, consists of identifying a specific mental disorder based on a pattern of symptoms that leads to a specific diagnosis. Both assessment and diagnosis can be understood as providing direction for the treatment process.

Psychodiagnosis is the analysis and explanation of a client's problems. It may include an explanation of the causes of the client's difficulties, an account of how these problems developed over time, a classification of any disorders, a specification of preferred treatment procedure, and an estimate of the chances for a successful resolution. The purpose of diagnosis in counseling and psycho-therapy is to identify disruptions in a client's present behavior and lifestyle. Once problem areas are clearly identified, the counselor and client are able to establish the goals of the therapy process, and then a treatment plan can be tailored to the unique needs of the client.

Most practitioners consider assessment and diagnosis to be a continuing process that focuses on understanding the client. The collaborative perspective that involves the client as an active participant in the therapy process implies that both the therapist and the client are engaged in a search-and-discovery process from the first session to the last.

Ethical dilemmas may be created when diagnosis is done strictly for purposes other than professional help, which often entails arbitrarily assigning a client to a diagnostic classification. However, it is a clinical, legal, and ethical obligation of therapists to screen clients for life-threatening problems such as organic disorders, schizophrenia, bipolar disorder, and suicidal types of depression.

It is essential to assess the whole person, which includes assessing dimensions of mind, body, and spirit. Therapists need to take into account the biological processes as possible underlying factors of psychological symptoms and work closely with physicians. Clients' values can be instrumental resources in the search for solutions to their problems, and spiritual and religious values often illuminate client concerns.

Dual and Multiple Relationships in Counseling Practice

Dual or multiple relationships, either sexual or nonsexual, occur when counselors assume two (or more) roles simultaneously or sequentially with a client. This may involve assuming more than one professional role or combining professional and nonprofessional roles.

Many forms of nonprofessional interactions or nonsexual multiple relationships pose a challenge to practitioners. Some examples of *nonsexual* dual or multiple relationships are combining the roles of teacher

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and therapist or of supervisor and therapist; bartering for goods or therapeutic services; borrowing money from a client; providing therapy to a friend, an employee, or a relative; engaging in a social relationship with a client; accepting an expensive gift from a client; or going into a business venture with a client. Some multiple relationships are clearly exploitative and do serious harm both to the client and to the professional. For example, becoming emotionally or sexually involved with a *current* client is clearly unethical, unprofessional, and illegal. Sexual involvement with a *former* client is unwise, can be exploitative, and is generally considered unethical.

Because nonsexual dual and multiple relationships are necessarily complex and multidimensional, there are few simple and absolute answers to resolve them. It is not always possible to play a single role in your work as a counselor, nor is it always desirable. You may have to deal with managing multiple roles, regardless of the setting in which you work or the client population you serve. Give careful thought to the complexities of multiple roles and relationships before involving yourself in ethically questionable situations. Ethical reasoning and judgment come into play when ethics codes are applied to specific situations. The revised edition of the *ACA Code of Ethics* (ACA, 2005) stresses that counseling professionals must learn how to *manage* multiple roles and responsibilities in an ethical way. This entails dealing effectively with the power differential that is inherent in counseling relationships and training relationships, balancing boundary issues, addressing nonprofessional relationships, and striving to avoid using power in ways that might cause harm to clients, students, or supervisees.

Although dual and multiple relationships do carry inherent risks, it is a mistake to conclude that these relationships are always unethical and necessarily lead to harm and exploitation. Some of these relationships can be beneficial to clients if they are implemented thoughtfully and with integrity.

Ways of minimizing risk

The following guidelines may be helpful in ensuring minimal risk:

- Set healthy boundaries early in the therapeutic relationship. Informed consent is essential from the beginning and throughout the therapy process.
- Involve clients in ongoing discussions and in the decision-making process, and document your discussions. Discuss with your clients what you expect of them and what they can expect of you.
- Consult with fellow professionals as a way to maintain objectivity and identify unanticipated difficulties. Realize that you don't need to make a decision alone.
- When dual relationships are potentially problematic, or when the risk for harm is high, it is always wise to work under

supervision. Document the nature of this supervision and any actions you take in your records.

- Self-monitoring is critical throughout the process. Ask yourself whose needs are being met and examine your motivations for considering becoming involved in a dual or multiple relationships.

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Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What is informed consent?

3. In what legal instances can the counselors break confidentiality?

2.12 CHARACTERISTICS OF A SUCCESSFUL COUNSELLEE

A large portion of a positive counseling outcome is determined by the counselee. The counselee's level of pathology, motivation for change, expectations from treatment, coping skills, personal history, and other external resources all influence how effective the counseling experience will be. Counselees clearly benefit by actively participating in the counseling process. The more collaborative, motivated, and engaged counselees are, the more they tend to be involved, which results in effective counseling. Counselee characteristics, such as help-seeking attitudes and attachment style have been found to be related to counselee's use of counseling, as well as expectations and outcome. Stigma against mental illness can keep people from acknowledging problems and seeking help. Counselees with avoidance styles have been perceived to face greater risks and fewer benefits, and are less likely to seek professional help, compared to counselees who are more secure. Educating counselees about expectations from counseling can improve counseling satisfaction, treatment duration and outcomes.

The counselee characteristics that strongly influence counseling include the following:

- The kind/nature of problem
- The scope of the problem
- The historical and idiosyncratic pattern employed to solve problems and resolve issues
- Demographic characteristics such as socioeconomic status, gender and developmental level
- Personality characteristics
- Intelligence
- Reading ability

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- Cognitive style
- Temperament
- Level of motivation
- Counselee's degree of functioning
- Strengths and resources of the counselee
- Reluctance and resistance
- Values and beliefs of the counselee
- Cultural background and experiences

Successful counselee will display the following characteristics:

- Openness to new experiences, willing to do something new or different
- Responsive, willing to listen to other people, to accept negative as well as positive feedback, to take instructions, and to do what is expected
- Assertive, willing to ask for help, clarification, or additional instruction or guidance
- Communicates expectations clearly
- Understands the process of counseling and allows a reasonable amount of time for progress
- Goal-oriented, focused on producing results or changes
- Enthusiastic, eager to learn
- Attending sessions regularly and being on time
- Working diligently on all the homework that they might be required to do
- Knowing that they are responsible for their own success

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. Enlist the characteristics of a successful counselee.

2.13 COUNSELLEE EXPECTATIONS

Counselees bring expectations and beliefs to counseling situations. These expectations can influence both the counseling process and its outcome. Counselee's expectations affect many aspects of counseling, including the length of their stay in counseling, their satisfaction with the counseling, and how much and how rapidly they improve. Counselee expectations need to be recognized and taken into account in order to enhance the efficacy of counseling.

The counselee's strongest expectation is to see an experienced, genuine, expert, and acceptable counselor they could trust. The counselor is expected to be warmly interested in each counselee, to be highly trained and experienced,

and to be confident of his or her ability to help the counselee. The counselor is expected to be problem-centered on a personal level, thoroughly prepared for each interview, to be at ease with the counselee and his or her individual problem and to maintain confidentiality.

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2.14 LET US SUM UP

This chapter explained the essential characteristics of the professional counselor, with specific reference to communication skills, empathy, cognitive abilities, professional knowledge base, values, ethics and a social-cultural understanding.

Counseling involves working with a variety of individuals and their everyday problems in individual, family, or group settings. Counselling psychologists typically work helping clients with a variety of problems, which are not usually severe disturbances.

2.15 UNIT-END EXERCISES

1. Discuss the aims and scope of counseling.
2. Elaborate on the ethical considerations that have to be observed by a counsellor.
3. What personality characteristics of the counselor ensure effective counseling?

2.16 ANSWER TO CHECK YOUR PROGRESS

1. Vocational psychology, Child development, Adolescent development, Adult development/aging, Health psychology, Mental illness, Forensic psychology, Sport psychology, Neuropsychology, Interpersonal relationships, Assessment, Rehabilitation, Community psychology, Crisis intervention, Developmental disabilities, Eating disorders, Suicidal and homicidal tendencies
2. In cases involving child abuse, abuse of the elderly, abuse of dependent adults, and danger to self or others.
3. Informed consent involves the right of clients to be informed about their therapy and to make autonomous decisions pertaining to it.
4. Openness to new experiences, Responsive, willing to listen to other people, Assertive, willing to ask for help, Communicates expectations clearly, Understands the process of counseling and allows a reasonable amount of time for progress, Goal-oriented, Enthusiastic, Attending sessions regularly and being on time, Working diligently on all the homework that they might be required to do, Knowing that they are responsible for their own success

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2.17 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

UNIT 3: PSYCHOANALYTIC THEORY AND TECHNIQUES

Psychoanalytic theory and techniques

Structure

- 3.1 Introduction
- 3.2 Objectives
- 3.3 Key concepts
 - 3.3.1 View of human nature
 - 3.3.2 Structure of Personality
 - 3.3.3 Consciousness and the unconscious
 - 3.3.4 Anxiety
 - 3.3.5 Ego-defense mechanisms
- 3.4 Jung's perspectives on the Development of personality
- 3.5 Let us sum up
- 3.6 Unit-End Exercises
- 3.7 Answer to Check your Progress
- 3.8 Suggested Readings

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3.1 INTRODUCTION:

Different approaches to counselling are based on the varying conceptions of human personality structure and dynamics, and are subject to the limitations to which the personality theories are prone. The term 'approach' is used in preference to 'theory' as no single theory has yet been able to encompass all the aspects of counselling.

Freud's psychoanalytic system is a model of personality development, a philosophy of human nature and a method of psychotherapy. He focused on the psychodynamic factors that motivates the motivated behaviour, on the role of the unconscious and developed the first therapeutic procedures for understanding and modifying the structure of one's basic character.

3.2 OBJECTIVES

After going through this unit you will be able to:

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- Understand human nature from the psychoanalytic perspective
- Explain the key concepts of psychoanalytic theory
- Relate the concepts to your day to day life
- Critically evaluate the importance of psychoanalytic theories

3.3 KEY CONCEPTS:

3.3.1 VIEW OF HUMAN NATURE:

The Freudian view of human nature is basically deterministic. According to Freud, people's behaviour is determined by irrational forces, unconscious motivations, biological and instinctual drives and certain psychosexual stages during the first six years of life.

Instincts are central to the Freudian approach. Freud originally used the term "*libido*" to refer to sexual energy; later broadened it to include the energy of all the life instincts. He included all pleasurable acts in his concepts of life instincts; he saw the goal of life as gaining pleasure and avoiding pain.

Freud also postulated the concept "*death instincts*" (*Thanatos*), which accounted for the *aggressive* drive. At times, he asserted, people manifest through their behaviour an unconscious wish to die or hurt themselves or others. In his view, both sexual and aggressive drives are powerful determinants of why people act as they do.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. Name the two important instincts as proposed by Freud

3.3.2 STRUCTURE OF PERSONALITY:

According to the psychoanalytic view, personality consists of three systems; the id, the ego, and the superego. However, one's personality should be understood as the functioning as a whole rather than three discrete segments. According to Freudian view, the dynamics of personality consists of the ways in which psychic energy is distributed to the id, ego and superego.

The Id

The Id is the biological component and the original system of personality. The Id is the primary source of psychic energy and the seat of the instincts. It lacks organizations, and it is blind, demanding and insistent. The Id cannot tolerate tension and it functions to discharge tension immediately and return to a homeostatic condition. Ruled by the pleasure principle, which is aimed at reducing tension, avoiding pain and gaining pleasure, the Id is illogical, amoral and driven by one consideration; to satisfy instinctual need in accordance with the pleasure principle. The Id never matures but remains the spoiled brat of

personality. It does not think but only wishes or acts. The Id is largely unconscious, or out of awareness.

The Ego

The Ego has contact with the external world of reality. It is the 'executive' that governs, controls and regulates the personality. It mediates between the instincts and the surrounding environment. The ego controls the consciousness and exercise censorship. Ruled by the reality principle, Ego does realistic and logical thinking and formulates plans of actions for satisfying needs. While the Id knows only subjective reality, the Ego distinguishes between mental images and the things in the external world.

The Superego

The Superego is the judicial branch of personality. It is a person's moral code, the main concern being whether action is good or bad, right or wrong. It represents the ideal rather than a real and strives not for pleasure but for perfection. It represents the traditional values and ideals of society. It functions to inhibit the id impulses, persuade the ego to substitute moralistic goals for realistic ones and to strive for perfection. The superego, as the internalization of the standards of parents and society, is related to psychological rewards (feelings of pride and self-love) and punishments (guilt and inferiority)

Check your Progress – 2

- Note: a. Write your answer in the space given below
b. Compare your answer with those given at the end of the unit.
2. "Personality consists of three subsystems"-Explain

3.3.3 CONSCIOUSNESS AND THE UNCONSCIOUSNESS:

For Freud, consciousness is a thin slice of the total mind. Like the greater part of the iceberg that lies below the surface of the water, the larger part of the mind exists below the surface of awareness. The unconsciousness stores up all experiences, memories and repressed material. Needs and motivations that are out of awareness are also outside the sphere of conscious control. Most psychological functioning exists in the out-of-awareness realm. The aim of psychoanalytic therapy, therefore, is to make the unconscious process, the roots of all forms of neurotic symptoms and behaviours.

3.3.4 ANXIETY:

The concept of anxiety is also essential to the psychoanalytic approach. Anxiety is a state of tension that motivates us to do something. It develops out of a conflict among the id, ego and superego over a control of the available psychic energy. It's function is to warn impending danger.

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There are three kinds of anxiety; reality, neurotic and moral. Reality anxiety is the fear of danger from the external world, and the level of such anxiety is proportionate to degree of real threat. Neurotic anxiety is the fear that the instincts will get out hand and cause to do something for which one will be punished. Moral anxiety is the fear of one's own conscience.

3.3.5 EGO-DEFENSE MECHANISMS

When the ego cannot control anxiety by rational and direct methods, it relies on unrealistic ones-Ego-defense mechanisms. Ego-defense mechanisms help the individual cope with anxiety and prevent the ego from being overwhelmed. They can have adaptive value if they do not become a style of life to void facing reality. Defense mechanisms have two characteristics in common; they either deny or distort reality and they operate on an unconscious level. Some common Ego defenses are;

- Repression – It is a means of defense through which threatening or painful thoughts are excluded from awareness. It is an involuntary removal of something from consciousness.
- Denial – Denial is a way of distorting what the individual thinks, feels or perceives in traumatic situation. It generally operates at preconscious and conscious levels. It consists of defending against anxiety, expressing the opposite impulse.
- Reaction formation – defending against a threatening impulse by actively expressing the opposite impulse.
- Displacement – Discharging impulses by shifting from a threatening object to a 'safer target'
- Rationalization – this involves explaining the failures or losses. It helps to justify specific behaviours and it aids in coping with disappointments.
- Sublimation – This involve diverting sexual energy into other channels, ones that are usually socially acceptable and sometimes even admirable.
- Regression – Reverting to a form of behaviours that they have outgrown.
- Introjection – This mechanism consists of taking in and 'swallowing' the values and standards of others.
- Identification – Although this is a part of the development process by which children learn sex role behaviours, it can also be a defensive reaction.
- Compensation – This consists of masking perceived weakness or developing certain positive aspects (skills, attributes,etc)to make up for limitations.
- Ritual and undoing – At times people perform elaborate rituals as a way of undoing acts for which they feel guilty.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What happens when the ego does not control the anxiety?

4. Enlist the different ego defense mechanisms.

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DEVELOPMENT OF PERSONALITY

- According to Freudian psychoanalytic view, the three areas of personal and social development – love and trust, dealing with negative feelings and developing a positive acceptance of sexuality are all grounded from the first six years of life. This period is the foundation on which later personality development is built.
- **The first year of life: the oral stage** – Two activities are developed during this developmental period- the oral-incorporative behaviour and oral aggressive behaviour are considered to be the prototypes of some of the character traits of adulthood.
- Oral incorporative behaviour involves pleasurable stimulation of mouth. Adults who exhibits excessive oral needs (such as excessive eating, chewing, talking, smoking and drinking) may have an *oral fixation*. Deprivation of oral gratification during infancy is assumed to lead to problems in adulthood.
- Oral-aggressive period begins when the infant teethes. Adult characteristics such as sarcasm, hostility, aggression, gossip, and making ‘biting’ comments are related to events of this development period.
- Later personality problems that stem from the oral stage are the development of a view about the world based on mistrust, fear of reaching out to others, rejection of affection, fear of loving and trusting, low self-esteem, isolation and withdrawal and inability to form or maintain intense relationships.
- **Ages 1-3: The anal stage** - The tasks to be mastered in this stage of development are learning independence, personal power and autonomy and learning how to recognize and deal with negative feelings. When toilet training begins during second year, children have their first major experience with discipline. The method of toilet training and the parents’ feeling attitudes and reactions toward the child can have far-reaching effects on the formation of reactions toward the child can have far-reaching effects on the formation of personality traits, Later personality problems. In contrast, other parents might focus too much attention on their children during this stage.
- If strict toilet – training methods are used, children may express their anger by expelling their faces at inappropriate places and times. This behaviour can lay the foundation for adult characteristics such as cruelty, inappropriate displays of anger and extreme disorderliness.

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Freud described this as *anal aggressive* personality. In contrast, other parents might focus too much attention on their children's bowel movements by giving praise whenever they defecate, which can contribute to a child's exaggerated view of the importance of this activity. This focus might be associated with a person's need for being productive.

- **Ages 3-6: The phallic stage** – In this period there is increased motor and perceptual development as well as interpersonal skills. Sexual activity becomes more intense and now the focus of attention is on the genitals – the boy's penis and the girl's clitoris.
- According to the orthodox Freudian view, the basic conflict of the phallic stage, centres on the unconscious desires that children develop for the parent of the opposite sex. Because these feelings are of such a threatening nature, they are typically repressed; yet powerful determinants of lateral sexual development and adjustment. Long with this comes the unconscious wish of the child to 'do away with' the competition – the parent of the same sex.
- In the *male phallic stage* the boy craves the attention of his mother, feels antagonistic toward his father and is known as the *Oedipus complex*. At this time the boy typically develops specific fears related to his penis. *Castration anxiety* plays a central role in the boy's life at this time. He fears that his father will retaliate by cutting off his offending organ. If the oedipal conflict is properly resolved, the boy replaces his sexual longings for his mother with more acceptable forms of affection. He develops strong identification with his father through which he experiences various satisfaction. He becomes more like his father and may adopt many of his father's mannerisms.
- The Electra complex is the girl's counterpart to the Oedipus complex. The girl is said to develop negative feelings toward her mother when she discovers the absence of a penis, the condition known as *penis envy*. The girl later on like boy begins identification process by taking on some of the characteristics of her mother's behaviour.
- **Ages 6-12: The latency stage** – This is the period of relative rest. The major structures of personality are largely formed, as are the relationships between these subsystems. New interests replaces the infantile sexual impulses. Socialization takes place and children direct their interests to the larger world. The sexual drive is sublimated, to some extent, to activities in school, hobbies, sports and friendships and with members of the same sex.
- A major characteristic of oral, anal and phallic stages is a *narcissistic* orientation or an inward and self-centered preoccupation. During the middle-childhood years there is a turning relationship with others. This period prevails until the onset of puberty.
- **Age 12-18: The genital stage** – Young adults move into the genital stage unless they become fixated at an earlier period of psychosexual development. Old themes of phallic stages are revived. Adolescents typically develop interest in the opposite sex, engage in some sexual

experimentation and begin to assume adult responsibilities. There is a trend away from narcissism and toward altruistic behaviour and concern for others. They develop intimate relationships, become free of parental influence, and develop the capacity to be interested in others. Freud was primarily concerned with the impact of resolving sexual issues during the first six years of life. He did not go into great detail in discussing the crises associated with adolescence or the stages of adulthood.

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Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What are the different stages of Personality Development as proposed by Freud?

3.4 JUNG’S PERSPECTIVES ON THE DEVELOPMENT OF PERSONALITY

Carl Jung focused on the role of purpose in human development, presenting a more creative, optimistic view of humankind. He believed that a person had more energy than that derived from sexual drives and that one was always developing towards the wholeness and self-fulfillment (Individuation), using energy to be “creatively purposeful” and searching for a balance among body, mind and spirit.

Jung believed that the “transcendent function” (use of the energy to integrate and transcend conflict) mediates the relation between the conscious and the unconscious. He differentiated between the personal unconscious (painful, threatening experiences repressed or ignored) and the collective unconscious (buried memories based on the wisdom of the ancestral past). This differentiation helps in understanding and interpreting unconscious material – that is symbols. Through his construct of collective unconscious, Jung paid more attention than did Freud to the role of culture in the development of the human personality. In time of war, for example, one can imagine the forces of collective unconscious, causing people to unite in aggression.

Other major Jungian concepts include the persona (public mask or social façade one displays in various situations), the animus (masculine side), the anima (feminine side), extroversion (orientation toward the outer, objective world), and introversion (orientation toward the inner, subjective world). These concepts led to Jung’s postulation of four types of people: thinking, feeling, sensing, and intuiting. In distinguishing among these psychological types, Jung pointed out that persons with different types communicate with great difficulty. For example, an intuitive person will be impatient with the practical approach of the sensation-oriented person. The thinking type will have trouble with the feeling type and vice-versa. All these types, in varying

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degrees of extroversion and introversion, exist within every human; however, one type tends to be more pronounced than the others.

Jung was not as deterministic as Freud. He postulated spiritual development throughout adult life, focusing particularly on one's capacity in midlife to integrate unconscious and conscious aspects of personality in order to become an authentic, spiritual individual.

3.5 LET US SUM UP

In this unit, we have focused on Freud's psychoanalytic approach and Jung's view of personality development. Freud's concepts on personality give deep insights on human nature and has also stimulated a good deal of critical views and doubts relating to empirical testing. However, there is no doubt that psychoanalytic theories and techniques are significant till date.

3.6 UNIT-END EXERCISES:

1. Explain how psychoanalysts' view of human nature.
2. Explain the importance of Consciousness and Unconsciousness according to Freud.
3. Explain the role of anxiety in Psychoanalytic approach.
4. "Jung focused on the role of purpose in human development". Explain.

3.7 ANSWER TO CHECK YOUR PROGRESS:

1. According to Freud, it is Life Instinct (Libido) which refers to Sexual Energy and Death Instinct (Thanatos) which refers to Aggression.

2. The three subsystems are Id, Ego and Super ego.

Id: Ruled by the pleasure principle, which is aimed at reducing tension, avoiding pain and gaining pleasure, the Id is illogical, amoral and driven by one consideration. It is largely of unconscious or unawareness.

Ego: It is the 'executive' that govern, controls and regulates the personality. It mediates between the instincts and the surrounding environment. The ego controls the consciousness and exercise censorship. It is ruled by the reality principle.

Super Ego: The Superego is the judicial branch of personality. It is a person's moral code, the main concern being whether action is good or bad, right or wrong.

3. When the ego does not control the anxiety, it leads to formation of ego-defense mechanism. When the ego cannot control anxiety by rational and direct methods, it relies on unrealistic ones-ego-defense mechanisms. Ego-defense

mechanisms help the individual cope with anxiety and prevent the ego from being overwhelmed.

4.Repression, Denial, Reaction formation, Displacement, Rationalization, Sublimation, Regression, Introjection, Identification, Compensation, Ritual and Undoing.

5. First year of life- Oral Stage, Age1-3 Anal stage, Age 3-6 Phallic Stage, Age 6-12 Phallic Stage, Age 12-18 Genital stage.

3.8SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. &Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper’s Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. &Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D.John Antony, Skills of Counselling, 2003, Anugraha Publications

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UNIT 4: Contemporary trends

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Structure

4.1 Introduction

4.2 Objectives

4.3 Self psychology and object-relations theory

4.4 Therapeutic process

4.4.1 Therapeutic Goals

4.4.2 Therapist's function and role

4.4.3 Client's Experiences and Relationships with the therapist

4.5 Techniques

4.5.1 Maintaining the analytic framework

4.5.2 Free association

4.5.3 Interpretation

4.5.4 Dream analysis

4.5.5 Analysis and interpretation of resistance

4.5.6 Evaluation

4.6 Let us sum up

4.7 Unit-end exercises

4.8 Answer to check your progress

4.9 Suggested readings

4.1 INTRODUCTION

The contemporary trends in psychoanalytic thinking contribute to the understanding of how our current behavior in the world is largely a repetition of patterns set during one of the early phases of development. Object-relations theory helps us see the ways in which clients interacted with significant others in the past and how they are superimposing these early experiences on present relationships. For the many clients in therapy who are struggling with issues such as separation and individuation, intimacy, dependence versus independence, and identity, these newer formulations can provide a framework for understanding how and where

aspects of development have been fixated. This unit elaborates on these perspectives and discusses the techniques used by the psychoanalytic approach.

4.2 OBJECTIVES

At the end of the unit, you will be able to:

- Understand the contemporary trends in psychoanalytic approach
- Comprehend the rationale of using appropriate techniques in the therapeutic process
- Experiment the use of different psychoanalytic techniques

4.3 SELF PSYCHOLOGY AND OBJECT-RELATIONS THEORY

Contemporary psychoanalytic thinkers (primarily Melanie Klein, Ronald Fairbairn, Donald W. Winnicott, Harry Guntrip, Margaret Mahler, Heinz Kohut, and Otto Kernberg) emphasize the ego and interpersonal relationships rather than the id and innate biological drives as the basis of personality development. A person's primary drive from birth is considered to be for relationship contact, as opposed to the discharge of tension from sexual and aggression drives. The focus is on the relationship between an individual and real people, between an individual and his or her mental image or representation of real people, and between an individual's mental images or representations from early significant relationships and current real people.

The crucial development of personality begins in the pre-oedipal phase, with the infant's relationship with the primary caregiver, usually the mother, rather than with the infant's relationship with the father during the Freudian oedipal phase. Mother becomes the infant's first love object. In the first stages of infancy, when the infant cannot differentiate self from other, the infant ego's ability to develop a sense of security within itself and the environment depends on the identification the mother feels with her infant and on her capacity to empathize and nurture. If the infant's needs are not met during the symbiotic phase, the infant's ego splits, withdrawing and hiding to avoid the anxiety resulting from not having primary essential needs consistently met. The ego splits into what Winnicott (1965) calls the true self and the false self. The true self is at the core of human existence and is able to relate to itself and to others. The false self arises as a protection for an undernourished, insecure ego. It hides from the outer world and relationships. Thus, shortcomings or failures in early maternal nurturance lead to false selves and inhibit the development of a whole ego. Aggression is viewed by these theorists as a response or reaction to frustrating relationships rather than as an instinct.

The ego passes through many stages or position during infancy and early childhood, from the symbiotic relationship with the mother on through the separation and individuation stages. The quality of the infant's experiences of attachment and separation in the object relations of early years shapes the

development of the ego, which includes the potential capacity to love and relate to others. Splitting and Projection, the defenses one use because of faulty object relations, disturb healthy ego development and can contribute to such pathologies as narcissistic character disorders, borderline states and psychoses.

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Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What is true self and false self according to Winnicott?

4.4 THERAPEUTIC PROCESS

4.4.1 Therapeutic Goals

Two goals of Freudian psychoanalytic therapy are to make the unconscious conscious and to strengthen the ego so that behaviour is based more on reality and less on instinctual cravings. Successful analysis is believed to result in significant modification of individual's personality and character structure. Childhood experience are reconstructed, discussed, interpreted and analysed. The process not limited to solving problems and learning new behaviours but to probe deeply into the past and develop the level of self-understanding which is assumed to be necessary for a change in character.

4.4.2 Therapist's function and role

In classical psychoanalysis the therapist engages in very little self-disclosure and maintains a sense of neutrality in an attempt to foster a *transference relationship*, in which their clients will make projections onto them. These projections, which have their origins in unfinished and repressed situations and their analysis, are considered to be very essence of therapeutic work.

Although the client regresses and displays primitive 'neurotic' symptoms during the sessions, the transference neurosis is not intended to disrupt the client's functioning outside the analytic hour. If the client's transference neurosis leads to negative behaviour outside the session, it is termed 'acting out'. Significant acting out is viewed as detrimental.

The central function of the analysis is to assist the client in achieving self-awareness, honesty and more effective personal relationships in dealing with anxiety in a realistic way, and in gaining control over impulsive and irrational behaviour. A working relationship is first established between the therapist by doing a lot of listening and interpreting. Particular attention is given to the client's resistances and the therapist decides to make appropriate interpretations. A major function of interpretation is to accelerate the process of unconscious material. The analyst listens for gaps and inconsistencies in the client's story. Infers the meaning of reported dreams and free associations, carefully observes during the therapy session, and remains sensitive to clues

concerning the client's feeling toward the analyst. The analyst also teaches the clients the meaning of therapeutic processes so that they are able to achieve insight into problems, increase their awareness of ways to change and thus gain more rational control over lives.

4.4.3 CLIENT'S EXPERIENCES AND RELATIONSHIPS WITH THE THERAPIST

Classical psychoanalysis is an intensive and a long term process. Free association, client reporting their feelings, experiences, associations, memories and fantasies to the analyst without any censorship is the "fundamental rule" of the process. However in psychoanalytically oriented practise though all these techniques are not followed the therapist remain alert to transference manifestations and work with dreams and with unconscious material. Therapeutic sessions are terminated when the clients have clarified and accepted their emotional problems, have understood the historical roots of their difficulties and can integrate their awareness of past problems with their present relationships.

The client's relationship with the analyst is conceptualized in the transference process, which is the core of the psychoanalytic approach. *Transference* is the unconscious shifting to the analyst by the client of feelings and fantasies, both positive and past. If therapy is to produce change, negative, that are displacements from reactions to significant, others in the client's past. If therapy is to produce change, the transference relationships must be worked through, by exploring the unconscious material and defenses. The therapist in the process becomes intimately involved in the unresolved conflicts within therapist. *Counter-transference* becomes an inevitable part of the therapeutic relationship. It refers to the irrational reactions therapists have toward clients that may interfere with their objectivity.

The client-therapist relationship is of vital importance in psychoanalytic theory, particularly in working through the transference situation, when the clients acquire insights into their own unconscious psychodynamics. This approach assumes that without this dynamic self-understanding there can be no substantial personality change or resolution of present conflicts.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What is transference?

3. What is Counter transference?

4.5 TECHNIQUES

4.5.1 MAINTAINING THE ANALYTIC FRAMEWORK

The psychoanalytic process stresses maintaining a particular framework

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aimed at accomplishing the goals of this type of therapy. Maintaining the analytic framework refers to a whole range of procedural factors, such as the analyst's relative anonymity, the regularity and consistency of meetings, and starting and ending the sessions on time. One of the most powerful features of psychoanalytically oriented therapy is that the consistent framework is itself a therapeutic factor, comparable on an emotional level to the regular feeding of an infant. Analysts attempt to minimize departures from this consistent pattern (such as vacations, changes in fees, or changes in the meeting environment).

4.5.2 FREE ASSOCIATION

Free association is a central technique in psychoanalytic therapy, and it plays a key role in the process of maintaining the analytic framework. In free association, clients are encouraged to say whatever comes to mind, regardless of how painful, silly, trivial, illogical, or irrelevant it may be. Clients flow with any feelings or thoughts by reporting them immediately without censorship. As the analytic work progresses, most clients will occasionally depart from this basic rule, and these resistances will be interpreted by the therapist when it is timely to do so.

Free association is one of the basic tools used to open the doors to unconscious wishes, fantasies, conflicts, and motivations. This technique often leads to some recollection of past experiences and, at times, a release of intense feelings (catharsis) that have been blocked. This release is not seen as crucial in itself, however. During the free-association process, the therapist's task is to identify the repressed material that is locked in the unconscious. The sequence of associations guides the therapist in understanding the connections clients make among events. Blockings or disruptions in associations serve as cues to anxiety-arousing material. The therapist interprets the material to clients, guiding them toward increased insight into the underlying dynamics.

As analytic therapists listen to their clients' free associations, they hear not only the surface content but also the hidden meaning. Nothing the client says is taken at face value. For example, a slip of the tongue can suggest that an expressed emotion is accompanied by a conflicting affect. Areas that clients do not talk about are as significant as the areas they do discuss.

4.5.3 INTERPRETATION

Interpretation consists of the analyst's pointing out, explaining and even teaching the client the meanings of behaviour that is manifested in dreams, free association, resistances and therapeutic relationship itself. The functions of interpretations are to allow the ego to assimilate new material and to speed up the process of uncovering further unconscious material.

4.5.4 DREAM ANALYSIS

During sleep, defenses are lowered, and repressed feelings surface, Freud saw dreams as the 'royal road to the unconscious', for in them one's unconscious the person that they have are expressed in disguised or symbolic form rather than being revealed directly.

Dreams have two levels of content: the latent content and the manifest content. The latent content consists of hidden, symbolic, and unconscious motives, wishes, needs and fears. Because they are so painful and threatening, the unconscious sexual and aggressive impulses that make up the latent content are transformed into the less threatening manifest content, which is the dream as it appears to the dreamer. The process by which the latent content is interpreted is called dream work. The therapist's task is to uncover disguised meanings by studying the symbols in the manifest content of the dream. During the session the therapist might ask the client to free-associate to some aspect of the manifest content of a dream for the purpose of uncovering the latent meanings. Gradually, they are able to uncover the meaning of their dream.

4.5.5 ANALYSIS AND INTERPRETATION OF RESISTANCE

Resistance, a concept fundamental to the practice of psychoanalysis, is anything that works against the progress of therapy and prevents the client from producing previously unconscious material. Specifically, resistance is the client's reluctance to bring to the surface of awareness unconscious material that has been repressed. Resistance refers to any idea, attitude, feeling, or action (conscious or unconscious) that fosters the status quo and gets in the way of change. During free association or association to dreams, the client may evidence an unwillingness to relate certain thoughts, feelings, and experiences. Freud viewed resistance as an unconscious dynamic that people use to defend against the intolerable anxiety and pain that would arise if they were to become aware of their repressed impulses and feelings.

As a defense against anxiety, resistance operates specifically in psychoanalytic therapy to prevent clients and therapists from succeeding in their joint effort to gain insights into the dynamics of the unconscious. Because resistance blocks threatening material from entering awareness, analytic therapists point it out, and clients must confront it if they hope to deal with conflicts realistically. The therapists' interpretation is aimed at helping clients become aware of the reasons for the resistance so that they can deal with them. As a general rule, therapists point out and interpret the most obvious resistances to lessen the possibility of clients' rejecting the interpretation and to increase the chance that they will begin to look at their resistive behavior.

Resistances are not just something to be overcome. Because they are representative of usual defensive approaches in daily life, they need to be

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recognized as devices that defend against anxiety but that interfere with the ability to accept change that could lead to experiencing a more gratifying life. It is extremely important that therapists respect the resistances of clients and assist them in working therapeutically with their defenses. When handled properly, resistance can be one of the most valuable tools in understanding the client.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What is Free association?
5. What is dream work?

4.5.6 EVALUATION

The Freudian discovery that man is often motivated in thought and behaviour by unconscious impulses is of great significance. Freud was perhaps the first among psychologists to identify the importance of anxiety. He also contributed therapist must have a non-moralization attitude.

The psychoanalytic technique requires enormous time, motivation and money. It is also criticized for the deterministic view of man, portraying him as a nasty repressed urges. Too much emphasis is placed upon childhood experiences. This approach also minimizes the importance of situational events. The constructs have been shown to be empirically demonstrable or verifiable.

4.6 LET US SUM UP

Competent use of psychoanalytic techniques requires training beyond what most therapists are afforded in their training program. Considering the early history of a client is often useful in understanding and working with a client's current situation. Even though you may not agree with all of the premises of the classical psychoanalytic position, you can still draw on many of the psychoanalytic concepts as a framework for understanding your clients and for helping them achieve a deeper understanding of the roots of their conflicts.

It is clearly demonstrated thus that the contemporary psychoanalytic trends have significant implications for many areas of human interaction such as intimate relationships, the family and child rearing, and the therapeutic relationship.

4.7 UNIT-END EXERCISES

1. Explain Self Psychology and Object Relations theory.
2. Elaborate on the various techniques used by the psychoanalytic therapists.

3. What is the rationale of use of various techniques of the psychoanalytic approach?

4.8 ANSWER TO CHECK YOUR PROGRESS

1. The true self is able to relate to itself and to others. The false self arises as a protection for an undernourished, insecure ego and inhibit the development of a whole ego.
2. Transference is the unconscious shifting of feelings and fantasies, both positive and past to the analyst by the client. If therapy is to produce change, the transference relationships must be worked through, by exploring the unconscious material and defenses.
3. Counter-transference refers to the irrational reactions therapists have toward clients that may interfere with their objectivity.
4. Free association is a central technique in psychoanalytic therapy, in which clients are encouraged to say whatever comes to mind, regardless of how painful, silly, trivial, illogical, or irrelevant it may be without any censorship.
5. Dreams have two levels of content: the latent content and the manifest content. The latent content consists of hidden, symbolic, and unconscious motives, wishes, needs and fears. Because they are so painful and threatening, the unconscious sexual and aggressive impulses that make up the latent content are transformed into the less threatening manifest content, which is the dream as it appears to the dreamer. The process by which the latent content is interpreted is called dream work.

NOTES

4.9 SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper's Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D. John Antony, Skills of Counselling, 2003, Anugraha Publications.

UNIT 5: HUMANISTIC THEORIES AND TECHNIQUES

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Structure

- 5.1 Introduction
- 5.2 Objectives
- 5.3 Person-Centered Theory
- 5.4 Key concepts
 - 5.4.1 View of human nature
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- 5.7 Evaluation
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5.1 INTRODUCTION

In the 1960s and 1970s there was a growing interest among counselors in a “third force” in therapy as an alternative to the psychoanalytic and behavioral approaches. Under this heading fall existential therapy, the person- centered approach, and Gestalt therapy, which are all experiential and relationship oriented.

In common, existentialism and humanism, both emphasize on concepts such as freedom, choice, values, personal responsibility, autonomy, purpose, and meaning. Both approaches place little value on the role of techniques in the therapeutic process, and emphasize instead the importance of genuine encounter. They differ in that existentialists take the position that we are faced with the anxiety of choosing to create an identity in a world that lacks intrinsic meaning. The humanists, in contrast, take the somewhat less anxiety-evoking position that each of us has a natural potential that we can actualize and through which we can find meaning.

5.2 OBJECTIVES

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

- Understand the key concepts and assumptions underlying person-centered theories and techniques
- Understand the conditions required for personality change
- Apply and evaluate the conceptual understanding to practical problems

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5.3 PERSON-CENTERED THEORY

The person-centered approach is based on concepts from humanistic psychology, and it can also be classified as a branch of the existential perspective. In the early 1940s Rogers developed what was known as non-directive counselling as a reaction against the directive and psychoanalytic approaches to individual therapy. His theory emphasized the counsellor's creation of a permissive and non-interventionist climate. Rogers challenged the validity of commonly accepted therapeutic procedures such as advice, suggestion, persuasion, teaching, diagnosis, and interpretation. Non directive counsellors avoided sharing a great deal about themselves with clients, and instead they focused mainly on reflecting and clarifying the verbal and nonverbal communications of clients. Roger's basic assumptions were that people are essentially trust worthy, that they have a vast potential for understanding themselves and resolving their own problems without direct intervention on the therapist's part, and that they are capable of self-directed growth if they are involved in a therapeutic relationship. The attitudes and personal characteristics of the therapist and the quality of the client / therapist relationship are the prime determinants of the outcome of the therapeutic process.

Rogers developed a systematic theory of personality and applied this self-theory to the practice of counselling individuals. His client-centered therapy approach gradually extended its sphere of influence into a variety of fields far from its point of origin. Because of Roger's ever-widening scope of influence, including his interest in how people obtain, possess, share, or surrender power and control over others and themselves, his theory has become known as the person-centered approach.

5.4 KEY CONCEPTS

5.4.1 VIEW OF HUMAN NATURE

A consistent theme pervades all of Rogers's writings and activities. This theme is a deep faith in the tendency of humans to develop in appositive and constructive manner if a climate of respect and trust is established. He firmly believed that people were resourceful, capable of self-direction, and able to live effective and productive lives, he maintained that there were three

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therapist attributes that released a growth-promoting climate in which individuals could move forward and become what they were capable of becoming. These attributes are (1) congruence (genuineness, or realness), (2) unconditional positive regard (acceptance and caring), and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person). According to Rogers, if these attitudes are communicated by the helper, those being helped will become less defensive and more open to themselves and their world, and they will behave in social and constructive ways. The basic drive to fulfilment implies that people move toward health if the way seems open for them to do so. Thus, the goals of counselling are to set clients free and to create those conditions that will enable them to engage in meaningful self-exploration. When people are free, they will be able to find their own way.

This positive view of human nature has significant implications for the practice of therapy. Because of the belief that the individual has an inherent capacity to move away from maladjustment towards psychological health, the therapist places the primary responsibility on the client. The person-centered approach rejects the role of the therapist as the authority who knows best and of the passive client who merely follows the dictates of the therapist. Therapy is thus rooted in the client's capacity for awareness and the ability to make decisions.

The therapist focuses on the constructive side of human nature, on what is right with the person, and on the assets that people bring with them to therapy. It focuses on how clients act in their world with others, how they can move forward in constructive directions, and how they can successfully encounter obstacles (both from themselves and outside of themselves) that are blocking their growth. The implication is that therapy is more than "adjustment to norms", and this approach does not stop with merely solving problems. Instead, practitioners with a humanistic orientation aim at challenging their clients to make changes that will lead to living fully and authentically, with the realization that this kind of existence demands a continuing struggle. People never arrive at a static state of being self-actualized; rather, at best they are continually involved in the process of actualizing themselves.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What were the three important attributes that Roger believed in?

5.4.2 BASIC CHARACTERISTICS

The person-centered approach focuses on client's responsibility and capacity to discover ways to more fully encounter reality. Clients, who know

themselves best, are the ones to discover more appropriate behaviour for themselves based on a growing self-awareness.

The approach emphasizes the phenomenal world of the client. With an attempt to apprehend the client's internal frame of reference, therapists concern themselves mainly with the client's perception of self and of the world, the principles of person-centered therapy apply to those who function at relatively normal levels as well as to those who experience a greater degree of psychological maladjustment.

According to the person-centered approach, psychotherapy is only one example of a constructive personal relationship. Clients experience psychotherapeutic growth in and through the relationship with another person who helps them do what they cannot do alone. It is the relationship with a counsellor who is congruent accepting, and empathetic that facilitates therapeutic change for the client. Person centered theory holds that the therapist's function is to be immediately present and accessible to the client and to focus on the here-and-now experience.

Person-centered therapy is not a set of techniques or a dogma. Rooted in a set of attitudes and beliefs that the therapist demonstrates, it is perhaps best characterized as a way of being and as a shared journey in which both therapist and client reveal their humanness and participate in a growth experience.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What is the important factor which facilitates the therapeutic change for the client according to person-centered approach

5.5 THERAPEUTIC PROCESS

5.5.1 THERAPEUTIC GOALS

The person-centered approach aims towards a greater degree of independence and integration of the individual. Its focus is on the person, not on the person's presenting problem. In Roger's view, the aim of therapy is not merely to solve problems. Rather, it is to assist clients in their growth process, so that they can better cope with problems they are not facing and with future problems.

The underlying aim of therapy is to provide a climate conducive in helping the individual to become a fully functioning person. Before clients are able to work toward that goal, they must first get behind the masks they wear, which they develop through the process of socialization. Clients come to recognize that they have lost contact with themselves by using these facades. In a climate of safety in the therapeutic session, they also come to realize that there are other possibilities. Rogers describes people who are becoming increasingly

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actualized, as having (1) an openness to experience (2) a trust in themselves (3) an internal source of evaluation, and (4) a willingness to continue growing. Encouraging these characteristics is the basic goal of person-centered therapy. The therapist does not choose specific goals for the client. The cornerstone of person-centered theory is the view that clients in relationship with a facilitating therapist have the capacity to define and clarify their own goals.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. How did Roger describe the increasingly actualized individual as?

5.5.2 THERAPISTS FUNCTION AND ROLE

The role of person-centered therapists is rooted in their ways of being and attitudes, not in techniques designed to get the client to “do something”. Research on person-centered therapy seems to indicate that the attitudes of therapist, rather than their knowledge, theories, or techniques, facilitate personality change in the client. Basically, therapists use themselves as an instrument of change. When they encounter the client on a person-to-person level, their “role” is to be without roles. Their function is to establish a therapeutic climate that helps the client grow. The person-centered therapist thus creates a helping relationship in which client experience the necessary freedom to explore areas of their life that are now either denied to awareness or distorted. Through the therapist’s attitudes of genuine caring, respect, acceptance, and understanding, they are able to loosen their defences and rigid perceptions and move to a higher level of personal functioning.

5.5.3 CLIENT’S EXPERIENCE IN THERAPY:

Clients come to the counsellor in a state of incongruence, that is, a discrepancy exists between their self-perception and their experience in reality. One of the reason that client seek therapy is a feeling of basic helplessness, powerlessness, and inability to make decisions or effectively direct their own life. They may hope to find “the way” through the teachings of the therapist. Within the person-centered framework, however, they soon learn that they can be responsible for themselves in the relationship and they can learn to be free by using the relationship to gain greater self-understanding. As counselling progresses, clients are able to explore a wider range of their feelings.

They increasingly discover aspects within themselves that had been kept hidden. As clients feel understood and accepted, their defensiveness is less necessary, and they become more open to their experience. Because they are not as threatened, feel safer, and are less vulnerable, they become more realistic, perceive others with greater accuracy, and become better able to understand and accept others. They come to appreciate themselves more as

they are, and their behaviour shows more flexibility and creativity. They become less oriented to meeting other's expectations, and thus they begin to behave in ways that are truer to themselves. They move in the direction of being more in contact with what they are experiencing at the present moment, less bound by the past, less determined, more free to make decisions, and increasingly trusting in themselves to effectively manage their own lives. In short, their experience in therapy is like throwing off the self-imposed shackles that had kept them in a psychological prison. With increased freedom they tend to become more mature psychologically and more actualized.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. When does client seek help?

5.5.4 SIX CONDITIONS ACCOUNTING FOR PERSONALITY CHANGE

Roger maintains that, personality and behavioural changes occur when the core therapeutic conditions exist. According to him, the following six conditions are necessary and sufficient for personality changes to occur:

- Two persons are in psychological contact.
- The first, whom we shall term the client, is experiencing in congruency.
- The second person, whom we shall term the therapist, is congruent or integrated in their relationship.
- The therapist experiences unconditional positive regard or real caring for the client.
- The therapist experiences an empathetic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.
- The communication to the client of the therapist's empathetic understanding and unconditional positive regard is to a minimal degree achieved.

The conditions do not vary according to client type. Further, they are necessary and sufficient for all approaches to therapy and apply to all personal relationships, not just to psychotherapy. The therapist need not have and specialized knowledge.

5.5.5 ROLE OF THE COUNSELLOR

From Rogers's perspective, the client / therapist relationship is characterized by equality, for therapists do not keep their knowledge a secret or attempt to

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mystify the therapeutic process. The process of change in the client depends, to a large degree, on the quality of this equal relationship. As clients experience the therapist listening in an accepting way to them, they gradually learn how to listen acceptingly to themselves. As they find the therapist caring for and valuing them (even the aspects that have hidden and regarded as negative), they begin to see worth and value in themselves. As they experience the realness of the therapist, they drop many of their pretences and are real with both themselves and the therapist.

Three personal characteristics, or attitude, of the therapist form a central part of the therapeutic relationship: (1) congruence, or genuineness (2) unconditional positive regard, and (3) accurate empathetic understanding.

Congruence implies that therapists are real, that is, they are genuine, integrated, and authentic during the therapy hour. They are without a false front, their inner experience and outer experience of that experience match, and they can openly express feelings and attitudes that are present in the relationship with the client.

The second attitude that therapists need to communicate to the client is a deep and genuine caring for him or her as a person. The caring is unconditional, in that it is not contaminated by evaluation or judgment of the client's feelings, thoughts, and behaviour as good or bad. Therapist value and warmly accept the client without placing stipulations on the acceptance. It is not an attitude if "I'll accept you when...", rather, it is one of "I'll accept you as you are". Acceptance is the recognition of the client's right to have feelings; it is not the approval of all behaviour. All overt behaviour need not be approved of or accepted. Research indicates that 'the' greater the degree of caring, prizing, accepting, and valuing the client in a non-possessive way, 'the' greater the chance that the therapy will be successful. Empathy is a deep and subjective understanding of the client with the client. It is a sense of personal identification with the client. Therapists are able to share the client's subjective world by running in to their own feelings that are like the client's feelings. Yet therapists must not lose their own separateness. Rogers believes that when therapists can grasp the client's private world, as the client sees and feels it, without losing the separateness of their own identify, constructive change is likely to occur.

Check your Progress – 5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What personal characteristics of the counsellor are significant in therapeutic relationship according to person-centered approach?

5.6 APPLICATION

In the person-centered framework the “techniques” are listening, accepting, respecting, understanding, and sharing. A preoccupation with using techniques is seen as depersonalizing the relationship. The techniques must be an honest expression of the therapy, they cannot be used self-consciously, for then the counsellor is not genuine.

Although the person-centered approach has been applied mainly to individual and group counselling, it has broadened considerably beyond therapeutic practice. Important areas of application include education, family life, leadership and administration, organizational development, health care, cross-cultural and interracial activity, international relations, and the search for world peace

5.7 EVALUATION

Person-centered therapy is based on a philosophy of human nature that postulates an innate striving for self-actualization. Further, Roger’s view of human nature is phenomenological, that is, we structure ourselves according to our perceptions of reality. We are motivated to actualize ourselves in the reality that we perceive.

Roger’s theory rests on the assumption that clients can understand the factors in their life that are causing them to be unhappy. They also have the capacity for self-direction and constructive personal change. The person-centered approach emphasizes this personal relationship between client and therapist. This approach places primary responsibility for the direction of therapy on the client. Clients are confronted with the opportunity to decide for themselves and come to terms with their own personal power.

One of the strengths of the person-centered approach is that it is not dogmatic and that practitioners have the latitude to develop their own counselling style. Specific techniques are not the focus, rather, the attitudes of the counsellor are considered crucial.

One limitation of the approach is the way in which some practitioners become “client centered” and lose a sense of their own person hood own uniqueness. Paradoxically, counsellors may focus on the client to such an extent that they diminish the value of their own power as a person and thus lose the impact of their personality on the client.

5.8 LET US SUM UP

Person-centered therapy is based on a philosophy of human nature that postulates an innate striving for self-actualization. Further, Rogers’s view of human nature is phenomenological; that is, we structure ourselves

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according to our perceptions of reality. We are motivated to actualize ourselves in the reality that we perceive. Therapeutic counseling is based on a person-to-person, relationship in the safety and acceptance of which clients drop their defenses and come to accept and integrate aspects that they have denied or distorted. The person-centered approach emphasizes this personal relationship between client and therapist; the therapist's attitudes are more critical than are knowledge, theory, or techniques. Clients are encouraged to use this relationship to unleash their growth potential and become more of the person they choose to become.

Rogers had, and his theory continues to have, a major impact on the field of counseling and psychotherapy. Rogers was a pioneer in shifting the therapeutic focus from an emphasis on technique and reliance on therapist authority to that of the therapeutic relationship. Among the major contributions of person-centered therapy are the implications of empathy for the practice of counseling. More than any other approach, person-centered therapy has demonstrated that therapist empathy plays a vital role in facilitating constructive change in the client.

A potential limitation of this approach is that some students-in-training and practitioners with a person-centered orientation may have a tendency to be very supportive of clients without being challenging. Another limitation is that, more than any other quality the therapist's genuineness determines the power of the therapeutic relationship. If therapists submerge their unique identity and style in a passive and nondirective way, they may not be harming many clients, but they may not be powerfully affecting clients.

5.9 UNIT-END EXERCISES

1. Why did Rogers call his approach 'person-centered'?
2. Discuss the contributions and limitations of person-centered approach.
3. What did Rogers mean by Congruence?
4. Explain empathy.

5.10 ANSWER TO CHECK YOUR PROGRESS

1. These attributes are (1) congruence (genuineness, or realness), (2) unconditional positive regard (acceptance and caring), and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person).

2. It is the relationship with a counsellor who is congruent accepting, and empathetic that facilitates therapeutic change for the client.

3. Rogers describes people who are becoming increasingly actualized, as having (1) an openness to experience (2) a trust in themselves (3) an internal source of evaluation, and (4) a willingness to continue growing. Encouraging these characteristics is the basic goal of person-centered therapy.

4. Clients seek therapy, when they feel of basic helplessness, powerlessness, and inability to make decisions or effectively direct their own life.

5. Three personal characteristics, or attitude, of the therapist form a central part of the therapeutic relationship: (1) congruence, or genuineness (2) unconditional positive regard, and (3) accurate empathetic understanding.

5.11 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
3. Patterson, L.W. &Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. &Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

Unit 6 – GESTALT THEORY

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Structure

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- 6.2 Objectives
- 6.3 Key concepts
 - 6.3.1 Principles of Gestalt therapy - Theory
 - 6.3.2 The Now
 - 6.3.3 Unfinished Business
 - 6.3.4 Personality as Peeling an Onion -Layers of neurosis
 - 6.3.5 Contact and Resistances to Contact
 - 6.3.6 Energy and Blocks to Energy
- 6.4 Therapeutic process
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 - 6.5.2 Making the rounds
 - 6.5.3 The reversal technique
 - 6.5.4 The rehearsal exercise
 - 6.5.5 The exaggeration exercise
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 - 6.5.7 The gestalt approach to dream work
- 6.6 Evaluation
- 6.7 Let us sum up
- 6.8 Unit-End Exercises
- 6.9 Answer to Check your Progress
- 6.10 Suggested Readings

6.1 INTRODUCTION

Gestalt therapy is an existential, phenomenological, and process-based approach created on the premise that individuals must be understood in the context of their ongoing relationship with the environment. The initial goal is for clients to gain *awareness* of what they are experiencing and how they are doing it. Through this awareness, change automatically occurs. The approach is phenomenological because it focuses on the client's perceptions of reality and existential because it is grounded in the notion that people are always in the process of becoming, remaking, and rediscovering themselves. As an existential approach, Gestalt therapy gives special attention to existence as individuals experience it and affirms the human capacity for growth and healing through interpersonal contact and insight.

6.2 OBJECTIVES

At the end of the unit you will be:

- Aware of the key concepts and the therapeutic process of the Gestalt approach
- Able to experiment with the various techniques under the guidance of the supervisor
- Able to relate to the application of the different techniques to various hypothetical problems
- Evaluate the strengths and weaknesses of the approach

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6.3 KEY CONCEPTS

A basic assumption of Gestalt therapy is that individuals can themselves deal effectively with their life problems, especially if they make full use of awareness of what is happening in and around them. Because of certain problems in development, people from various ways of avoiding problems and therefore, reaches impasses in their personal growth. Therapy provides the necessary intervention and challenge to help them proceed toward integration and a more authentic and vital existence.

6.3.1 PRINCIPLES OF GESTALT THERAPY - THEORY

Gestalt therapy, developed by Perls is an existential approach based on the premise that people must find their own way in life and accept personal responsibility if they hope to achieve maturity. The basic, initial goal is for clients to gain awareness of what they are experiencing and doing. Clients learn that they are responsible for what they are thinking, feeling and doing. The approach is phenomenological in its focus on the client's perceptions of reality. The approach is existential in that it is grounded in the here and now. Being in the present moment, it involves a transition between one's past and one's future. The clients are asked to bring any concerns about what was or will be, into the present and directly experience these concerns. Therefore, this approach is experiential rather than being abstract. In therapy, growth occurs from genuine contact between the therapist and the client, not from the therapist's interpretations or techniques.

Experiments are devised by the therapist to increase clients' self-awareness. The focus is more on process than on content. Emphasis is given to what is presently experienced, rather than to the content of what client's reveal. Perls believed that how individuals behave in the present moment is far more crucial to self-understanding than why they behave as they do.

Check your Progress – 1

Note: a. Write your answer in the space given below
b. Compare your answer with those given at the end of the unit.

1. Why is Gestalt approach understood to be experiential?

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6.3.2 THE NOW

One of the main contributions of the Gestalt approach is its emphasis on learning to appreciate and fully experience the present moment (now). To help the client make contact with the present moment, the Gestalt therapist asks “what” and “how” questions rather than “why” questions. According to Perls “why” questions lead to rationalizations and self-deceptions and away from the immediacy of experiencing. It leads to an endless rumination about the past that only serves to encourage resistance to present experience.

Most people can stay in the present only for a short while. If a client begins to talk about their feelings like sadness, pain or confusion, the therapist makes every attempt to have the client experience those feelings now. However, past is important when it is related in some way to significant themes in the individual’s present functioning. The therapist directs clients to “bring the fantasy here” and strive to relieve the feelings they experience earlier. For example, rather than talking about a past childhood trauma with their father, clients become the hurt child and talk directly to the father in fantasy. Through this process there is a relieving of the hurt and a potential to change it to the understanding and resolution.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. Why did Perls give more importance to “Why” questions rather than “What” and “How”?

6.3.3 UNFINISHED BUSINESS

Another key concept is unfinished business or unexpressed feelings such as resentment, rage, hatred, pain, anxiety, guilt, abandonment and so on. Even though the feelings are unexpressed, they are associated with distinct memories and fantasies. Because the feelings are not fully experienced in awareness, they linger in the background and are carried into present life in ways that interfere with effective contact with oneself and others. Unfinished business persists until the individual faces and deals with the unexpressed feelings. Unacknowledged feelings create unnecessary emotional debris that clutters present-centered awareness.

6.3.4 PERSONALITY AS PEELING AN ONION - LAYERS OF NEUROSIS

According to Perls, for individuals to achieve psychological maturity, they must strip off five layers of neurosis. They are (1) the phony (2) the phobic (3)

the impasse (4) the implosive and (5) the explosive. The phony layer consists of reacting to others in stereotypical and inauthentic ways. This is the level where we play games and get lost in roles. By behaving as if we are a person that we are not, we are trying to live up to a fantasy that we or others have created. Once we become aware of the phoniness of game playing and become more honest, then we experience unpleasantness and pain.

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In the next layer, the phobic layer, we attempt to avoid the emotional pain that is associated with seeing aspects of ourselves that we would prefer to deny. At this point resistances pop up. We have catastrophic fears that if we recognize who we are really are and present that side of ourselves to others, they will surely reject us.

Beneath this layer is the impasse, or the point where we are stuck in our own maturation. This is the point when we convince ourselves that we do not have the resources within ourselves to move beyond the stuck point without environmental support. At the impasse we often feel a sense of deadness and feel that we are nothing. If we hope to feel alive, it is essential that we get through the impasse.

If we allow ourselves to fully experience our deadness, rather than denying it or running away, then the implosive level comes into being. By getting into contact with this layer, or our deadness and inauthentic ways, we expose our defenses and begin to make contact with our genuine self.

Perls contends that peeling back the implosive layer creates an explosive state. When we contact the explosive layer, we let go of phony roles and pretenses and we release a tremendous amount of energy that we have been holding in by pretending to be who we are not and become alive and authentic.

6.3.5 CONTACT AND RESISTANCES TO CONTACT

In Gestalt therapy contact is necessary if change and growth are to occur. Contact is made by seeing, hearing, smelling, touching and moving. Effective contact means interacting with nature and with other people without losing one's sense of individuality. Prerequisites of good contact are clear awareness, full energy and the ability to express oneself, rather than a final state to achieve contact, may be thought of as different levels. After a contact experience there is typically a withdrawal to integrate what has been learned.

The Gestalt therapist also focuses on resistances to contact. From a Gestalt perspective resistance refers to defenses that we develop to prevent us from experiencing the present in a full and real way. The five layers of neurosis represents a person's style of keeping energy pent up in the service of maintaining pretenses. There are also ego-defence mechanisms that prevent people from being authentic.

Introjection, projection, retroflection, deflection and confluence are five major channels of resistance that are challenged in Gestalt therapy.

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Introjection is the tendency to uncritically accept others' beliefs and standards without assimilating them to make them congruent with who we are.

Projection is the reverse of introjections. In this we disown certain aspects of ourselves by assigning them to the environment.

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. If we lash out and injure ourselves, for example, we are often directing aggression inward that we are fearful of directing aggression inward that we are fearful of directing toward others.

Deflection is the process of distraction so that it is difficult to maintain a sustained sense of contact. People who deflect attempt to diffuse contact through the overuse of humour, abstract generalizations and questions rather than statements.

Confluence involves blurring of awareness of the differentiation between the self and the environment. Confluence in relationship involves an absence of conflicts, or a belief that all parties experience the same feelings and thoughts.

The concern of Gestalt therapist is the interruption of contact with the environment when the individual is unaware of this process. Terms such as resistance to contact or boundary disturbance refer to the characteristic styles that people employ in their attempt to control their environment. The premise to Gestalt therapy is that contact is both normal and healthy.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What does the five layer of neurosis represent in Gestalt approach?

4. Name the five major channels of resistance that are challenged in Gestalt therapy.

6.3.6 ENERGY AND BLOCKS TO ENERGY

In Gestalt therapy special attention is given to where energy is located, how it is used, and how it can be blocked. Blocked energy is another form of resistance. In commenting on the value of focusing on the client's energy in therapeutic work, Zinker writes that clients may not be aware of energy or where it is located, and they may experience it in a negative way. From his perspective therapy at its best involves a dynamic relationship that awakens

and nourished the client without sapping the therapist of his or her own energy.

Zinker maintains that it is the therapist's job to help clients locate the ways in which they are blocking energy and to help them transform this blocked energy into more adaptive behaviours. This process is best accomplished when resistance is not viewed as a client's refusal to cooperate and as something simply to be gotten around. Clients can be encouraged to recognize how their resistance is being expressed in their body and rather than trying to rid themselves of certain bodily symptoms, they can actually delve fully into tension states. By allowing themselves to exaggerate their tight mouth and shaking legs, they can discover for themselves how they are diverting energy and keeping themselves powerless.

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6.4 THERAPEUTIC PROCESS

Gestalt therapy is an existential encounter between people, out of which clients tend to move in certain directions:

- move toward increased awareness of themselves
- gradually assume ownership of their experience
- develop skills and acquire values that will allow them to satisfy their needs without violating the right of other
- become more aware of all their senses
- learn to accept responsibility for what they do, including accepting the consequences of their actions
- move from outside support toward increasing internal support
- Nevertheless be able to ask and get help from others and to give to others.

The major aim of the Gestalt process is the attaining of awareness-which by and of itself, is seen as curative. With awareness they have the capacity to face and accept denied parts of their being and to get in touch with subjective experiences and with reality.

The therapist focuses on the client's feelings, awareness at the moment, body messages, energy, avoidance and blocks to awareness. Perls demonstrated an anti-intellectual bias, asserting that much of our thinking is a way of avoiding feelings. According to Perls neurosis do not see the obvious. They are unaware of their tightly clenches fist, of their controlled voice, or of not having responded to the therapist's suggestion. The therapist's job is to challenge clients so that they learn to use their senses fully and get in touch with body messages.

An important function of the Gestalt therapist is paying attention to the client's body language. The therapist needs to be alert for splits in attention and awareness and for incongruities between verbalizations and what clients are

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doing with their body. In addition, the Gestalt counsellor places emphasis on the relationship between language patterns and personality. This approach suggests that client's speech patterns are often an expression of their feelings, thoughts and attitudes. Other issues that can become the focal point of therapy include the client-therapist relationship and the similarities in the ways clients relate to the therapist and to others in their environment.

Miriam Polster describes a three-stage integration sequence that characterizes client's growth in therapy. The first part of this sequence consists of discovery. Clients are likely to reach a new realization about themselves or to acquire a novel view of an old situation, or they may take a new look at some significant person in their life. The second stage is accommodation, which involves clients' recognizing that they have a choice. Clients begin by trying out new behaviours in the supportive environment and then they expand their awareness. The third stage is assimilation, which involves clients' learning how to influence their environment. At this phase, clients feel capable of dealing with the surprise they encounter in everyday living. Behaviour at this stage may include a client's taking a stand on a critical issue. Eventually, clients develop confidence in their ability to improve and improvise.

Gestalt practice involves a person-person relationship between the therapist and the client. The therapist's experiences, awareness and perceptions provide the background of the therapy process and the client's awareness and reactions constitute the forefront.

The therapist gives feedback, particularly of what clients are doing with their body. Feedback allows clients to develop an awareness of what they are actually doing. Therapists are responsible for the quality of their presence, for knowing themselves and the client, and for remaining open to the client. They are also responsible for establishing and maintaining a therapeutic atmosphere that will foster a spirit of work on the client's part.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What are the important aspects that the gestalt therapist should focus on during the sessions?

6.5 APPLICATION/TECHNIQUES

Techniques can be useful tools to help the client gain fuller awareness, experience internal conflicts resolve inconsistencies and dichotomies and work through an impasse that is preventing completion of unfinished business.

6.5.1 The Internal Dialogue Exercise

Gestalt therapists pay close attention to splits in personality function. Therapy focuses on the war between the ‘top dog’ and the ‘under dog’. The former is righteous, authoritarian, moralistic, demanding, bossy and manipulative. The latter plays the role of victim by being defensive, apologetic, helpless and weak and by feigning powerlessness. The conflict between the two opposing poles in the personality is rooted in the mechanism of introjections, which involves incorporating aspects of others, usually parents, into one’s ego system. It is essential that once becomes aware of one’s introjects, especially the toxic ones that poison the system and prevent personality integration.

The empty-chair technique is a way of getting the client to externalize introject. Two chairs are used in this technique where the therapist asks the client to sit in one chair and be fully the top dog and then shift to the other chair and become the underdog. Essentially, this is a role-playing technique in which all the parts are played by the client. The conflict can be resolved by the client’s acceptance and integration of both sides. This technique helps the clients get in touch with a feeling or a side of themselves that they may be denying and help them to identify distasteful parental introjects.

6.5.2 Making the rounds

This is an exercise that involves asking a person in a group to go up to others in the group and either speak or to do something with each. The purpose is to confront, to risk, to disclose the self, to experiment with new behaviour and to grow and change.

“I take responsibility for...”

A meaningful technique which is an extension of the continuum of awareness and is designed to help clients recognize and accept their feelings instead of projecting their feelings onto others. In this, the therapist may ask the client to make a statement and then add “and I take responsibility for it”. Ex., “I’m feeling bored and I take responsibility for my boredom”.

Playing the projection

The therapist asks the person who says “I can’t trust you” to play the role of the untrustworthy person – that is, to become the other – in order to discover the degree to which the distrust is an inner conflict.

6.5.3 The reversal technique

The therapist could ask a person who claims to suffer from sever inhibitions and excessive timidity to play the role of an exhibitionist in the group. This

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technique helps clients begin to accept certain personal attributes that they have tried to deny.

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6.5.4 The rehearsal exercise

Internal rehearsal consumes much energy and frequently inhibits our spontaneity and willingness to experiment with new behaviour. The members of a therapy group can share their rehearsals with one another in order to become more aware of the many preparatory means they use in bolstering their social roles.

6.5.5 The exaggeration exercise

The person is asked to exaggerate the movement or gesture or verbal behaviour repeatedly, which usually intensifies the feeling attached to the behaviour and makes the inner meaning clearer.

Ex., if the client reports that his/her legs are shaking, the therapist may ask the client to stand up and exaggerate the shaking.

6.5.6 Staying with the feeling

When a client refers to a feeling or a mood that is unpleasant and from which he or she has a great urge to flee, the therapist urges the client to stay with or retain the feeling.

6.5.7 The gestalt approach to dream work

The Gestalt approach does not interpret and analyse a dream. Instead, the intent is to bring the dream back to life and relive it as though it were happening now. Because each part of the dream is assumed to be a projection of oneself, one creates scripts for encounters between various characters or parts. By engaging in a dialogue between these opposing sides, one gradually becomes more aware of the range of one's own feelings.

6.6 Evaluation

Gestalt therapy is an experiential therapy stressing here-and-now awareness. The major focus is on that and how of behaviour and the role of unfinished business from the past that prevents effective functioning in the present. Some key goals of the approach are accepting personal responsibility, living in the immediate moment and direct experiencing as opposed to abstract talking about experience. This approach helps the clients deal with avoidance, unfinished business and impasses. Expansion of awareness is the basic goal. With awareness, clients are able to reconcile polarities and reintegrate all aspects of themselves.

It is an action approach with a range of experiments and exercises. This approach is a perspective on growth and enhancement, not merely a system of techniques to treat disorders. It also has the greatest potential for creativity. Gestalt experiments can be tailored to fit the unique way in which an individual perceives and interprets his or her culture.

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A chief criticism of the Perlsian style of Gestalt therapy involves its de-emphasis of the cognitive factors of personality. Further for the Gestalt experiments to be effective, clients must be prepared for them. Gestalt techniques tend to produce a high level of intense feelings. This focus on affect, has some clear limitations with those clients who have been conditioned to be emotionally reserved. The techniques are designed to expand the client's awareness and to help him or her experiment with new modes of behaviour. These techniques are only means to the end of helping people change, not ends in themselves. Most techniques are confrontational. Counsellors must be willing to be active and challenging and clients must also be willing to take risk and challenge themselves.

Check your Progress – 5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

6. What are the criticism and limitation of gestalt approach?

6.7 LET US SUM UP

Gestalt therapy is an experiential approach that stresses present awareness and the quality of contact between the individual and the environment. The major focus is on assisting the client to become aware of how behaviors that were once part of creatively adjusting to past environments may be interfering with effective functioning and living in the present. The goal of the approach is, first and foremost, to gain awareness. Another therapeutic aim is to assist clients in exploring how they make contact with elements of their environment. Change occurs through the heightened awareness of “what is.” The therapist works with the client to identify the figures, or most salient aspects of the individual–environmental field, as they emerge from the back- ground. The Gestalt therapist believes each client is capable of self-regulating if those figures are engaged and resolved so others can replace them. The role of the Gestalt therapist is to help clients identify the most pressing issues, needs, and interests and to design experiments that sharpen those figures or that explore resistances to contact and awareness.

One contribution of Gestalt therapy is the exciting way in which the past is dealt with in a lively manner by bringing relevant aspects into the present.

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Therapists challenge clients in creative ways to become aware of and work with issues that are obstructing current functioning. Further, paying attention to the obvious verbal and nonverbal leads provided by clients is a useful way to approach a counseling session. The focus is on growth and enhancement rather than being a system of techniques to treat disorders. Gestalt therapy is a holistic approach that values each aspect of the individual's experience equally. Therapists allow the figure-formation process to guide them. They do not approach clients with a preconceived set of biases or a set agenda. Instead, they place emphasis on what occurs at the boundary between the individual and the environment. A key strength of Gestalt therapy is the attempt to integrate theory, practice, and research.

Most of my criticisms of Gestalt therapy pertain to the older version, or the style of Fritz Perls, which emphasized confrontation and de-emphasized the cognitive factors of personality. For Gestalt therapy to be effective, the therapist must have a high level of personal development. Being aware of one's own needs and seeing that they do not interfere with the client's process, being present in the moment, and being willing to be non-defensive and self-revealing all demand a lot of the therapist. There is a danger that therapists who are inadequately trained will be primarily concerned with impressing clients.

6.8 UNIT-END EXERCISES

1. Describe Perls five layers of neurosis.
2. Describe the techniques used by Gestalt approach.
3. What are the goals of gestalt counseling?
4. Evaluate the Gestalt approach to counseling.

6.9 ANSWER TO CHECK YOUR PROGRESS

1. The clients are asked to bring any concerns about what was or will be, into the present and directly experience these concerns. Therefore, this approach is experiential rather than being abstract.
2. According to Perls "why" questions lead to rationalizations and self-deceptions and away from the immediacy of experiencing. It leads to an endless rumination about the past that only serves to encourage resistance to present experience.
3. The five layers of neurosis represents a person's style of keeping energy pent up in the service of maintaining pretenses.
4. Introjection, projection, retroflection, deflection and confluence are five major channels of resistance that are challenged in Gestalt therapy.
5. An important function of the Gestalt therapist is paying attention to the client's body language. The therapist needs to be alert for splits in attention

and awareness and for incongruities between verbalizations and what clients are doing with their body. In addition, the Gestalt counsellor places emphasis on the relationship between language patterns and personality. Other issues that can become the focal point of therapy include the client-therapist relationship and the similarities in the ways clients relate to the therapist and to others in their environment.

6. A chief criticism of Gestalt therapy involves its de-emphasis of the cognitive factors of personality. Gestalt techniques tend to produce a high level of intense feelings. This focus on affect, has some clear limitations with those clients who have been conditioned to be emotionally reserved.

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6.10 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
3. Patterson, L.W. &Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. &Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

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UNIT 7: REALITY THEORY

Structure

7.1 Introduction

7.2 Objectives

7.3 Reality Theory

7.4 Key concepts

7.4.1 Human needs and purposeful behaviour

7.4.2 Existential\Phenomenological Orientation

7.4.3 Total Behaviour

7.4.4 Success Identity and Positive Addiction

7.4.5 The Essence of Control Theory

7.4.6 A choice theory explanation of Behaviour

7.4.7 Characteristics of Reality therapy

7.5 Therapeutic process

7.5.1 Eight Stage Model

7.5.2 Therapeutic Procedures

7.6 Application

7.6.1 Procedures that lead to change

7.6.2 The “WDEP” system

7.7 Let us sum up

7.8 Unit-End Exercises

7.9 Answer to Check your Progress

7.10 Suggested Readings.

7.1 INTRODUCTION

Reality therapists believe the underlying problem of most clients is the same - they are either involved in a present unsatisfying relationship or lack what could even be called a relationship. Many of the problems of clients are caused by their inability to connect, to get close to others, or to have a satisfying or successful relationship with at least one significant person in their lives. The therapist guides clients toward a satisfying relationship and teaches them to behave in more effective ways than they are presently behaving. The more clients are able to connect with people, the greater chance they have to experience happiness.

Reality therapy is based on choice theory. Choice theory explains why and how we function, and reality therapy provides a delivery system for helping individuals take more effective control of their lives. Therapy consists mainly of teaching clients to make more effective choices as they deal with the people they need in their lives.

7.2 OBJECTIVES

After going through this unit you will:

- Become familiar with the key concepts of reality theory
- Understand the therapeutic process of reality therapy
- Be familiar with the application of concepts in counselling

7.3 REALITY THEORY

William Glasser who was psychoanalytically trained, quickly became disenchanted with this approach, and began to experiment with innovative methods, which later came to be called reality therapy. Glasser's early work focused on asking clients to recognize and take responsibility for what they were doing in the present, rather than dwelling on what they had done, thought, or felt in the past.

In reality therapy clients are asked to identify their wants and needs. Additionally, they are challenged to evaluate their behaviour, formulate a plan for change, commit themselves to such a plan, and follow through with their commitment. By avoiding making excuses and blaming others and by evaluating what they are doing to get what they want, they are able to achieve increasing control over their life.

A basic assumption of Glasser's approach is that everyone has a “*growth force*”; this force impels one to develop a “*success identity*” (viewing oneself as being worthy of love and as being a significant person). A further assumption is that any change in one's identity is contingent on behavioural change. Like behaviour therapy, transactional analysis, and rational emotive therapy, reality therapy is an active, directive, and didactic model. It stresses present behaviour, not attitudes, insight, one's past, or unconscious motivations.

7.4 KEY CONCEPTS

7.4.1 Human needs and purposeful behaviour

William Glasser identifies four essential psychological needs *belonging, power, freedom, and fun* and the physiological need for survival. **Control**

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theory explains how we attempt to satisfy these basic needs, which are the powerful forces that drive us.

People develop an inner “*picture album*” of specific wants that contains precise snapshots of how they wish to fulfill their needs. A major goal of reality therapy is to teach people better ways of fulfilling their needs and to help them effectively get what they want from life.

Responsibility consists of learning how to realistically meet these basic psychological needs, and the essence of therapy consists of teaching people to accept that responsibility. People behave for a purpose: to mold their environment as sculptor molds clay, matching their own inner pictures of what they want. These goals are achievable only through hard work

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What is the major goal of reality therapy?
2. What are for essential psychological needs according to Glasser?

7.4.2 Existential/Phenomenological Orientation

In many ways Glasser's approach is grounded on phenomenological and existential premises. He maintains that we perceive the world in the context of our own needs, not how it really is. It is important for therapists to understand that clients live both in the external world and in their own internal world.

Glasser does not accept the notion that misery simply happens to us rather, it is something that we often choose. He observes that clients are typically quick to complain that they are upset because people in their life are not behaving as they world like them to. It is important to reorganize that all behaviours are chosen, including feeling miserable and thinking that they are victims. People choose misery in the attempt to reduce their frustration.

- To keep anger under control
- To get others to help them
- To excuse their unwillingness to do something more effective , and
- To gain powerful control

Glasser speaks of people depressing or angering themselves, rather than being depressed or being angry. With this perspective, depression can be explained as an active choice that they make rather than the result of being a passive victim. This process of “depressing” keeps anger in check, and it also allows them to ask for help. Glasser contends that as long as people cling to the notion that they are victims of depression and that misery is something that happens to them, they will not change for the better. They can change only

when they recognize and act on the reality that what they are doing is the result of their choices.

7.4.3 Total Behaviour

According to Glasser's latest formulation of control theory (1985), people always have control over what they do. This basic premise clarified in the context of understanding their total behaviour, which always includes four components; doing (or active behaviours such as talking or jogging); thinking (voluntary thoughts and self-statements); feeling such as anger, joy, depression, anxiety); and physiology (such as sweating, "head aching", or developing other psychosomatic symptoms).

Wubbolding uses the "suitcase" analogy to describe the concept of total behaviour. In lifting a suitcase you grab it by the easiest part, the handle. Total behaviour is like a suitcase. The handle is the doing part. Lift the handle and total behaviour follows the sequence of doing, thinking, feeling and physiology. It is typically easier to force ourselves to do something different than it is to feel or think something different.

Control theory is grounded on the assumption that it is impossible to choose a total behaviour and not choose all its components. If a total behaviour is hoped to be changed (such as experiencing the emotional and physiological consequences of depressing ourselves), then it is necessary to change what one is doing and what one is thinking. For example, one might feel upset then depress oneself if he/she fails to get a job that they had applied for. One does not have the ability to directly change how they are feeling, independently of what they are doing and some ability to change what they are thinking in spite of how they might be feeling. Therefore, the key to changing a total behaviour lies in choosing to change what they are doing. If one markedly change the doing component they cannot avoid changing the thinking, feeling, and physiological components as well.

7.4.4 Success Identity and Positive Addiction

A primary goal of reality therapy is to help people achieve a success identity. Those who possess a success identity see themselves as able to give and accept love, to feel that they are significant to others, to experience a sense of self-worth, to become involved with others in a caring way, and to meet their needs in ways that are not at the expense of others.

Those who seek therapy are often people who have a "failure identity". They see themselves as unloved, rejected, and unwanted, unable to become intimately involved with others, incompetent to make and stick with commitments, and generally helpless.

Typically individuals with a failure identity meet challenges with a despairing "I can't", a self-fulfilling prophecy that leads to further lack of success, which in turn supports a negative self-view and eventually makes these people see themselves as hopeless failures in life. Because reality therapy assumes

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that people are ultimately self-determining beings who become what they decide to become, the system is designed to teach people how they can change behaviour that fosters a failure identity and develop behaviour that leads to a success identity.

7.4.5 The Essence of Control Theory

Control theory is based on the premise that behaviour is the control of our perceptions. Although one may not be able to control what is actually in the real world, he/she do attempt of control to control their perceptions to meet their own needs. In this process one creates his/her internal world.

Everything that people does, think, and feel is generated by what happens inside them. In other words, how one feels is not controlled by others or events. People are not psychological slaves to others, unless they choose to be. Regardless of circumstances, what one do, think, and feel is always their best attempt at the time to satisfy internal forces. People can more easily choose better behaviour if they come to realize that what that they are doing, thinking and feeling is not simply happening to them but that they are, indeed, making choices`

7.4.6 A Choice theory explanation of behaviour

Choice theory explains that all we ever do from birth to death is behave and, with rare exceptions, everything we do is chosen. Every total behavior is our best attempt to get what we want to satisfy our needs. **Total behavior** teaches that all behavior is made up of four inseparable but distinct components— *acting, thinking, feeling, and physiology*—that necessarily accompany all of our actions, thoughts, and feelings. Behavior is purposeful because it is designed to close the gap between what we want and what we perceive we are getting. Specific behaviors are always generated from this discrepancy. Our behaviors come from the inside, and thus we choose our destiny.

Glasser says that to speak of being depressed, having a headache, being angry, or being anxious implies passivity and lack of personal responsibility, and it is inaccurate. It is more accurate to think of these as parts of total behaviors and to use the verb forms *depressing, headaching, angering, and anxietying* to describe them. It is more accurate to think of people depressing or angering themselves rather than being depressed or being angry. When people choose misery by developing a range of “**paining**” behaviors, it is because these are the best behaviors they are able to devise at the time, and these behaviors often get them what they want.

When a reality therapist starts teaching choice theory, the client will often protest and say, “I’m suffering, don’t tell me I’m choosing to suffer like this.” As painful as depressing is, the therapist explains that people do not choose pain and suffering directly; rather, it is an unchosen part of their

total behavior. The behavior of the person is the best effort, ineffective as it is, to satisfy needs.

Robert Wubbolding has added a new idea to choice theory. He believes that behavior is a language, and that we send messages by what we are doing. The purpose of behavior is to influence the world to get what we want. Therapists ask clients what messages they are sending to the world by way of their actions: “What message do you want others to get?” “What message are others getting whether or not you intended to send them?” By considering the messages that clients send to others, counselors can help clients indirectly gain a greater appreciation of messages they unintentionally send to others.

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7.4.7 Characteristics of Reality Therapy

Contemporary **reality therapy** focuses quickly on the unsatisfying relationship or the lack of a relationship, which is often the cause of clients’ problems. Clients may complain of a problem such as not being able to keep a job, not doing well in school, or not having a meaningful relationship. When clients complain about how other people are causing them pain, the therapist does not get involved with finding fault. Reality therapists ask clients to consider how effective their choices are, especially as these choices affect their relationships with significant people in their lives. Choice theory teaches that there is no sense talking about what clients can’t control; the emphasis is on what clients *can* control in the relationship. The basic axiom of choice theory, which is crucial for clients to understand, is this: “The only person you can control is yourself.”

Reality therapists do not listen very long to complaining, blaming, and criticizing, for these are the most ineffective behaviors in our behavioral repertoire. Because reality therapists give little attention to these self-defeating *total behaviors*, they tend to disappear from therapy. What do reality therapists focus on? Here are some underlying characteristics of reality therapy.

Choice theory changes the focus of responsibility to choice and choosing. Reality therapists deal with people “as if” they have choices. Therapists focus on those areas where clients have choice, for doing so gets them closer to the people they need. For example, being involved in meaningful activities, such as work, is a good way to gain the respect of other people, and work can help clients fulfill their need for power. It is very difficult for adults to feel good about themselves if they don’t engage in some form of meaningful activity. As clients begin to feel good about themselves, it is less necessary for them to continue to choose ineffective and self-destructive behaviors.

Reality therapists strive to be themselves in their professional work. By being

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themselves, therapists can use the relationship to teach clients how to relate to others in their lives. Glasser contends that transference is a way that both therapist and client avoid being who they are and owning what they are doing right now. It is unrealistic for therapists to go along with the idea that they are anyone but themselves. Assume the client claims, "I see you as my father or mother and this is why I'm behaving the way I am." In such a situation a reality therapist is likely to say clearly and firmly, "I am not your mother, father, or anyone but myself."

Some clients come to counseling convinced that their problems started in the past and that they must revisit the past if they are to be helped. Glasser contends that we are products of our past but argues that we are not victims of our past unless we choose to be. Still, many therapeutic models continue to teach that to function well in the present we must understand and revisit our past. Glasser disagrees with this belief and contends that whatever mistakes were made in the past are not pertinent now. We can only satisfy our needs in the present.

The reality therapist does not totally reject the past. If the client wants to talk about past successes or good relationships in the past, the therapist will listen because these may be repeated in the present. Reality therapists will devote only enough time to past failures to assure clients that they are not rejecting them. As soon as possible, therapists tell clients: "What has happened is over; it can't be changed. The more time we spend looking back, the more we avoid looking forward." Although the past has propelled us to the present, it does not have to determine our future.

Glasser contends that people who have symptoms believe that if they could only be symptom-free they would find happiness. Whether people are depressing or paining, they tend to think that what they are experiencing is happening to them. They are reluctant to accept the reality that their suffering is due to the total behavior they are choosing. Their symptoms can be viewed as the body's way of warning them that the behavior they are choosing is not satisfying their basic needs. The reality therapist spends as little time as he or she can on the symptoms because they will last only as long as they are needed to deal with an unsatisfying relationship or the frustration of basic needs.

Choice theory rejects the traditional notion that people with problematic physical and psychological symptoms are mentally ill. Glasser (2003) has warned people to be cautious of psychiatry, which can be hazardous to both one's physical and mental health. He criticizes the traditional psychiatric establishment for relying heavily on the *DSM-IV-TR* for both diagnosis and treatment. Glasser (2003) challenges the traditionally accepted views of mental illness and treatment by the use of medication. He asserts that psychiatric drugs generally have negative side effects both physically and psychologically.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. Explain the suitcase analogy.

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7.5 THERAPEUTIC PROCESS

7.5.1 Eight Stage Model:

Glasser originally conceptualized reality therapy in eight steps:

- Make friends or get involved, or get alone: create relationship or give rapport
- De-emphasize the client's history and find out what you are doing now.
- Help the client learn to make an evolution of his or her behaviour. Help the client find out if what he or she is saying is really helpful.
- Once you have evaluated the behaviour, then you can begin to explore alternative behaviours. Behaviours that may prove more helpful.
- Get a commitment to a plan of change.
- Maintain an attitude of "no excuses if you don't do it".by now the client is committed to the change and must learn to be responsible in carrying it out.
- Be tough without punishment. Teach people to do things without being punished if they do not; it creates a more positive motivation.
- Refuse to give up Once clients realize the counsellor will not give up, they feel more support and work proceeds with more efficiency and promise.

7.5.2 THERAPEUTIC PROCEDURES

The practice of reality therapy begins with the counsellor's efforts to create a supportive environment within which clients can begin to make changes in their lives. Counsellors consistently attempt to focus on what they are doing now.

They also avoid discussing client's feelings or physiology as though these were separate from their total behaviour. They help their clients see connections between what they are feeling and their concurrent actions and thoughts. Reality therapists accept no excuses for irresponsible behaviour and they show the clients that excuses are from of self-deception that may offer temporary relief but ultimately leads to failure and failure identity.

Part of the therapists work is to explore the clients' "picture album" and the ways in which their behaviour is aimed at moving their perception of the external world closer to their inner world of wants. Reality therapy stresses current behaviour and concentrates on changing current total behaviour, not

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merely attitudes and feelings. Past events are concerned only in so far as they influence how the client is behaving now.

The clients are helped to identify specific ways to fulfill their wants. The process of creating and carrying out plans is how people gain control over their lives. The purpose of plan is to arrange for successful experiences. Throughout this planning phase the counsellor continually urges clients to assume responsibility for their own choices and actions.

7.6 APPLICATION

7.6.1 Procedures that lead to change

The practice of reality therapy can best be conceptualized as the **cycle of counselling**, which consists of two major components: (1) creating the counseling environment and (2) implementing specific procedures that lead to changes in behavior. The art of counseling is to weave these components together in ways that lead clients to evaluate their lives and decide to move in more effective directions.

The cycle of counseling begins with creating a working relationship with clients. The process proceeds through an exploration of clients' wants, needs, and perceptions. Clients explore their total behavior and make their own evaluation of how effective they are in getting what they want. If clients decide to try new behavior, they make plans that will lead to change, and they commit themselves to those plans. The cycle of counseling includes following up on how well clients are doing and offering further consultation as needed.

The art of practicing reality therapy involves far more than following procedures in a step-by-step cookbook fashion. Although these procedures are described in simple, jargon-free language, they can be challenging to implement.

The practice of reality therapy rests on the assumption that a supportive and challenging environment allows clients to begin making life changes. The therapeutic relationship is the foundation for effective practice; if this is lacking, there is little hope that the system can be successfully implemented.

According to Glasser (1992), the procedures that lead to change are based on the assumption that human beings are motivated to change (1) when they are convinced that their present behavior is not getting them what they want and (2) when they believe they can choose other behaviors that will get them closer to what they want.

7.6.2 The "WDEP" System

The acronym WDEP is used to describe key procedures in the practice of reality therapy. The **WDEP system** of reality therapy can be used to help

clients explore their *wants*, possible things they can *do*, opportunities for *self-evaluation*, and design *plans* for improvement (Wubbolding, 2007a, 2007b). Each of the letters refers to a cluster of strategies: W = wants and needs; D = direction and doing; E = self-evaluation; and P = planning. These strategies are designed to promote change.

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Wants (Exploring wants, needs, and Perceptions)

Reality therapists assist clients in discovering their wants and hopes. All wants are related to the five basic needs. They ask, “What do you want?” Through the therapist’s skillful questioning, clients are assisted in defining what they want from the counseling process and from the world around them. It is useful for clients to define what they expect and want from the counselor and from themselves. Part of counseling consists of exploring the “picture album,” or quality world, of clients and how their behavior is aimed at moving their perception of the external world closer to their inner world of wants.

Clients are given the opportunity to explore every facet of their lives, including what they want from their family, friends, and work. Furthermore, this exploration of wants, needs, and perceptions should continue throughout the counseling process as clients’ pictures change.

Direction and Doing

Reality therapy stresses current behavior and is concerned with past events only insofar as they influence how clients are behaving now. The focus on the present is characterized by the question so often asked by the reality therapist: “What are you doing?” Even though problems may be rooted in the past, clients need to learn how to deal with them in the present by learning better ways of getting what they want. The past may be discussed if doing so will help clients plan for a better tomorrow. The therapist’s challenge is to help clients make more need-satisfying choices.

Early in counseling it is essential to discuss with clients the overall direction of their lives, including where they are going and where their behavior is taking them. This exploration is preliminary to the subsequent evaluation of whether it is a desirable direction. The therapist holds a mirror before the client and asks, “What do you see for yourself now and in the future?” It often takes some time for this reflection to become clearer to clients so they can verbally express their perceptions. Reality therapy focuses on gaining awareness of and changing current total behavior.

Evaluation

The core of reality therapy is to ask clients to make the following **self-evaluation**: “Does your present behavior have a reasonable chance of getting you what you want now, and will it take you in the direction you want to go?” Specifically, evaluation involves the client examining

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behavioral direction, specific actions, wants, perceptions, new directions, and plans. According to Wubbolding, clients often present a problem with a significant relationship, which is at the root of much of their dissatisfaction. The counselor can help clients evaluate their behavior by asking this question: “Is your current behavior bringing you closer to people important to you or is it driving you further apart?”

Reality therapists may be directive with certain clients at the beginning of treatment. This is done to help clients recognize that some behaviors are not effective. In working with clients who are in crisis, for example, it is sometimes necessary to suggest straightforwardly what will work and what will not. Other clients, such as alcoholics and children of alcoholics, need direction early in the course of treatment, for they often do not have the thinking behaviors in their control system to be able to make consistent evaluations of when their lives are seriously out of effective control. These clients are likely to have blurred pictures and, at times, to be unaware of what they want or whether their wants are realistic. As they grow and continue to interact with the counselor, they learn to make evaluations with less and less help from the counselor.

The WDEP system can be applied to helping people satisfy their basic needs in a group context as well. Reality therapy is applicable to individual counselling, marriage and family therapy, group counselling, social work, education, crisis intervention, corrections and rehabilitation, institutional management and community development. Most of the military clinics that treat drug and alcohol abusers use reality therapy as their preferred therapeutic approach. This therapy is applicable to people with any sort of psychological problem. It is used with children, adolescence, adults and the aged. According to Glaser, the only factor limiting its applicability is the technical skill of the therapist.

Planning and Action

Much of the significant work of the counseling process from this approach involves helping clients identify specific ways to fulfill their wants and needs. Once clients determine what they want to change, they are generally ready to explore other possible behaviors and formulate an action plan. The process of creating and carrying out plans enables people to begin to gain effective control over their lives. If the plan does not work, for whatever reason, the counselor and client work together to devise a different plan. The plan gives the client a starting point, but plans can be modified as needed.

Wubbolding discusses the central role of planning and commitment. The culmination of the cycle of counseling rests with a plan of action. He uses the acronym SAMIC³ to capture the essence of a good plan: simple, attainable, measurable, immediate, controlled by the planner, committed to, and continuously done.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What does the acronym ‘WDEP’ stand for?

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7.7 LET US SUM UP

The reality therapist functions as a teacher, a mentor, and a model, confronting clients in ways that help them evaluate what they are doing and whether their behavior is fulfilling their basic needs without harming themselves or others. The heart of reality therapy is learning how to make better and more effective choices and gain more effective control. People take charge of their lives rather than being the victims of circumstances beyond their control. Practitioners of reality therapy focus on what clients are *able and willing to do in the present* to change their behavior. Practitioners teach clients how to make significant connections with others. Therapists continue to ask clients to evaluate the effectiveness of what they are choosing to do to determine if better choices are possible.

The practice of reality therapy weaves together two components, the counseling environment and specific procedures that lead to changes in behavior. This therapeutic process enables clients to move in the direction of getting what they want. The goals of reality therapy include behavioral change, better decision making, improved significant relationships, enhanced living, and more effective satisfaction of all the psychological needs.

Among the advantages of reality therapy are its relatively short-term focus and the fact that it deals with conscious behavioral problems. The existential underpinnings of choice theory are a major strength of this approach. People are not viewed as being hopelessly and helplessly depressed. Instead, people are viewed as doing the best they can, or making the choices they hope will result in fulfilling their needs.

One of the main limitations of reality therapy is that it does not give adequate emphasis to the role of these aspects of the counseling process: the role of insight, the unconscious, and the power of the past and the effect of traumatic experiences in early childhood, the therapeutic value of dreams, and the place of transference. Because reality therapy focuses almost exclusively on consciousness, it does not take into account factors such as repressed conflicts and the power of the unconscious in influencing how we think, feel, behave, and choose.

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7.8 UNIT-END EXERCISES

1. Explain Choice theory.
2. Explain the 'WDEP system'.
3. According to reality therapy what is the cause of current problems in a person's life?

7.9 ANSWER TO CHECK YOUR PROGRESS

1. Major goal of reality therapy is to teach people better ways of fulfilling their needs and to help them effectively get what they want from life.
2. Four essential psychological needs - *belonging, power, freedom, and fun* and the physiological need for survival.
3. According to total behaviour (doing, thinking, feeling and physiology) is like a "suitcase". In lifting a suitcase you grab it by the easiest part, the handle. Total behaviour is like a suitcase. The handle is the doing part. Lift the handle and total behaviour follows the sequence of doing, thinking, feeling and physiology. It is typically easier to force ourselves to do something different than it is to feel or think something different.
4. Wants (exploring wants, needs, and perceptions), Direction and doing, self-evaluation and planning and action.

7.10 SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper's Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D. John Antony, Skills of Counselling, 2003, Anugraha Publications.

UNIT 8:– BEHAVIOURAL COUNSELLING: THEORY AND PRACTICE

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Structure

- 8.1 Introduction
- 8.2 Objectives
- 8.3 Theory – Introduction
- 8.4 Pavlov’s Classical Conditioning
- 8.5 Watson’s Conditioned Behaviourism
- 8.6 Skinner’s Operant Behaviourism
- 8.7 Wolpe’s Reciprocal Inhibition
- 8.8 Eysenck’s Incubation Theory
- 8.9 Let us sum up
- 8.10 Unit-End Exercises
- 8.11 Answer to Check your Progress
- 8.12 Suggested Readings

8.1 INTRODUCTION

Behavioural counselling view its practice as firmly rooted in experimentally derived principles of learning. This model offers a greater degree of specificity in analyzing observable, as contrasted with intrapsychic, human behaviour than that offered by the humanistic, existential, or psychoanalytic models.

8.2 OBJECTIVES

At the end of this unit, you will be able to

- Comprehend the basic assumptions of the behavioural approach
- Differentiate between various approaches of different contributors to this approach
- Relate how the behavioural principles can be helpful in solving day to day problems
- Compare and contrast this approach from the psychoanalytic approach

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8.3 THEORY – INTRODUCTION

The term behaviour therapy refers to the application of a diversity of techniques and procedures that are rooted in a variety of learning theories. A basic assumption of the behavioural perspective is that all problematic behaviours, cognitions and emotions have been learned and that they can be modified by new learning. It also assumes that the behaviours that clients express are the problem. Successful resolution of these problematic behaviours resolves the problem. This approach is in contrast to the relationship-oriented and insight-oriented approaches which place considerable emphasis on clients' achieving insight into their problems as a prerequisite for change. Behavioural approach assumes that change can take place without insight and that behavioural changes may well lead to an increased level of self-understanding.

This approach

- Focuses on selecting target behaviours to be changed and specifying the nature of the changes desired
- Studies the observable events in the environment that are maintaining the behaviour
- Clearly specifies both the environmental changes and the intervention strategies that can modify behaviour
- Insist on data-based assessment and evaluation of treatment
- Ask the question "once a new behaviour is established, how can it be maintained and generalized to new situations over a period of time?"

Three areas of development

Contemporary behaviour therapy can be understood by considering three major areas of development: classical conditioning, operant conditioning and cognitive therapy. First is the approach **classical conditioning** in which certain respondent behaviours, such as knee jerks and salivation are elicited from a passive organism. This approach was based on HULLIAN learning theory and PAVLOVIAN (or classical) conditioning. Second is the approach of operant conditioning. Operant behaviours consist of actions that operate on the environment to produce consequences. Examples of operant behaviour include reading, writing, driving a car and eating with utensils. Such behaviours include most of the significant responses we make in everyday life. If the environmental changes brought about by the behaviour are reinforcing (if they provide some reward to the organism or eliminate aversive stimuli) the changes are strengthened so that the behaviour will occur again. If the environmental changes produce no reinforcement, the changes are lessened so that the behaviour will recur. B.F. SKINNER was studying the use of principles of operant

conditioning. Skinner's view of controlling behaviour is based on the principles of operant conditioning which rest on the assumption that changes in behaviour are brought about when that behaviour is followed by a particular kind of consequences. Skinner contends that learning cannot occur in the

absence of some kind of reinforcements, either positive or negative. For him actions that are reinforced tend to be repeated, and those that are discouraged tend to be extinguished. This model is based on reinforcement principles and has the goal of identifying controlling environment factors that lead to behavioural change.

Positive reinforcement is a procedure in which a response is followed by the presentation of stimulus. It involves the addition of something (such a praise or money) as a consequence of certain behaviour. The stimulus is positive reinforce, which is something the organism seeks, such a food. **Negative reinforcement** involves the removal of unpleasant stimuli from a situation once a certainbehaviour has occurred. Negative reinforces are generally unpleasant, so that the individual is motivated to execute a desired behaviour in order to avoid the unpleasant condition.

Third is the **Cognitive trend** in behaviour therapy. The behaviourist of both the classical conditioning and operant-conditioning models excluded any reference to meditation concepts (such as the role of thinking processes, attitude and values) perhaps as a reaction against the insight-oriented psycho dynamic approaches. Since the 1970's the behavioural movement has conceded a legitimate place to thinking, even to extent of giving cognitive factors a central role in the understanding of and treating of behaviourism problem. Cognitive-behavioural therapy is now established as a part of mainstream behaviour therapy. Behaviour therapy has undergone important changes and has expanded considerably. It is no longer grounded exclusively in learning theory, nor is it a narrowly defined set of techniques. Contemporary behaviour therapy encompasses a variety of conceptualizations, research methods, and treatment procedure to explain and change behaviour.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What are the basic assumptions of behavioural approach?

8.4 PAVLOV'S CLASSICAL CONDITIONING

Classical conditioning (respondent conditioning) refers to what happens prior to learning that creates a response through pairing. A key figure in this area is Ivan Pavlov who illustrated classical conditioning through experiments with dogs. Placing food in a dog's mouth leads to salivation, which is respondent behavior. When food is repeatedly presented with some originally neutral stimulus (something that does not elicit a particular response), such as the sound of a bell, the dog will eventually salivate to the sound of the bell alone. However, if a bell is sounded repeatedly but not paired again with food, the salivation response will

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eventually diminish and become extinct. An example of a procedure that is based on the classical conditioning model is Joseph Wolpe's systematic desensitization. This technique illustrates how principles of learning derived from the experimental laboratory can be applied clinically. Desensitization can be applied to people who, through classical conditioning, developed an intense fear of flying after having a frightening experience while flying.

Diagrammatic representation of Pavlov's experiments

Stage One

Unconditioned Stimulus →
Unconditioned Response
Food (UCS)
Salivation (UCR)

Stage two

Conditioned Stimulus (CS)
Bell
Reinforced by
Unconditioned Stimulus →
Unconditioned Response
Food (UCS)
Salivation (UCR)

Stage three

Conditioned Stimulus (CS) →
Conditioned Response (CR)
Bell
Salivation

Stage four

Conditioned Stimulus (CS) →
Extinguished Conditioned
Bell no longer reinforced by Response
(ECR) Absence
feeding of Salivation

Check your Progress – 2

Note: a. Write your answer in the space given below
b. Compare your answer with those given at the end of the unit.
2. What is learning according to classical conditioning?

8.5 WATSON'S CONDITIONED BEHAVIOURISM

John B. Watson believed that there were two points of view dominant in the American psychological thinking of his time: introspective or subjective psychology, which he called the old psychology and the new objective psychology of behaviourism. Concepts such as consciousness and introspection, the subject matter of the old psychology, were magic. Psychology, being an objective and experimental branch of the natural sciences, needs such concepts as little as do the sciences of chemistry and physics. As the behaviour of animals can be investigated without referring to consciousness, so can the behaviour of man. Watson devoted nearly 12 years to experimentation on animals and he observed that it was natural that he should drift to a theoretical position in harmony with his experimental work.

The Watsonian behaviourist sees all psychological problems and their solutions as being schematized in stimulus and response terms, often abbreviated as S-R. Stimuli may be unconditioned in that from birth they call forth definite responses, such as turning the eyes away from or closing the eyes to light. On the other hand, most stimuli to which humans respond are conditioned or learned.

Watson believed that, given total control over a dozen healthy infants from birth, he could take any one at random and train him to become any type of person he might select, be it a doctor, lawyer, artist, beggar or thief. Inheritance of capacity, talent, temperament, mental constitution and characteristics does not really exist, since these things depend on training.

Watson explained how emotions are conditioned. According to him, there are three types of unlearned beginnings of emotional reactions, or unlearned emotional responses to stimuli. These responses are fear, rage and love. These emotional reactions might be viewed as unconditioned reflexes or responses. For instance, a loud sound is a fundamental stimulus for eliciting the fear response. Watson demonstrated this through a series of experiments on a 11-month old baby called Albert in which he established a conditioned emotional response of fear by the boy to a white rat. He achieved this by linking on some trials of loud sound of the striking of a bar when Albert touched the white rat. Later when the rat was presented alone, Albert exhibited fear response of crying, falling over and crawling away.

Watson argued that 'thinking' referred to all subvocal word behaviour. That is, thinking is the same as talking to oneself. And in other situations such as reacting to a new situation, human thinking is similar to the trial-and-error behaviour of a rat in a maze. When subjects are asked to think aloud it is easy to see how they worked out their problem by word behaviour. Memory is viewed as the retention of verbal habits. If people meet a stimulus again after a period of time they do the habitual thinking they learned to do when the stimulus was first present.

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Watson defined personality as ‘the sum of activities that can be discovered by actual observation of behaviour over a long enough time to give reliable information. In other words, personality is the end product of our habit systems according to Watson. Thus, personality is defined in terms of behaviours or habits which may be observed objectively and which may give rise to accurate predictions of future behaviour. He suggested five ways of obtaining a more accurate estimate of personality, namely by studying the individual’s (a) education chart, (b) achievement chart, (c) spare time and recreation record, (d) emotional make-up under the practical situations of daily living and (e) responses to psychological tests. Personality problems are behaviour disturbances and habit conflicts which need to be cured by unconditioning and conditioning.

8.6 SKINNER’S OPERANT BEHAVIOURISM

Most of the significant responses we make in everyday life are examples of operant behaviors, such as reading, writing, driving a car, and eating with utensils. **Operant conditioning** involves a type of learning in which behaviors are influenced mainly by the consequences that follow them. If the environmental changes brought about by the behavior are reinforcing—that is, if they provide some reward to the organism or eliminate aversive stimuli—the chances are increased that the behavior will occur again. If the environmental changes produce no reinforcement or produce aversive stimuli, the chances are lessened that the behavior will recur. Positive and negative reinforcement, punishment, and extinction techniques, illustrate how operant conditioning in applied settings can be instrumental in developing prosocial and adaptive behaviors. Operant techniques are used by behavioral practitioners in parent education programs and with weight management programs.

The term ‘operant’ emphasizes the fact that behaviour operates on the environment to generate consequences. In Pavlov’s approach the reinforcer is paired with the stimulus, whereas in operant behaviour it is contingent upon a response. Skinner stressed the role of the environment in shaping and maintaining behaviour. The probability of a response is increased after both positive and negative reinforcement. Positive reinforcements consist of presenting something, such as food, water in a situation. Negative reinforcements consist of removing something, such as a bright light or an electric shock from the situation. The difference between positive and negative reinforcement hinges on whether it is the presence or absence of a given reinforcer which increases the probability of a response. The withdrawal of a positive reinforcer has the same effect as the presentation of a negative reinforcer.

The effects of reinforcement differ based on the schedules of reinforcements – when and how it is presented.

Non-intermittent schedules of reinforcement are:

1. Continuous reinforcement where every response emitted is reinforced
2. Extinction, where no responses are reinforced

Intermittent schedules of reinforcement include:

1. Fixed interval, in which the first response occurring after a given period of time is reinforced, with another period beginning immediately after the reinforcement.
2. Fixed ratio, in which every nth response is reinforced
3. Variable interval, in which reinforcements are scheduled according to a random series of intervals having a given mean and lying between arbitrary values.
4. Variable ratio, in which reinforcements are scheduled according to a random series of ratios having a given mean and lying between arbitrary values.
5. Multiple, in which one schedule of reinforcement is in force in the presence of one stimulus and different schedule in the presence of another stimulus.
6. Differential reinforcement of rate of response, in which a response is reinforced only if it follows the preceding response after a specified interval of time or before the end of a given interval.

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Operant conditioning focuses on both acquisition and maintenance of behaviour. Behaviour continues to have consequences, and if these consequences or reinforcements are not forthcoming then extinction occurs. Behaviour may be shaped by reinforcing successive approximations to the desired response. When the reinforcing effect of one stimulus spreads to other stimuli, the effect is that of generalization.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What are the different schedules of reinforcement?

8.7 WOLPE'S RECIPROCAL INHIBITION

Reciprocal inhibition is a form of behavioral therapy in which a desired behavioral response is repeatedly carried out in the presence of a stimulus that normally triggers an undesired response. For example, a client with a phobia of snakes might be repeatedly exposed to the presence of a snake, while practicing a relaxation procedure. The theory behind this type of reciprocal inhibition therapy is that, with sufficient repetition, the old, undesirable response can be unlearned, and a new behavioral pattern can be permanently established.

Reciprocal inhibition has produced a variety of specific approaches to therapy, including desensitization therapy, assertion therapy, and avoidance

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conditioning. The original theory of reciprocal inhibition psychotherapy, was developed by a South African psychologist, Joseph Wolpe, who published his ideas in 1958 in a paper titled “Psychotherapy by Reciprocal Inhibition.” In this seminal work, Wolpe claimed that it was possible to treat anxiety and phobic disorders by teaching clients to relax during a process of gradual exposure to the anxiety-producing stimulus.

Wolpe first demonstrated this concept in a series of experiments on cats. The first step in this process was to expose the cats to an unpleasant shock, paired with a specific sound. After some conditioning, the cats would react with fear to the sound alone. This is an example of classic Pavlovian conditioning. Next, Wolpe showed that the fear response could be gradually unlearned, if he reversed the stimulus, and combined the same sound with the presentation of food.

In the theory of reciprocal inhibition, reciprocal behaviors are defined as behaviors that compete against each other. For example, a relaxation behavior in which the skeletal muscles are relaxed is considered reciprocal to a “fight or flight” stress response in which the muscles become tense. By repeatedly practicing the desired behavior in the presence of the stimulus that used to trigger the undesired behavior, the response to the stimulus is weakened and eventually, if the treatment is successful, the undesired behavior is eliminated.

Wolpe developed his ideas by working with soldiers who suffered from post-traumatic stress disorder, and met with considerable success. Initially, much of the psychotherapeutic community was doubtful regarding the theory of reciprocal inhibition, suggesting that this method would result only in substitution of symptoms in a patient, and not in a permanent cure. However, Wolpe's work formed a pioneering psychotherapeutic theory that has been largely incorporated into modern behavioral therapy.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What is reciprocal inhibition?

8.8 EYSENCK’S INCUBATION THEORY

Eysenck observed that neurotic behaviour, a distinctive feature of which is that behaviour followed by negative consequences is not eliminated, neither follows Skinner’s law of reinforcement nor can be explained adequately in Skinnerian terms. Furthermore, he considered that Watson’s view of neurosis as classically conditioned emotional responses was not elaborated in any detail.

Eysenck acknowledged four sources of neurotic fear/anxiety responses. First, they may be innate. Second, they may be attributed to ‘preparedness’, when

the fear is weak. Preparedness means that certain fears are highly 'prepared' to be learned by humans. Third, fears may be learned through modeling (imitation). Fourth, and the most important source of the learning of fear responses, is classical or Pavlovian conditioning. The main unconditioned stimulus (UCS) generating fear response is frustration or 'frustrative non-reward', which can have physiological and behavioural consequences identical to those of pain.

Eysenck tentatively proposed his incubation theory of neurosis, hoping to encourage the collection of relevant clinical and research data. While a CS-only presentation always provokes a decrease in CR strength, it may also provoke an increase. Thus there are two possible consequences of CS-only presentation. The first is *extinction* of the CR, and the other is enhancement of the CR or *incubation* of anxiety/fear responses. Extinction occurs if the decreasing exceed the increasing tendencies, while incubation takes place if the increasing exceed the decreasing tendencies. There are two classes of CR: those which have drive properties and those which do not, the former leading to enhancement and the latter leading to extinction. A CR leading to extinction, when the CS alone is presented, is a dog's salivation, since the salivation does not produce the hunger drive. However, giving rats a shock after a CS-only presentation does produce a CS-induced drive, or enhancement, and rats will learn new activities and practice established ones.

Eysenck proposed that fear/anxiety is a response which possesses drive properties and hence not only resists extinction but is enhanced by the presentation of the CS. By definition, the initial position is that the UCS produces fear/anxiety, while the CS does not. Pairing the UCS with the CS leads to a situation in which, after conditioning the presentation of the CS alone produces a CR of fear/anxiety which is identical to the UCR. It is the drive properties of the CR which makes it functionally equivalent to the UCR, so providing reinforcement for the CS-only presentation. Thus where the CR for example fear/anxiety, has drive properties, presentation of the CS-only stimuli produces incubation (enhancement) of the CR. A positive feedback cycle is established in which the fear/anxiety associated with CS-only presentation is itself a painful event, and the stimuli associated with the CS, by classical conditioning, come to evoke more fear. This process is responsible for not only the continuation but also the growth of neurotic responses.

Incubation has the effect of allowing the CR to exceed the strength of the UCR. Furthermore, it may account for the slow growth of neurotic responses over a period of time, with a few exposures to CS only. There is much evidence that the duration of the CS-only presentation is a critical factor, with short rather than long presentations favouring incubation of fear/anxiety responses. There is less evidence that a strong as opposed to a weak UCS presentation does so. Eysenck observed that stable extroverts extinguish more readily than other extroversion-neuroticism groupings, while neurotic introverts show most evidence of incubation.

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8.9 LET US SUM UP

The behavioural approach to counselling focuses on the assumption that the environment determines an individual's behaviour. How an individual responds to a given situation is the result of past learning, and usually behaviour that has been reinforced in the past. For example, suppose that a child picked up a spider and took it to their mother. If she was frightened of spiders, she might scream. The child would then learn that spiders are frightening. Next time, instead of picking up the spider, the child will probably scream and run to their mother, who may say 'ooh, I hate spiders, they're so creepy', reinforcing the child's behaviour. As a result, the child may develop a fear of spiders and run away screaming (response) at the sight of a spider (stimulus). Behaviourists believe that that behaviour is 'learned' and can therefore be unlearned. Basic assumptions of behaviour according to the significant contributors to this approach were elaborated in this chapter.

8.10 UNIT-END EXERCISES

1. Who are the major contributors to behavioural approach? What are their basic assumptions?
2. What are the strengths and limitations of behavioural approach
3. Write a note on Eysenck's incubation theory.

8.11 ANSWER TO CHECK YOUR PROGRESS

1. All problematic behaviours, cognitions and emotions have been learned and that they can be modified by new learning. It also assumes that the behaviours that clients express are the problem. Successful resolution of these problematic behaviours resolves the problem.
2. Learning is a conditioned response which occurs through repeated pairing of conditioned stimulus and unconditioned stimulus which will eventually produce the conditioned response when conditioned stimulus is presented.
3. Variable ratio, Fixed ratio, Variable Interval, Fixed interval, Multiple, Differential
4. Reciprocal inhibition is a form of behavioral therapy in which a desired behavioral response is repeatedly carried out in the presence of a stimulus that normally triggers an undesired response.

8.12 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
3. Patterson, L.W. &Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. &Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

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BLOCK III: ASSESSMENT AND APPROACHES

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UNIT 9: PRACTICE

Structure

9.1 Introduction

9.2 Objectives

9.3 Goals for counselling

9.4 Behavioural Assessment

9.5 Relaxation Procedures

9.5.1 Systematic Desensitization

9.6 Behaviour Rehearsal and Assertive Training

9.7 Reinforcement Methods

9.8 Let us sum up

9.9 Unit-End Exercises

9.10 Answer to Check your Progress

9.11 Suggested Readings

9.1 INTRODUCTION

Behavior therapy practitioners focus on observable behavior, current determinants of behavior, learning experiences that promote change, tailoring treatment strategies to individual clients, and rigorous assessment and evaluation. Behavior therapy has been used to treat a wide range of psychological disorders with different client populations. Anxiety disorders, depression, substance abuse, eating disorders, domestic violence, sexual problems, pain management, and hypertension have all been successfully treated using this approach. Behavioral procedures are used in the fields of developmental disabilities, mental illness, education and special education, community psychology, clinical psychology, rehabilitation, business, self-management, sports psychology, health-related behaviors, and gerontology.

The behavioral approach had its origin in the 1950s and early 1960s, and it was a radical departure from the dominant psychoanalytic perspective. The

behavior therapy movement differed from other therapeutic approaches in its application of principles of classical and operant conditioning to the treatment of a variety of problem behaviors. By the early 2000s, the “third wave” of the behavioral tradition emerged, enlarging the scope of research and practice. This newest development includes dialectical behavior therapy, mindfulness-based stress reduction, mindfulness-based cognitive therapy, and acceptance and commitment therapy.

9.2 OBJECTIVES

At the end of this unit, you will be able to:

- Understand the goals for counselling in behavioural approach
- Make an assessment of what precedes a behaviour and what will ensure strengthening of a desirable behaviour
- Practice and apply different behavioural techniques to different problems

9.3 GOALS FOR COUNSELLING

Six key characteristics of behavior therapy are described below.

1. Behavior therapy is based on the principles and procedures of the scientific method. Experimentally derived principles of learning are systematically applied to help people change their maladaptive behaviors. The distinguishing characteristic of behavioral practitioners is their systematic adherence to precision and to empirical evaluation. Behavior therapists state treatment goals in concrete objective terms to make replication of their interventions possible. Treatment goals are agreed upon by the client and the therapist. Throughout the course of therapy, the therapist assesses problem behaviors and the conditions that are maintaining them. Research methods are used to evaluate the effectiveness of both assessment and treatment procedures. In short, behavioral concepts and procedures are stated explicitly, tested empirically, and revised continually.
2. Behavior therapy deals with the client’s current problems and the factors influencing them, as opposed to an analysis of possible historical determinants. Emphasis is on specific factors that influence present functioning and what factors can be used to modify performance. At times understanding of the past may offer useful information about environmental events related to present behavior. Behavior therapists look to the current environmental events that maintain problem behaviors and help clients produce behavior change by changing environmental events, through a process called *functional assessment*, or what Wolpe (1990)

referred to as a “behavioral analysis.”

3. Clients involved in behavior therapy are expected to assume an active role by engaging in specific actions to deal with their problems. Rather than simply talking about their condition, they are required to *do* something to bring about change. Clients monitor their behaviors both during and outside the therapy sessions, learn and practice coping skills, and role-play new behavior. Therapeutic tasks that clients carry out in daily life, or homework assignments, are a basic part of this approach. Behavior therapy is an action-oriented and an educational approach, and learning is viewed as being at the core of therapy. Clients learn new and adaptive behaviors to replace old and maladaptive behaviors.
4. This approach assumes that change can take place without insight into underlying dynamics. Behavior therapists operate on the premise that changes in behavior can occur prior to or simultaneously with understanding of one-self, and that behavioral changes may well lead to an increased level of self- understanding. While it is true that insight and understanding about the possibilities that worsen one’s problems can supply motivation to change, knowing that one has a problem and knowing *how* to change it are two different things.
5. The focus is on assessing overt and covert behavior directly, identifying the problem, and evaluating change. There is direct assessment of the target problem through observation or self-monitoring. Therapists also assess their clients’ cultures as part of their social environments, including social support networks relating to target behaviors. Critical to behavioral approaches is the careful assessment and evaluation of the interventions used to determine whether the behavior change resulted from the procedure.
6. Behavioral treatment interventions are individually tailored to specific problems experienced by clients. Several therapy techniques may be used to treat an individual client’s problems. An important question that serves as a guide for this choice is: “*What* treatment, by *whom*, is the most effective for *this* individual with *that* specific problem and under *which* set of circumstances?”

Goals occupy a place of central importance in behavior therapy. The general goals of behavior therapy are to increase personal choice and to create new conditions for learning. The client, with the help of the therapist, defines specific treatment goals at the outset of the therapeutic process. Although assessment and treatment occur together, a formal

assessment takes place prior to treatment to determine behaviors that are targets of change. Continual assessment throughout therapy determines the degree to which identified goals are being met. It is important to devise a way to measure progress toward goals based on empirical validation.

Contemporary behavior therapy stresses clients' active role in deciding about their treatment. The therapist assists clients in formulating specific measurable goals. Goals must be clear, concrete, understood, and agreed on by the client and the counsellor. The counsellor and client discuss the behaviors associated with the goals, the circumstances required for change, the nature of subgoals, and a plan of action to work toward these goals. This process of determining therapeutic goals involves a negotiation between client and counsellor that results in a contract that guides the course of therapy. Behavior therapists and clients alter goals throughout the therapeutic process as needed.

NOTES

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What is the focus of behaviour therapists?
2. What are the general goals of behaviour therapy?

9.4 BEHAVIOURAL ASSESSMENT

Behavior therapists conduct a thorough **functional assessment** (or **behavioral analysis**) to identify the maintaining conditions by systematically gathering information about situational antecedents, the dimensions of the problem behavior, and the consequences of the problem. This is known as the **ABC model**, which addresses antecedents, behaviors, and consequences. This model of behavior suggests that *behavior* (B) is influenced by some particular events that precede it, called *antecedents* (A), and by certain events that follow it called *consequences* (C). **Antecedent events** are ones that cue or elicit a certain behavior. For example, with a client who has trouble going to sleep, listening to a relaxation tape may serve as a cue for sleep induction. Turning off the lights and removing the television from the bedroom may elicit sleep behaviors as well. **Consequences** are events that maintain a behavior in some way either by increasing or decreasing it. For example, a client may be more likely to return to counselling after the counsellor offers verbal praise or encouragement for having come in or having completed some homework. A client may be less likely to return after the counsellor is consistently late to sessions. In doing an **assessment interview**, the therapist's task is to identify the particular antecedent and consequent events that influence or are functionally related to an individual's behavior.

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Behaviorally oriented practitioners tend to be active and directive and to function as consultants and problem solvers. They pay close attention to the clues given by clients, and they are willing to follow their clinical hunches. They use some techniques common to other approaches, such as summarizing, reflection, clarification, and open-ended questioning. However, behavioral clinicians perform other functions as well:

- Based on a comprehensive functional assessment, the therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals.
- The behavioral clinician uses strategies that have research support for use with a particular kind of problem. These strategies are used to promote generalization and maintenance of behavior change.
- The clinician evaluates the success of the change plan by measuring progress toward the goals throughout the duration of treatment. Outcome measures are given to the client at the beginning of treatment (called a baseline) and collected again periodically during and after treatment to determine if the strategy and treatment plan are working. If not, adjustments are made in the strategies being used.
- A key task of the therapist is to conduct follow-up assessments to see whether the changes are durable over time. Clients learn how to identify and cope with potential setbacks. The emphasis is on helping clients maintain changes over time and acquire behavioral and cognitive coping skills to prevent relapses.

Let's examine how a behavior therapist might perform these functions. A client comes to therapy to reduce her anxiety, which is preventing her from leaving the house. The therapist is likely to begin with a specific analysis of the nature of her anxiety. The therapist will ask how she experiences the anxiety of leaving her house, including what she actually *does* in these situations. Systematically, the therapist gathers information about this anxiety. When did the problem begin? In what situations does it arise? What does she do at these times? What are her feelings and thoughts in these situations? Who is present when she experiences anxiety? What does she do to reduce the anxiety? How do her present fears interfere with living effectively? After this assessment, specific behavioral goals will be developed, and strategies such as relaxation training, systematic desensitization, and exposure therapy will be designed to help the client reduce her anxiety to a manageable level. The therapist will get a commitment from her to work toward the specified goals, and the two of them will evaluate her progress toward meeting these goals throughout the duration of therapy.

9.5 RELAXATION PROCEDURES

Practice

Relaxation training is aimed at achieving muscle and mental relaxation and is easily learned. Jacobson (1938) is credited with initially developing the progressive relaxation procedure. It has since been refined and modified, and relaxation procedures are frequently used in combination with a number of other behavioural techniques. These include imaginal-desensitization procedures, systematic desensitization, assertion, training, self-management programs, tape-recorded instruction, biofeedback-induced relaxation, hypnosis, meditation, and autogenic training-teaching control of bodily and imaginal functions through autosuggestion.

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Relaxation training involves several components that typically require from four to eight hours of instruction. Clients are given a set of instructions that asks them to relax. They assume a passive and relaxing muscles. Deep and regular breathing is also associated with producing relaxation. At the same time, clients learn to mentally “let go”, perhaps by focusing on pleasant thoughts or images. Relaxation becomes a well-learned response, which can become a habitual pattern if practiced daily for 20 or 25 minutes. During these exercise it helps clients to actually feel and experience the tension building up to notice their muscles getting tighter and study this tension, and hold and fully experience the tension. Also, it is useful to experience the difference between a tense and a relaxed state.

Until the last few years relaxation training was primarily used as a part of systematic-desensitization procedures. Recently, relaxation procedures have been applied to a variety of clinical problems, either as a separate technique or in conjunction with related methods. The most common use has been with problems related to stress and anxiety, which often are manifested in psychosomatic symptoms. Other ailments for which relaxation training is helpful include high blood pressure and other cardiovascular problems, migraine headaches, asthma and insomnia.

9.5.1 SYSTEMATIC DESENSITIZATION

Systematic desensitization, which is based on the principle of classical conditioning, is a basic behavioral procedure developed by Joseph Wolpe, one of the pioneers of behavior therapy. Clients imagine successively more anxiety-arousing situations at the same time that they engage in a behavior that competes with anxiety. Gradually, or systematically, clients become less sensitive (desensitized) to the anxiety-arousing situation. This procedure can be considered a form of exposure therapy because clients are required to expose themselves to anxiety-arousing images as a way to reduce anxiety.

Systematic desensitization is an empirically researched behavior therapy procedure that is time consuming, yet it is clearly an effective and efficient treatment of anxiety-related disorders, particularly in the area of specific phobias. Before implementing the desensitization procedure, the

therapist conducts an initial interview to identify specific information about the anxiety and to gather relevant background information about the client. This interview, which may last several sessions, gives the therapist a good understanding of who the client is. The therapist questions the client about the particular circumstances that elicit the conditioned fears. For instance, under what circumstances does the client feel anxious? If the client is anxious in social situations, does the anxiety vary with the number of people present? Is the client more anxious with women or men? The client is asked to begin a self-monitoring process consisting of observing and recording situations during the week that elicit anxiety responses. Some therapists also administer a questionnaire to gather additional data about situations leading to anxiety.

If the decision is made to use the desensitization procedure, the therapist gives the client a rationale for the procedure and briefly describes what is involved. McNeil and Kyle (2009) describe several steps in the use of systematic desensitization: (1) relaxation training, (2) development of the anxiety hierarchy, and (3) systematic desensitization proper.

The steps in *relaxation training* are presented to the client. The therapist uses a very quiet, soft, and pleasant voice to teach progressive muscular relaxation. The client is asked to create imagery of previously relaxing situations, such as sitting by a lake or wandering through a beautiful field. It is important that the client reach a state of calm and peacefulness. The client is instructed to practice relaxation both as a part of the desensitization procedure and also outside the session on a daily basis.

The therapist then works with the client to develop an *anxiety hierarchy* for each of the identified areas. Stimuli that elicit anxiety in a particular area, such as rejection, jealousy, criticism, disapproval, or any phobia, are analyzed. The therapist constructs a ranked list of situations that elicit increasing degrees of anxiety or avoidance. The hierarchy is arranged in order from the worst situation the client can imagine down to the situation that evokes the least anxiety. If it has been determined that the client has anxiety related to fear of rejection, for example, the highest anxiety-producing situation might be rejection by the spouse, next, rejection by a close friend, and then rejection by a coworker. The least disturbing situation might be a stranger's indifference toward the client at a party.

Desensitization does not begin until several sessions after the initial interview has been completed. Enough time is allowed for clients to learn relaxation in therapy sessions, to practice it at home, and to construct their anxiety hierarchy. The desensitization process begins with the client reaching complete relaxation with eyes closed. A neutral scene is presented, and the client is asked to imagine it. If the client remains relaxed, he or she is asked to imagine the least anxiety-arousing scene on the hierarchy of situations that has been developed. The therapist moves progressively up the hierarchy until the client signals that he or she is

experiencing anxiety, at which time the scene is terminated. Relaxation is then induced again, and the scene is reintroduced again until little anxiety is experienced to it. Treatment ends when the client is able to remain in a relaxed state while imagining the scene that was formerly the most disturbing and anxiety-producing. The core of systematic desensitization is repeated exposure in the imagination to anxiety-evoking situations without experiencing any negative consequences.

Homework and follow-up are essential components of successful desensitization. Clients can practice selected relaxation procedures daily, at which time they visualize scenes completed in the previous session. Gradually, they also expose themselves to daily-life situations as a further way to manage their anxieties. Clients tend to benefit the most when they have a variety of ways to cope with anxiety-arousing situations that they can continue to use once therapy has ended.

Systematic desensitization is an appropriate technique for treating phobias, but it is a misconception that it can be applied only to the treatment of anxiety. It has also been used to treat a variety of conditions beside anxiety, including anger, asthmatic attacks, insomnia, motion sickness, nightmares, and sleep- walking.. Systematic desensitization is often acceptable to clients because they are gradually and symbolically exposed to anxiety-evoking situations. A safeguard is that clients are in control of the process by going at their own pace and terminating exposure when they begin to experience more anxiety than they want to tolerate.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. Who developed Progressive relaxation therapy and Systematic desensitization respectively?

4. How is anxiety hierarchy constructed in systematic desensitization?

9.6 BEHAVIOUR REHEARSAL AND ASSERTIVE TRAINING

Behaviour Rehearsal

Social skills training is a broad category that deals with an individual's ability to interact effectively with others in various social situations; it is used to correct deficits clients have in interpersonal competencies. *Social skills* involve being able to communicate with others in a way that is both appropriate and effective. Individuals who experience psychosocial problems that are partly caused by interpersonal difficulties are good

candidates for social skills training. Some of the desirable aspects of this training are that it has a very broad base of applicability and it can easily be tailored to suit the particular needs of individual clients. Social skills training include psychoeducation, modeling, reinforcement, behavioral rehearsal, role playing, and feedback. Another popular variation of social skills training is anger management training, which is designed for individuals who have trouble with aggressive behavior. *Assertion training*, which is described next, is for people who lack assertive skills.

Assertive Training

One specialized form of social skills training that has gained increasing popularity is teaching people how to be assertive in a variety of social situations. Many people have difficulty feeling that it is appropriate or right to assert themselves. People who lack social skills frequently experience interpersonal difficulties at home, at work, at school, and during leisure time. Assertion training can be useful for those (1) who have difficulty expressing anger or irritation, (2) who have difficulty saying no, (3) who are overly polite and allow others to take advantage of them, (4) who find it difficult to express affection and other positive responses, (5) who feel they do not have a right to express their thoughts, beliefs, and feelings, or (6) who have social phobias.

The basic assumption underlying **assertion training** is that people have the right (but not the obligation) to express themselves. One goal of assertion training is to increase people's behavioral repertoire so that they can make the *choice* of whether to behave assertively in certain situations. It is important that clients replace maladaptive social skills with new skills. Another goal is teaching people to express themselves in ways that reflect sensitivity to the feelings and rights of others. Assertion does not mean aggression; truly assertive people do not stand up for their rights at all costs, ignoring the feelings of others.

Assertion training is based on the principles of social learning theory and incorporates many social skills training methods. Generally, the therapist both teaches and models desired behaviors the client wants to acquire. These behaviors are practiced in the therapy office and then enacted in everyday life. Most assertion training programs focus on clients' negative self-statements, self-defeating beliefs, and faulty thinking. People often behave in unassertive ways because they don't think they have a right to state a viewpoint or ask for what they want or deserve. Thus their thinking leads to passive behavior. Effective assertion training programs do more than give people skills and techniques for dealing with difficult situations. These programs challenge people's beliefs that accompany their lack of assertiveness and teach them to make constructive self-statements and to adopt a new set of beliefs that will result in assertive behavior.

Assertion training is often conducted in groups. When a group format is used, the modeling and instructions are presented to the entire group, and members rehearse behavioral skills in role-playing situations. After the rehearsal, the member is given feedback that consists of reinforcing the correct aspects of the behavior and instructions on how to improve the behavior. Each member engages in further rehearsals of assertive behaviors until the skills are performed adequately in a variety of simulated situations.

Because assertion training is based on Western notions of the value of assertiveness, it may not be suited for clients with a cultural background that places more emphasis on harmony than on being assertive. This approach can be an effective treatment for clients who have skill deficits in assertive behavior or for individuals who experience difficulties in their interpersonal relationships. Although counsellors can adapt this form of social skills training procedures to suit their own style, it is important to include behavioral rehearsal and continual assessment as basic aspects of the program.

9.7 REINFORCEMENT METHODS

This section describes a few key principles of operant conditioning: positive reinforcement, negative reinforcement, extinction, positive punishment, and negative punishment.

In applied behavior analysis, operant conditioning techniques and methods of assessment and evaluation are applied to a wide range of problems in many different settings. The most important contribution of applied behavior analysis is that it offers a functional approach to understanding clients' problems and addresses these problems by changing antecedents and consequences (the ABC model).

Behaviorists believe we respond in predictable ways because of the gains we experience (positive reinforcement) or because of the need to escape or avoid unpleasant consequences (negative reinforcement). Once clients' goals have been assessed, specific behaviors are targeted. The goal of reinforcement, whether positive or negative, is to increase the target behavior. **Positive reinforcement** involves the *addition* of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behavior. The stimulus that follows the behavior is the positive reinforcer. For example, a child earns excellent grades and is praised for studying by her parents. If she values this praise, it is likely that she will have an investment in studying in the future. When the goal of a program is to decrease or eliminate undesirable behaviors, positive reinforcement is often used to increase the frequency of more desirable behaviors, which replace undesirable behaviors.

Negative reinforcement involves the *escape* from or the avoidance of aversive (unpleasant) stimuli. The individual is motivated to exhibit a desired behavior to avoid the unpleasant condition. For example, a person who does not appreciate waking up to the shrill sound of an alarm clock has trained herself to wake up a few minutes before the alarm sounds to avoid the aversive stimulus of the alarm buzzer.

Another operant method of changing behavior is **extinction**, which refers to withholding reinforcement from a previously reinforced response. In applied settings, extinction can be used for behaviors that have been maintained by positive reinforcement or negative reinforcement. For example, in the case of children who display temper tantrums, parents often reinforce this behavior by the attention they give to it. An approach to dealing with problematic behavior is to eliminate the connection between a certain behavior (tantrums) and positive reinforcement (attention). Doing so can decrease or eliminate such behaviors through the *extinction process*. It should be noted that extinction might well have negative side effects, such as anger and aggression. Extinction can reduce or eliminate certain behaviors, but extinction does not replace those responses that have been extinguished. For this reason, extinction is most often used in behavior modification programs in conjunction with various reinforcement strategies.

Another way behavior is controlled is through **punishment**, sometimes referred to as aversive control, in which the consequences of a certain behavior result in a decrease of that behavior. The goal of reinforcement is to *increase target behavior*, but the goal of punishment is to *decrease target behavior*. There are two kinds of punishment that may occur as a consequence of behavior: positive punishment and negative punishment. In **positive punishment** an aversive stimulus is *added* after the behavior to decrease the frequency of a behavior (such as withholding a treat from a child for misbehavior or reprimanding a student for acting out in class). In **negative punishment** a reinforcing stimulus is *removed* following the behavior to decrease the frequency of a target behavior (such as deducting money from a worker's salary for missing time at work, or taking television time away from a child for mis-behavior). In both kinds of punishment, the behavior is less likely to occur in the future. These four operant procedures form the basis of behavior therapy programs for parent skills training and are also used in the self-management procedure.

Skinner (1948) believed punishment had limited value in changing behavior and was often an undesirable way to modify behavior. He opposed using aversive control or punishment, and recommended substituting positive reinforcement. The key principle in the applied behavior analysis approach is to use the least aversive means possible to change behavior, and positive reinforcement is known to be the most powerful change agent. Skinner believed in the value of analyzing environmental factors for both the causes and remedies for behavior

problems and contended that the greatest benefits to the individual and to society occur by using systematic positive reinforcement as a route to behavior control.

Practice

In everyday life, punishment is often used as a means of getting revenge or expressing frustration. However, punishment in everyday life is not likely to teach lessons or suppress intolerable behavior because of the specific punishments that are used and how they are applied. Even in those cases when punishment suppresses undesirable responses, punishment does not result in teaching desirable behaviors. Punishment should be used only after non-aversive approaches have been implemented and found to be ineffective in changing problematic behavior. It is essential that reinforcement be used as a way to develop appropriate behaviors that replace the behaviors that are suppressed.

NOTES

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. Distinguish between positive reinforcement and negative reinforcement.

9.8 LET US SUM UP

Behavior therapy is diverse with respect not only to basic concepts but also to techniques that can be applied in coping with specific problems with a diverse range of clients. The behavioral movement includes four major areas of development: classical conditioning, operant conditioning, social learning theory, and increasing attention to the cognitive factors influencing behavior. A unique characteristic of behavior therapy is its strict reliance on the principles of the scientific method. Concepts and procedures are stated explicitly, tested empirically, and revised continually.

A cornerstone of behavior therapy is identifying specific goals at the outset of the therapeutic process. In helping clients achieve their goals, behavior therapists typically assume an active and directive role. Although the client generally determines *what* behavior will be changed, the therapist typically determines *how* this behavior can best be modified. In designing a treatment plan, behavior therapists employ techniques and procedures from a wide variety of therapeutic systems and apply them to the unique needs of each client.

The specificity of the behavioral approaches helps clients translate unclear goals into concrete plans of action, and it helps both the

counsellor and the client to keep these plans clearly in focus. An advantage behavior therapists have is the wide variety of specific behavioral techniques at their disposal. Techniques such as role playing, behavioral rehearsal, coaching, guided practice, modeling, feedback, learning by successive approximations, mindfulness skills, and homework assignments can be included in any therapist's repertoire, regardless of theoretical orientation. Behavior therapy stresses *doing*, as opposed to merely talking about problems and gathering insights. This approach has made significant contributions to health psychology, especially in helping people maintain a healthy lifestyle.

A major contribution of behavior therapy is its emphasis on research into and assessment of treatment outcomes. Another strength of the behavioral approaches is the emphasis on ethical accountability. Behavior therapy is ethically neutral in that it does not dictate whose behavior or what behavior should be changed. Clients have a good deal of control and freedom in deciding *what* the goals of therapy will be.

Limitations and Criticisms of Behavior Therapy

Behavior therapy has been criticized for a variety of reasons. Common criticisms and misconceptions people often have about behavior therapy are: (i) *Behavior therapy may change behaviors, but it does not change feelings.* Some critics argue that feelings must change before behavior can change. A general criticism of both the behavioral and the cognitive approaches is that clients are not encouraged to experience their emotions (ii) *Behavior therapy ignores the important relational factors in therapy.* The charge is often made that the importance of the relationship between client and therapist is discounted in behavior therapy. (iii) *Behavior therapy does not provide insight.* If this assertion is indeed true, behavior therapists would probably respond that insight is not a necessary requisite for behavior change. However, a change in behavior often leads to a change in understanding or to insight, and often it leads to emotional changes. (iv) *Behavior therapy treats symptoms rather than causes.* Behavior therapists may acknowledge that deviant responses have historical origins, but they contend that history is seldom important in the maintenance of current problems. However, behavior therapists emphasize changing current environmental circumstances to change behavior. (v) *Behavior therapy involves control and manipulation by the therapist.* All therapists have a power relationship with the client and thus have control. Surely, in all therapeutic approaches there is control by the therapist, who hopes to change behavior in some way. This does not mean, however, that clients are helpless victims at the mercy of the whims and values of the therapist. Contemporary behavior therapists employ techniques aimed at increased self-direction and self-modification, which are skills clients actually learn in the therapy process.

9.9 UNIT-END EXERCISES

1. Elucidate on the goals of behaviour therapy.
2. Explain the methods used for relaxation and its usefulness in therapy.
3. Write a note on assertion training.
4. Explain the difference between positive reinforcement, negative reinforcement and punishment.

9.10 ANSWER TO CHECK YOUR PROGRESS

1. Behaviour therapists focus on observable behaviour and current determinants of behaviour.
2. The general goals of behavior therapy are to increase personal choice and to create new conditions for learning.
3. Jacobson and Wolpe respectively
4. The therapist constructs a ranked list of situations that elicit increasing degrees of anxiety or avoidance. The hierarchy is arranged in order from the worst situation the client can imagine down to the situation that evokes the least anxiety.
5. Positive reinforcement involves the addition of something of value to the individual (such as praise, attention, money, or food) as a consequence of certain behavior. Negative reinforcement involves the escape from or the avoidance of aversive (unpleasant) stimuli. The individual is motivated to exhibit a desired behavior to avoid the unpleasant condition.

9.11 UGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper’s Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D.John Antony, Skills of Counselling, 2003, Anugraha Publications.

Practice

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UNIT 10: COGNITIVE BEHAVIOUR THERAPY

NOTES

Structure

- 10.1 Introduction
- 10.2 Objectives
- 10.3 Key concepts and Applications
- 10.4 Techniques
- 10.5 Albert Ellis's Rational Emotive Behaviour Therapy
 - 10.5.1 The ABCDE Model of Emotional Disturbance
- 10.6 Aaron Beck's Cognitive Therapy
 - 10.6.1 Basic Principles of Cognitive Therapy
 - 10.6.2 The core ideas of cognitive therapy
- 10.7 Donald Meichenbaum's Cognitive Behaviour Modification
 - 10.7.1 Change in Behaviour
 - 10.7.2 Coping Skills Programs
- 10.8 Let us sum up
- 10.9 Unit-End Exercises
- 10.10 Answer to Check your Progress
- 10.11 Suggested Readings

10.1 INTRODUCTION

Cognitive Behaviour Therapy (CBT) is a form of psychotherapy that focuses on examining the relationships between thoughts, feelings, and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, clients can modify their patterns of thinking to improve coping. It refers to a group of interventions that share the idea that psychological distress is sustained by cognitive elements. Pioneered by Ellis (1962) and Beck (1970), the principle of CBT is that maladaptive thoughts promote the continuance of psychological distress and behavioral difficulties. These maladaptive thoughts include the individual's general beliefs about themselves, the world, and the future (Beck, 1970), creating automatic thoughts that may be faulty, inaccurate, or unhelpful in certain situations.

10.2 OBJECTIVES

The aim of this chapter is to make you understand

- The basic assumption of Cognitive behaviour therapy
- The difference between different approaches
- The application of the principle of this approach to solve emotional and behavioural problems

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10.3 KEY CONCEPTS AND APPLICATION

The idea behind cognitive therapy is that how you think determines how you feel and act. CBT as a treatment focuses on the fundamental premise that negative behaviors arise from faulty cognitions of a person, which can be elicited by stressors from one's self, environment, and/or others. The basic premise of CBT is that emotions are difficult to change directly, so CBT targets emotions by changing thoughts and behaviors that are contributing to the distressing emotions. Utilizing an evidence-based approach, CBT is a time-limited, present-oriented psychotherapy to help people modify dysfunctional thinking and behavior, as a way to help solve current problems (Beck, 1967).

10.4 TECHNIQUES

Cognitive-behaviour therapists use both behavioral and cognitive strategies to create new treatment approaches specific to the client's needs. There are many different CBT approaches and techniques that can be blended together to work as one. All of the techniques include the core element of cognitive restructuring as developed by Ellis and Beck. Below is a list of techniques and strategies that can be incorporated into treatment:

Stress Inoculation Training (SIT): An approach to reduce stress that consists of three phases; conceptualization skills, skills acquisition and rehearsal, and application and follow-through. This approach assumes that if people can successfully cope with relatively mild stressors, they will be able to tolerate and successfully cope with more severe ones. Treatment usually consists of 12-15 weekly sessions plus additional follow-up sessions over 6-12 months.

Behavioral Activation Therapy (BAT): Involves increasing activity on a daily basis to help motivate people with depression who may experience low energy and may have withdrawn from life. BAT is usually started at the beginning of treatment for depression, to help people increase their activity levels, improve their mood, and provide a source of pleasure on which they can build. Strategies used include establishing a list of pleasant activities, scheduling, monitoring, and charting activities; relaxation and skills training; recognizing aversive and avoidant behaviors; and confronting cognitive distortions.

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Habit Reversal Training (HAT): Uses reinforcement and other behavior techniques to help people recognize signs of non-adaptive behaviours before they happen, monitor their own behavior during stressful situations, use relaxation techniques, and perform alternative behaviors that are incompatible with the behavior they are trying to extinguish.

Exposure: Exposure is one of the most important components of cognitive or cognitive-behavioral therapy for anxiety disorders. Through the use of exposure, the person learns to identify his or her fear responses; recognize maladaptive cognitions, confront uncomfortable feelings without avoiding, running away or otherwise modifying the experience; and achieve a certain amount of self-efficacy or control over the feelings of distress. Techniques like Flooding, graduated exposure, and systematic desensitization are all different kinds of exposure based therapy.

Eye movement Desensitization and Reprocessing (EMDR): A form of exposure therapy that combines bilateral stimulation (eye movement, alternating sounds, and tapping), behavioral desensitization, and cognitive restructuring in a structured eight phase process. EMDR is effective in the treatment of anxiety and mood disorders, specific phobias, eating and conduct disorders.

Problem Solving Therapy (PST): Consists of a four step process: Identifying the problem, brainstorming alternatives, conducting a cost/benefit analysis of possible solutions, and monitoring and evaluating outcomes. Through PST, clients reduce impulsive decisions, minimize conflict, and decrease the use of maladaptive coping skills such as avoidance, passivity, or emotion dysregulation. Visualization can be used to help clients imagine achieving the goal successfully.

Check your Progress -1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

1. What is the basic assumption of Cognitive behaviour therapy?

10.5 ALBERT ELLIS'S RATIONAL EMOTIVE BEHAVIOUR THERAPY

Rational emotive behavior therapy (REBT) was one of the first cognitive behavior therapies, and it continues to be a major cognitive behavioral approach. The basic assumption of REBT is that people contribute to their own psychological problems, as well as to specific symptoms, by the way they interpret events and situations. REBT is based on the assumption that cognitions, emotions, and behaviors interact significantly and have a reciprocal cause-and-effect relationship. REBT has consistently emphasized all three of

these modalities and their interactions, thus qualifying it as an integrative approach.

Not only does REBT rest on the belief that the way we think influences our emotions and behavior, it attempts to help clients change the way they think to reduce negative symptoms and improve their quality of life.

“People are not disturbed by things but rather by their view of things.” – Albert Ellis

Rational Emotive Behavior Therapy assumes that many people with emotional or behavioral problems struggle due to the way they perceive their experiences rather than simply the experiences themselves. REBT aims to facilitate change in core beliefs and thought patterns that will clients more effectively deal with their problems and improve their ability to function and feel in a healthy way.

According to Ellis the psychoanalytic approach is sometimes very inefficient because people often seem to get worse instead of better. He began to encourage his clients to do the very things they were most afraid of doing, such as risking rejection by significant others. Although REBT is generally conceded to be the parent of today’s cognitive behavioral approaches, Greek philosophy, especially, Stoicism has influenced Ellis’s theory. Epictetus, who said around 2,000 years ago: “People are disturbed not by events, but by the views which they take of them”. Ellis contends that how people disturb themselves is more comprehensive and precise than that: “People disturb themselves by the things that happen to them, and by their views, feelings, and actions”.

Ellis also gives credit to Adler as an influential forerunner. Adler believed that our emotional reactions and lifestyle are associated with our basic beliefs and are therefore cognitively created. Like the Adlerian approach, REBT emphasizes the role of social interest in determining psychological health. There are other Adlerian influences on REBT, such as the importance of goals, purposes, values, and meanings in human existence.

Ellis believed that approaching our problems in a more rational way could have a significant impact on our negative emotions and dysfunctional behaviors. The most important challenge to tackle on the road to rationality is our dysfunctional or illogical thinking.

Ellis theorized that many of our emotional and behavioral problems arise from basic irrational assumptions or assumptions that are not totally grounded in reality and influence people to act in ways that are inappropriate, unhelpful, or even destructive. Based on this idea, Ellis developed a model to help explain, describe, and treat emotional and behavioral disturbances.

10.5.1 The ABCDE Model of Emotional Disturbance

Ellis hypothesized that irrational beliefs are the result of a person’s goals or desires being inhibited or blocked. When we don’t get or accomplish what we

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wanted to, we may develop irrational beliefs about ourselves or the world that helps explain what happened.

For example, imagine you are very keen on getting a job you applied for. You study up on the company, practice your interview answers, and make sure you're looking extra sharp the day of the interview. Although you prepared extensively, the hiring manager decided to go with another candidate.

You may accept that this just wasn't meant to be, or that you just weren't the right fit for the job. However, you may also be heavily impacted by the decision and develop an irrational belief about why you didn't get the job.

You might think, "I didn't get this job because they can see that I'm a loser. I'm not good at anything and I never will be."

Or, you might think, "The only reason I didn't get this job is because the hiring manager had it out for me. It's like the universe has it out for me!"

Both of these are thoughts that can help you explain why you didn't get the job, but they are irrational and can lead to negative emotions and behavior.

Using this scenario as an example, this is how the ABCDE model can explain the development (and the solution) of such problems:

A – Activating Event / Adversity

An activating event or adversity is something that triggers you to form an irrational belief, such as being turned down for the position. It is the first step in developing an irrational thought because the irrational thought is formed to help you deal with the event.

B – Irrational Belief

The "B" stands for the irrational belief that is formed in response to the activating event. This is a belief that you use to cope with the event, such as "I'm a loser, I'm useless, and I wouldn't be able to do the job anyway." While this is, of course, an incredibly hurtful thought, it can still be more comforting than having no idea why you didn't get the job.

C – Emotional and Behavioral Consequences

The third component is the consequences of this irrational belief. Irrational beliefs always have consequences, sometimes emotional, sometimes behavior, and sometimes both. In this case, the consequences may be that you lose your self-confidence or frequently feel sad (emotional) and stop applying to any jobs (behavioral).

D – Disputes or Arguments

At some point, you may realize that you have an irrational belief that is causing you problems. You notice your loss of self-confidence and negative thoughts about yourself and begin to argue against your irrational belief. If

you're working with a therapist, the therapist may help guide you in developing arguments against the belief and help you come up with evidence to the contrary, such as "I have an amazing wife (Life partner). Women (Spouse) wouldn't be with a 'loser' so I must not be a loser."

E – New Effect

When you have successfully countered the irrational belief, you will notice new (hopefully more positive) consequences or effects. In our example, these effects might be increased confidence, applying to more jobs, and feeling good about your abilities. These effects are the positive outcomes of holding more rational thoughts, like "I just wasn't a good fit for that job, but I'll find another" or "Maybe the hiring manager really didn't like me, but that's her loss".

The ABCDE model can be extremely helpful in tracing the development of an irrational thought and providing a high-level outline of how to challenge and replace it.

REBT's basic hypothesis is that our emotions stem mainly from our beliefs, evaluations, interpretations, and reactions to life situations. Through the therapeutic process, clients learn skills that give them the tools to identify and dispute irrational beliefs that have been acquired and self-constructed and are now maintained by self-belief. They learn how to replace such ineffective ways of thinking with effective and rational cognitions, and as a result they change their emotional reactions to situations. The therapeutic process allows clients to apply REBT principles of change not only to a particular presenting problem but also to many other problems in life or future problems they might encounter.

Several therapeutic implications flow from these assumptions: The focus is on working with thinking and acting rather than primarily with expressing feelings. Therapy is seen as an educational process. The therapist functions in many ways like a teacher, especially in collaborating with a client on homework assignments and in teaching strategies for straight thinking; and the client is a learner, who practices the newly learned skills in everyday life.

REBT differ from other early forms of therapy in its focus on the present; in fact, according to Ellis, a common irrational belief is that our past has a significant influence on our present life. While our past does, of course, shape who we are today, it is an irrational belief if you feel you cannot escape your past.

The goal of Rational Emotive Behavior Therapy is best summarized as "disputing" – challenging and questioning our irrational and dysfunctional beliefs and replacing them with more sensible and functional beliefs. The result is not just changes in a few thought patterns or reducing some problematic symptoms, but a new perspective on life.

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REBT also differ from many other therapeutic approaches in that it does not place much value on free association, working with dreams, focusing on the client's past history, expressing and exploring feelings, or dealing with transference phenomena. Although transference and countertransference may spontaneously occur in therapy, Ellis (2008) claimed "they are quickly analyzed, the philosophies behind them are revealed, and they tend to evaporate in the process". Furthermore, when a client's deep feelings emerge, "the client is not given too much chance to immerse in these feelings or abreact strongly about them". Ellis believes that such cathartic work may result in clients feeling better, but it will rarely aid them in getting better.

Check your Progress -2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

2. What is Rational Emotional Behaviour Therapy?
3. List the ABCDE models steps.

10.6 AARON BECK'S COGNITIVE THERAPY

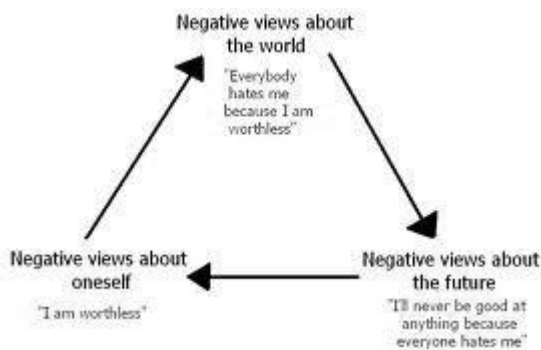
Aaron Beck (1921-) is considered the father of cognitive therapy, developed an approach known as cognitive therapy (CT) as a result of his research on depression. Beck developed cognitive therapy with the belief that a person's experiences result in cognitions or thoughts. These cognitions are connected with schemas, which are core beliefs developed from early life, to create our view of the world and determine our emotional states and behaviors. Beck believed disorders are maintained by negative attitudes and distorted thinking. Beck was designing his cognitive therapy about the same time as Ellis was developing REBT, yet both of them appear to have created their approaches independently. Beck's observations of depressed clients revealed that they had a negative bias in their interpretation of certain life events, which contributed to their cognitive distortions. Cognitive therapy has a number of similarities to both rational emotive behavior therapy and behavior therapy. All of these therapies are active, directive, time-limited, present-centered, problem-oriented, collaborative, structured, empirical, make use of homework, and require explicit identification of problems and the situations in which they occur.

Cognitive therapy perceives psychological problems as stemming from commonplace processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality. Like REBT, CT is an insight-focused therapy that emphasizes recognizing and changing negative thoughts and maladaptive

beliefs. Thus, it is a psychological education model of therapy. Cognitive therapy is based on the theoretical rationale that the way people feel and behave is determined by how they perceive and structure their experience. The theoretical assumptions of cognitive therapy are (1) that people's internal communication is accessible to introspection, (2) that clients' beliefs have highly personal meanings, and (3) that these meanings can be discovered by the client rather than being taught or interpreted by the therapist.

Cognitive therapy was originally designed for the treatment of depression and later extended to treat other mental health disorders including anxiety, anorexia, bulimia, sexual dysfunction, body dysmorphic disorder, post-traumatic stress disorder, and substance abuse. It has been found to be useful as a short-term therapy and a long-term treatment model for adults, children, adolescents, and groups.

Cognitive therapy is based on the belief that what we think influences how we feel, behave, and react to our environment. In fact, studies show that our emotional difficulties can be traced to our beliefs regarding our experiences. The goal of cognitive therapy is to identify and alter our distorted or negative beliefs in order to improve our behaviors and lives. Cognitive therapists believe that clients' distorted thinking about themselves, the world, and the future is the main cause of their experiences of depression as displayed in the figure below.



In cognitive therapy, clients learn about the connection between their emotional responses and automatic thoughts, which are surface-level cognitions; schemas, and cognitive distortions, which are biases in thinking. For example, thinking 'I am worthless' might cause you to feel sad.

The basic theory of CT holds that to understand the nature of an emotional episode or disturbance it is essential to focus on the cognitive content of an individual's reaction to the upsetting event or stream of thoughts. The goal is to change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schema restructuring. This is done by encouraging clients to gather and weigh the evidence in support of their beliefs.

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10.6.1 Basic Principles of Cognitive Therapy

Beck, a practicing psychoanalytic therapist for many years, grew interested in his clients' automatic thoughts (personalized notions that are triggered by particular stimuli that lead to emotional responses). As a part of his psychoanalytic study, he was examining the dream content of depressed clients for anger that they were turning back on themselves. He began to notice that rather than retroflected anger, as Freud theorized with depression, clients exhibited a negative bias in their interpretation or thinking. Beck asked clients to observe negative automatic thoughts that persisted even though they were contrary to objective evidence, and from this he developed a comprehensive theory of depression.

Beck contends that people with emotional difficulties tend to commit characteristic "logical errors" that lead to blurring of objective reality and the individual feels low about self. Listed below are some of the systematic errors in reasoning that lead to faulty assumptions and misconceptions, which are termed cognitive distortions.

- **Arbitrary inferences** refer to making conclusions without supporting and relevant evidence. This includes "catastrophizing," or thinking of the absolute worst scenario and outcomes for most situations. You might begin your first job with the conviction that you will not be liked or valued by either your colleagues or your clients. You are convinced that you fooled your professors and somehow just managed to get your degree, but now people will certainly know who you are.
- **Selective abstraction** consists of forming conclusions based on an isolated detail of an event. In this process other information is ignored, and the significance of the total context is missed. The assumption is that the events that matter are those dealing with failure and deprivation. As a new employee, you might measure your worth by your errors and weaknesses, not by your successes.
- **Overgeneralization** is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to dissimilar events or settings. If you have difficulty working with one aspect of a job, for example, if you are working as a counsellor based on difficulty working with one adolescent you might conclude that you will not be effective counselling any adolescents. You might also conclude that you will not be effective working with any clients.
- **Magnification and minimization** consist of perceiving a case or situation in a greater or lesser light than it truly deserves. You might make this cognitive error by assuming that even minor mistakes in counselling a client could easily create a crisis for the individual and might result in psychological damage.
- **Personalization** is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection.

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If a client does not return for a second counselling session, you might be absolutely convinced that this absence is due to your terrible performance during the initial session. You might tell yourself, “This situation proves that I really let that client down, and now she may never seek help again.”

- **Labeling and mislabeling** involve portraying one’s identity on the basis of imperfections and mistakes made in the past and allowing them to define one’s true identity. Thus, if you are not able to live up to all of a client’s expectations, you might say to yourself, “I’m totally worthless and should stop practicing right away.”
- **Dichotomous thinking** involves categorizing experiences in either-or extremes. With such polarized thinking, events are labeled in black or white terms. You might give yourself no scope for being an imperfect person and imperfect counsellor. You might view yourself as either being the perfectly competent counsellor (which means you always succeed with all clients) or as a total flop if you are not fully competent (which means there is no room for any mistakes).

10.6.2 The Core Ideas of Cognitive Therapy

- Cognitive therapy is based on the finding that changes in thinking lead to changes in feeling and acting.
- Treatment requires a sound and collaborative therapeutic alliance.
- Treatment is generally short term, problem focused, and goal oriented.
- Cognitive therapy is an active and structured approach to treatment.
- It focuses on the present, although attention is paid to the past when indicated.
- Careful assessment, diagnosis, and treatment planning are essential.
- Cognitive therapy uses a broad range of strategies and interventions to help people evaluate and change their cognitions.
- Inductive reasoning and Socratic questioning are particularly important strategies.
- This is a psychoeducational model that promotes emotional health and prevents relapse by teaching people to identify, evaluate, and modify their own cognitions.
- Task assignments, follow-up, and client feedback are important in ensuring the success of this approach.

The cognitive therapist operates on the assumption that the most direct way to change dysfunctional emotions and behaviors is to modify inaccurate and dysfunctional thinking. The cognitive therapist teaches clients how to identify these distorted and dysfunctional cognitions through a process of evaluation. Through a collaborative effort, clients learn the influence that cognition has on their feelings and behaviors and even on environmental events. In cognitive therapy, clients learn to engage in more realistic thinking, especially if they consistently notice times when they tend to get caught up in catastrophic thinking. After they have gained insight into how their unrealistically negative thoughts are affecting them, clients are trained to test these automatic thoughts

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against reality by examining and weighing the evidence for and against them. They can begin to monitor the frequency with which these beliefs intrude in situations in everyday life. The frequently asked question is, “Where is the evidence for?” If this question is raised often enough, clients are likely to make it a practice to ask themselves this question, especially as they become more adept at identifying dysfunctional thoughts. This process of critically examining their core beliefs involves empirically testing them by actively engaging in a Socratic dialogue with the therapist, carrying out homework assignments, gathering data on assumptions they make, keeping a record of activities, and forming alternative interpretations. Clients form hypotheses about their behavior and eventually learn to employ specific problem-solving and coping skills. Through a process of guided discovery, clients acquire insight about the connection between their thinking and the ways they act and feel.

Cognitive therapy is focused on present problems, regardless of a client’s diagnosis. The past may be brought into therapy when the therapist considers it essential to understand how and when certain core dysfunctional beliefs originated and how these ideas have a current impact on the client’s specific schema. The goals of this brief therapy include providing symptom relief, assisting clients in resolving their most pressing problems, and teaching clients relapse prevention strategies.

10.6.3 SOME DIFFERENCES BETWEEN CT AND REBT

In both Beck’s cognitive therapy and REBT, reality testing is highly organized. Clients come to realize on an experiential level that they have misconstrued situations. Yet there are some important differences between REBT and CT, especially with respect to therapeutic methods and style.

REBT is often highly directive, persuasive, and confrontational; it also focuses on the teaching role of the therapist. The therapist models rational thinking and helps clients to identify and dispute irrational beliefs. In contrast, CT uses a Socratic dialogue by posing open-ended questions to clients with the aim of getting clients to reflect on personal issues and arrives at their own conclusions. CT places more emphasis on helping clients discover and identify their misconceptions for themselves than does REBT. Through this reflective questioning process, the cognitive therapist attempts to collaborate with clients in testing the validity of their cognitions (a process termed collaborative empiricism). Therapeutic change is the result of clients confronting faulty with contradictory evidence that they have gathered and evaluated.

There are also differences in how Ellis and Beck view faulty thinking. Through a process of rational disputation, Ellis works to persuade clients that certain of their beliefs are irrational and nonfunctional. Beck (1976) takes exception to REBT’s concept of irrational beliefs. Cognitive therapists view dysfunctional beliefs as being problematic because they interfere with normal cognitive processing, not because they are irrational. Instead of irrational

beliefs, Beck maintains that some ideas are too absolute, broad, and extreme. For him, people live by *rules* (premises or formulas); they get into trouble when they label, interpret, and evaluate by a set of rules that are unrealistic or when they use the rules inappropriately or excessively. If clients make the determination that they are living by rules that are likely to lead to unhappiness, the therapist may suggest alternative rules for them to consider, without brainwashing them. Although cognitive therapy often begins by recognizing the client's frame of reference, the therapist continues to seek evidence for the type of belief system.

NOTES**Check your Progress -3**

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

4. What is cognitive Therapy?

10.7 DONALD MEICHENBAUM'S COGNITIVE BEHAVIOUR MODIFICATION

Another major alternative to rational emotive behavior therapy is Donald Meichenbaum's cognitive behavior modification (CBM), which focuses on changing the client's self-verbalizations. According to Meichenbaum, self-statements affect a person's behavior in much the same way as statements made by another person. A basic premise of CBM is that clients, as a prerequisite to behavior change, must notice how they think, feel, and behave and the impact they have on others. For change to occur, clients need to interrupt the scripted nature of their behavior so that they can evaluate their behavior in various situations.

Cognitive-behavioral modification (CBM) is an approach to cognitive-behavioral therapy that focuses on changing negative self-talk and life narrative to positive self-talk. The premise of this approach to therapy is that negative self-talk can reflect in a person's behaviors. The goal of CBM is to change a person's narrative or life story from negative to positive. This is done by focusing on the client's strengths and resilience. CBM also helps clients forgive themselves for misdoings in the past and move forward with hope and positivity for the future. With a favorable change of perspective and life narrative, a client's actions and behaviors will expectantly follow suit.

This approach shares with REBT and Beck's cognitive therapy the assumption that distressing emotions are typically the result of maladaptive thoughts. There are differences, however. Whereas REBT is more direct and confrontational in uncovering and disputing irrational thoughts, Meichenbaum's self-instructional training focuses more on helping clients become aware of their self-talk. The therapeutic process consists of teaching clients to make self-statements and training clients to modify the instructions

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they give to themselves so that they can cope more effectively with the problems they encounter. Together, the therapist and client practice the self-instructions and the desirable behaviors in role-play situations that simulate problem situations in the client's daily life. The emphasis is on acquiring practical coping skills for problematic situations such as impulsive and aggressive behavior, fear of taking tests, and fear of public speaking.

Cognitive restructuring plays a central role in Meichenbaum's (1977) approach. He describes cognitive structure as the organizing aspect of thinking, which seems to monitor and direct the choice of thoughts. Cognitive structure implies an "executive processor," which "holds the blueprints of thinking" that determine when to continue, interrupt, or change thinking.

10.7.1 Change in Behavior

Meichenbaum (1977) proposes that "behavior change occurs through a sequence of mediating processes involving the interaction of inner speech, cognitive structures, and behaviors and their resultant outcomes". He describes a three-phase process of change in which those three aspects are interwoven. According to him, focusing on only one aspect will probably prove insufficient.

Phase 1: Self-observation. The beginning step in the change process consists of clients learning how to observe their own behavior. When clients begin therapy, their internal dialogue is characterized by negative self-statements and imagery. A critical factor is their willingness and ability to listen to themselves. This process involves an increased sensitivity to their thoughts, feelings, actions, physiological reactions, and ways of reacting to others. If depressed clients hope to make constructive changes, for example, they must first realize that they are not "victims" of negative thoughts and feelings. Rather, they are actually contributing to their depression through the things they tell themselves. Although self-observation is necessary if change is to occur, it is not sufficient for change. As therapy progresses, clients acquire new cognitive structures that enable them to view their problems in a new light. This reconceptualization process comes about through a collaborative effort between client and therapist.

Phase 2: Starting a new internal dialogue. As a result of the early client-therapist contacts, clients learn to notice their maladaptive behaviors, and they begin to see opportunities for adaptive behavioral alternatives. If clients hope to change what they are telling themselves, they must initiate a new behavioral chain, one that is incompatible with their maladaptive behaviors. Clients learn to change their internal dialogue through therapy. Their new internal dialogue serves as a guide to new behavior. In turn, this process has an impact on clients' cognitive structures.

Phase 3: Learning new skills. The third phase of the modification process consists of teaching clients more effective coping skills, which are practiced in

real-life situations. (For example, clients who can't cope with failure may avoid appealing activities for fear of not succeeding at them. Cognitive restructuring can help them change their negative view, thus making them more willing to engage in desired activities.) At the same time, clients continue to focus on telling themselves new sentences and observing and assessing the outcomes. As they behave differently in situations, they typically get different reactions from others. The stability of what they learn is greatly influenced by what they say to themselves about their newly acquired behavior and its consequences.

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10.7.2 Coping Skills Programs

The rationale for coping skills programs is that we can acquire more effective strategies in dealing with stressful situations by learning how to modify our cognitive “set,” or our core beliefs. The following procedures are designed to teach coping skills:

- Exposing clients to anxiety-provoking situations by means of role playing and imagery
- Requiring clients to evaluate their anxiety level
- Teaching clients to become aware of the anxiety-provoking cognitions they experience in stressful situations
- Helping clients examine these thoughts by reevaluating their self-statements
- Having clients note the level of anxiety following this reevaluation

Research studies have demonstrated the success of coping skills programs when applied to problems such as speech anxiety, test anxiety, phobias, anger, social incompetence, addictions, alcoholism, sexual dysfunctions, posttraumatic stress disorders, and social withdrawal in children.

A particular application of a coping skills program is teaching clients stress management techniques by way of a strategy known as stress inoculation.

Using cognitive techniques, Meichenbaum has developed stress inoculation procedures that are a psychological and behavioral analog to immunization on a biological level. Individuals are given opportunities to deal with relatively mild stress stimuli in successful ways, so that they gradually develop a tolerance for stronger stimuli. This training is based on the assumption that we can affect our ability to cope with stress by modifying our beliefs and self-statements about our performance in stressful situations. Meichenbaum's stress inoculation training is concerned with more than merely teaching people specific coping skills. His program is designed to prepare clients for intervention and motivate them to change, and it deals with issues such as resistance and relapse. Stress inoculation training (SIT) consists of a combination of information giving, Socratic discussion, cognitive restructuring, problem solving, relaxation training, behavioral rehearsals, self-

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monitoring, self-instruction, self-reinforcement, and modifying environmental situations. This approach is designed to teach coping skills that can be applied to both present problems and future difficulties. Meichenbaum (2003) contends that SIT can be used for both preventive and treatment purposes with a broad range of people who experience stress responses.

Meichenbaum has designed a three-stage model for stress inoculation training: (1) the conceptual-educational phase, (2) the skills acquisition, consolidation, and rehearsal phase, and (3) the application and follow-through phase.

During the *conceptual-educational phase*, the primary focus is on creating a working relationship with clients. This is mainly done by helping them gain a better understanding of the nature of stress and reconceptualizing it in social-interactive terms. The therapist enlists the client's collaboration during this early phase and together they rethink the nature of the problem. Initially, clients are provided with a conceptual framework in simple terms designed to educate them about ways of responding to a variety of stressful situations. They learn about the role that cognitions and emotions play in creating and maintaining stress through didactic presentations, Socratic questioning, and by a process of guided self-discovery.

Clients often begin treatment feeling that they are the victims of external circumstances, thoughts, feelings, and behaviors over which they have no control. Training includes teaching clients to become aware of their own role in creating their stress. They acquire this awareness by systematically observing the statements they make internally as well as by monitoring the maladaptive behaviors that flow from this inner dialogue. Such self-monitoring continues throughout all the phases. Clients typically keep an open-ended diary in which they systematically record their specific thoughts, feelings, and behaviors. In teaching these coping skills, therapists strive to be flexible in their use of techniques and to be sensitive to the individual, cultural, and situational circumstances of their clients.

During the *skills acquisition, consolidation, and rehearsal phase*, the focus is on giving clients a variety of behavioral and cognitive coping techniques to apply to stressful situations. This phase involves direct actions, such as gathering information about their fears, learning specifically what situations bring about stress, arranging for ways to lessen the stress by doing something different, and learning methods of physical and psychological relaxation. During the *application and follow-through phase*, the focus is on carefully arranging for transfer and maintenance of change from the therapeutic situation to everyday life. It is clear that teaching coping skills is a complex procedure that relies on varied treatment programs. For clients to merely say new things to themselves is generally not sufficient to produce change. They need to practice these self-statements and apply their new skills in real-life situations. To consolidate the lessons learned in the training sessions, clients participate in a variety of activities, including imagery and behavior rehearsal, role playing, modeling, and in vivo practice.

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Once clients have become proficient in cognitive and behavioral coping skills, they practice behavioral assignments, which become increasingly demanding. They are asked to write down the homework assignments they are willing to complete. The outcomes of these assignments are carefully checked at subsequent meetings, and if clients do not follow through with them, the therapist and the client collaboratively consider the reasons for the failure. Clients are also provided with training in relapse prevention, which consists of procedures for dealing with the inevitable setbacks they are likely to experience as they apply their learning to daily life. Follow-up and booster sessions typically take place at 3-, 6-, and 12-month periods as an incentive for clients to continue practicing and refining their coping skills. SIT can be considered part of an ongoing stress management program that extends the benefits of training into the future.

Stress management training has potentially useful applications for a wide variety of problems and clients and for both remediation and prevention. Some of these applications include anger control, anxiety management, assertion training, improving creative thinking, treating depression, and dealing with health problems. Stress inoculation training has been employed with medical patients and with psychiatric patients. SIT has been successfully used with children, adolescents, and adults who have anger problems; anxiety disorders; and posttraumatic stress disorder (PTSD).

Check your Progress -4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

6. What is cognitive behaviour modification

10.8 LET US SUM UP

Cognitive Behavioral Therapy (CBT) is a form of treatment that focuses on examining the relationships between thoughts, feelings, and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, clients can modify their patterns of thinking to improve coping.

Rational emotive behavior therapy (REBT) is focused on helping clients change irrational beliefs. Ellis' goal was to develop an action-oriented approach to psychotherapy designed to produce results by helping clients manage their emotions, thoughts, and behaviors. Rational Emotive Therapists believe that the way people feel is largely influenced by how they think. When people hold irrational beliefs about themselves or the world, problems result.

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Because of this, the goal of REBT is to help people alter illogical beliefs and negative thinking patterns in order to overcome psychological problems and mental distress. REBT is structured and active and has its own approach to disputing and modifying distorted cognitions. Persuasion and teaching, along with gathering evidence, are important strategies for rational emotive behavior therapists.

Cognitive therapy was created by Aaron Beck to provide a structured treatment of depression. Cognitive behavior therapy is based on the cognitive model: the way we perceive situations influences how we feel emotionally. It helps clients identify their distressing thoughts and evaluate how realistic the thoughts are. Clients then learn to change their distorted thinking. When clients think more realistically, they feel better. The emphasis is also consistently on solving problems and initiating behavioral change.

Cognitive-behaviour modification (CBM) is an approach to cognitive-behavioral therapy that focuses on changing negative self-talk and life narrative to positive self-talk. The premise of this approach to therapy is that negative self-talk can reflect in a person's behaviors. The goal of CBM is to change a person's narrative or life story from negative to positive. This is done by focusing on the client's strengths and resilience. CBM also helps clients forgive themselves for misdoings in the past and move forward with hope and positivity for the future. With a favorable change of perspective and life narrative, a client's actions and behaviors will expectantly change too.

10.9 UNIT-END EXERCISES

1. What is Cognitive Behaviour Therapy? What is its basic premise?
2. Identify the difference between REBT , CT and CBM
3. List the nature of cases where CBT can be used with suitable examples.
4. Discuss the strengths and limitations of the cognitive behaviour approach.
5. Explain cognitive distortions.

10.10 ANSWER TO CHECK YOUR PROGRESS

1. Cognitive behaviour therapy is a form of psychotherapy that focuses on how a person's thoughts lead to feelings of distress, with the aim of helping them change these irrational thoughts through changing cognitive distortions and self-defeating behaviour.
2. Rational emotive behavior therapy (REBT), is an active-directive, philosophically and empirically based psychotherapy, the aim of which is to resolve emotional and behavioral problems and disturbances and to help people to lead happier and more fulfilling lives, created and developed by Albert Ellis,

3. A– Activating event, B- Beliefs about event, C- Emotional and behavioural Consequences, D- Disputes or arguments, E-New effect.
4. Cognitive therapy is based on the cognitive model, which states that thoughts, feelings and behavior are all connected, and that individuals can move toward overcoming difficulties and meeting their goals by identifying and changing unhelpful or inaccurate thinking, problematic behavior, and distressing emotional responses . It was pioneered by Beck.
5. Cognitive-behavioral modification (CBM) is an approach to cognitive-behavioral therapy that focuses on changing negative self-talk and life narrative to positive self-talk. The premise of this approach to therapy is that negative self-talk can reflect in a person's behaviors.

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10.11 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

UNIT 11: Basic Concepts

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Structure

11.1 Introduction

11.2 Objectives

11.3 Meaning of Guidance and Counselling and their differences

11.4 Approaches to counselling

11.4.1 Person centered approach

11.4.2 Gestalt approach

11.4.3 Psychoanalytic approach

11.4.4 Cognitive approach

11.4.5 Trait factor approach

11.4.6 Behavioral and eclectic approach

11.5 Assessment Techniques

11.5.1 Important Factors

11.5.2 Tools of Assessment

11.6 Let us sum up

11.7 Unit-End Exercises

11.8 Answer to Check your Progress

11.9 Suggested Readings

11.1 INTRODUCTION

11.2 OBJECTIVES

On completion of this unit you will be able to:

- Understand the meaning and difference between the terms Guidance and Counselling
- Explain the basic assumptions of different approaches to counselling
- Appreciate the usefulness of different assessment techniques

- Evaluate the strengths and limitations of different approaches

11.3 MEANING OF GUIDANCE AND COUNSELLING AND THEIR DIFFERENCES

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Guidance refers to the advice and instructions given to a person by a more experienced or authoritative person on varied problems. Guidance happens in almost all fields; however, it is in the field of education where guidance is more common. Teachers, lecturers, or professors guide the students in their education pathways. Counselling refers to the professional help given by a counsellor based on personal or psychology related problems of the individuals. In brief, counselling is a form of psychological guidance for an individual.

Therefore, unlike general guidance one can receive, counselling is mostly meant to help people deal with minor psychological issues such as anxiety, stress etc. Similarly, to become a professional counsellor, one should have extensive academic knowledge and training in the field of psychology and a natural predisposition to help people. A counsellor directly deals with someone who needs the psychological assistance to alleviate his living condition whereas guidance is more universal. The main goals of guidance are to help individual to understand and accept the positive and negative aspects of his personality, interests, aptitudes, attitudes etc. Provide a wide choice and opportunities and help make adjustment in the new life situation. These are the main differences between guidance and counselling.

Check your progress-1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

1. Differentiate between guidance and counseling.

11.4 APPROACHES TO COUNSELLING

To provide a framework for understanding how to apply counselling skills and strategies, we must first review the major formal theories which are the basis for various approaches to helping.

11.4.1 PERSON CENTERED APPROACH

The person centered or client centered approach was established by Carl Rogers in the 1930s and 1940s. This theory is a “self” theory, based on the belief that people act in accordance to with their self-concept and their self-concept is heavily influenced by their experiences with others. It assumes that all human beings are rational, good and capable of assuming responsibility and making choices that lead to independence, self-actualization and autonomy. Moreover, this theory is not concerned with causes of behavior or with

changing behavior; rather it focuses on the individual's current experiences, feelings and actions.

The following are the major client-centered constructs:

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1. Self-concept comprises of the individual's perceptions of himself or herself based on interactions with others.
2. The phenomenal field is the individual's reality and consists of his/her self-concept and perceptions of his/her world
3. Individuals will behave in ways that will enhance their self-concept
4. Problems arise out of incongruences between self-concept and life experiences which causes the individual to use defenses such as denial or distortion of experiences which leads to pain and disorganization.
5. Only by receiving unconditional positive regard (acceptance) from a significant other can persons open up and develop more congruence between self-concept and behavior.

The goals of this therapy are self-actualization and self-realization which can be achieved if there is an empathic relationship between client and counsellor. Major verbal techniques employed by the counsellor are minimal leads like "Mm-hmm", "I see", and "yes". The counsellor also uses reflection, clarification, summarization and confrontation with the client.

The major advantages of this approach are that this therapy offers a platform for individual discovery and growth. The approach meets all the needs of the client at every level, thereby dealing with every problem affecting the client which will lead to success. It also helps clients identify diverse ways of communicating and thinking through expressing themselves. The disadvantages are that this treatment method is highly optimistic and is quite a bit unstructured. Moreover, it leaves the process to the client without considering that the client sought help first which may lead to failure.

11.4.2 GESTALT APPROACH

Gestalt therapy is experiential (emphasizes on doing and acting out, not just talking), existential (helps people make independent choices and be responsible), and experimental (encourages trying out new expressions of feelings). 'Gestalt' is a German word meaning "configuration". It was developed by Fritz Perls in the 1940s. All human behaviors and experiences are organized into Gestalts, in which the whole is greater than the sum of its parts. Individuals and their behaviors must be perceived as wholes. The organism is contained within his/her environment by an ego boundary. The environment is the source of activities, people and experiences to fill the individual's needs. The self-aware individual takes responsibility for seeking from the environment to become more self-supportive and psychologically stable.

Gestalt approach focusses on the here and now. Only the 'how' and 'what' of the present are questioned and not the 'why' and 'when', the past or the future. Feelings are considered to be energy. The individual must develop self-

awareness, acceptance, wholeness and responsibility to achieve ‘organismic balance’.

The major constructs of Gestalt theory are:

1. Maturity (wholeness) is achieved when persons are able mobilize their own resources rather than manipulate others and when they are self-supported rather than environment-supported.
2. Awareness reduced avoidance behavior which allows one to face previously denied parts and become whole.
3. Change occurs when people assume responsibility and terminate unfinished business (repressed feelings related to past events that interfere with present functioning)
4. Focus of the therapy is on the individual’s current feelings, thoughts, fantasies, sensations etc. and on encouraging him/her to take ownership of these things to achieve integration.
5. The individual is encouraged to trust their intuition rather than adjust to society.

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Gestalt therapy uses rules and games to increase awareness in clients. Helpers ask clients to act out conflicts using role-play, exaggeration and role reversal techniques and prevent the client from escaping to the past or daydreaming about the future.

The major advantages of this approach are that it is in the here and now and encourages clients to act out uncomfortable situations. The disadvantages are that this approach focusses less on empathy and warmth and more on verbal and non-verbal behavior. Moreover, it is quite confrontational and is effective only when the client believes in the counsellor’s effectiveness as a practitioner.

11.4.3 PSYCHOANALYTIC APPROACH

Psychoanalytic therapy is a form of talking therapy based on the theories of Sigmund Freud. The approach explores how the unconscious mind influences thoughts and behaviours, with the aim of offering insight and resolution to the person seeking therapy. Psychoanalytic therapy typically looks at the client’s experiences of early childhood, to see if any events have had particular impact on their lives, or contributed in some way to current concerns. This form of therapy is considered a long-term choice, and sessions can continue for weeks, months or even years, depending on the depth of the concern being explored.

Psychoanalytic therapy is insight driven, and therefore looks to foster change by helping to understand one’s past and how events from one’s early life could be affecting one now. The therapist will listen to the client’s concerns and look out for patterns or certain events that may hold significance. As well as listening to the client talk about their experiences and concerns, the therapist may use other techniques to help them understand and identify potential causes for concerns, such as free association, therapeutic transference and interpretation. Psychoanalytic work is better suited to more general concerns

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such as anxiety, relationship difficulties, sexual issues, low self-esteem, phobias, social shyness and difficulties in sleeping.

Psychoanalysts such as Carl Jung believed in spiritual development and focused on integrating conscious and unconscious aspects of personality. Alfred Adler used techniques like 'psycho-education' to develop social interest and change faulty thinking. On the other hand, ego psychologists and self-psychologists believed in the importance of ego in terms of development of an individual.

The major advantages of this approach are that these approaches are long-term which generally produces better results and they are primarily based on "insight". The major drawbacks are that this approach is based on Freud's theory which is very crude and sexist in nature. Moreover, they ignore individual differences.

11.4.4 COGNITIVE APPROACH

Cognitive therapy centers on the belief that our thoughts are influenced by how we feel. There are a number of different cognitive therapies, including Cognitive-Behavioral therapy, Reality therapy, and Rational Emotive therapy.

Cognitive-behavioral therapy focusses on systematic errors in reasoning that underlie psychological problems. It was given by Beck and uses techniques like cognitive rehearsal, questioning, searching for alternatives, monitoring thoughts, reality testing, thought substitution, and teaching coping skills and self-control techniques. Reality therapy is a therapeutic approach that focuses on problem-solving and making better choices in order to achieve specific goals. The point of this therapy is to assist people to make responsible choices (involving consistency between value systems and behavior) and to meet basic psychological needs without depriving others' needs. Rational Emotive therapy (REBT) centres on the belief that human beings have a tendency to develop irrational behaviour and beliefs. REBT acknowledges that past and present conditions affect a person's thinking and utilises a framework so that the counsellor can apply activating events that allow the client to identify beliefs and consequences. Finally, Transactional analysis is based on the notion that our personality consists of three states of ego – parent, adult and child. Certain types of behavior are associated with each of the ego roles, and using this form of cognitive approach to counselling allows the client to understand the different ego stages and how they interact with each other.

Cognitive therapy focuses on the present. This means that issues from the past that are influencing current thinking, are acknowledged but not concentrated on. Instead a counsellor will work with the client on identifying what is causing distress in present thinking. Assertiveness exercises, role-playing and homework are also part of the supportive one-to-one sessions a client will have with a counsellor. The major disadvantage is that its structured nature may not

be suitable for people with more complex mental health needs or learning difficulties.

11.4.5 TRAIT FACTOR APPROACH

Trait-factor counselling approaches assume that career choice may be facilitated and career outcomes optimized through a fairly straightforward process of matching an individual's most relevant work-relevant characteristics (abilities, interests, values, etc.) with information regarding job activities, demands, rewards, and availability. The counselling process for this approach typically starts with a client interview, then proceeds to extensive psychometric assessment of the client's work-relevant characteristics, and is finalized with an interpretation of assessment results with connections being drawn between these results and one or more occupational classification systems. Trait-factor counselling assumes that having been provided with accurate information about self and jobs, most individuals will be able to make a rational choice of career.

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The major advantages of this approach are that it laid the foundation for career counselling, is high in validity, and can be applied to a large population. The drawbacks are that it is too directive and prescriptive. Moreover, it works on the assumption that individuals will always make rational decisions which is not true.

11.4.6 BEHAVIORAL AND ECLECTIC APPROACH

According to the behavioral approach, human behavior is determined by its immediate consequences in the environment (reinforcement). Therefore, what is learned can be unlearned and human beings are viewed as organisms capable of being manipulated. This view assumes that people have no internal control over their behavior and all behavior is determined by environmental variables.

The behavioral helping approach is specifically directive and controlled. The helper identifies unsuitable stimulus-response bonds (causes and effects of target behavior) and arranges to interfere with or extinguish these unsuitable bonds. The helper then sets to conditions to teach new, more desirable stimulus-response bonds as that appropriate behaviors will be learnt. The four general behavior modification methods are- (1) imitative learning (modelling, which teaches new behaviors through video or audio tape; (2) cognitive learning, which teaches new behavior through role-play or 'contingency contracts' (they spell out clearly what the client is to do and what the consequences of reinforcement of this behavior will be); (3) emotional learning, like 'implosive therapy' (a form of exposure therapy similar to the imaginal form of flooding, in which anxiety is aroused by only imagining the stimuli without direct contact), systematic desensitization (aims to remove the fear response of a phobia, and substitute a relaxation response to the conditional stimulus gradually using counter conditioning) and covert sensitization (undesirable behavior is paired with an unpleasant image in order

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to eliminate that behavior); (4) operant conditioning, whereby selected behaviors are immediately reinforced using schedules of reinforcement.

This approach is advantageous as it focusses on the here and now rather than on unseen experiences as seen with the psychodynamic/psychoanalytic approach. A disadvantage of this approach is that it undermines the amount of free will a person has and does not take individual differences into consideration. It relies too much on external factors “shaping” behavior.

The eclectic approach on the other hand is a therapeutic approach that incorporates a variety of therapeutic principles and philosophies in order to create the ideal treatment program to meet the specific needs of the patient or client. The primary benefit of eclectic therapy is that the therapy is customized to meet the unique needs of the patient. By personalizing the therapeutic experience in order to best address and respond to the needs of the patient, the eclectic therapist ensures that the most effective therapeutic techniques are integrated into treatment. Any condition that can be treated via any type of therapy is capable of being treated with eclectic therapy. Thus, individuals with addictions, substance abuse disorders, eating disorders, behavior compulsions, mood disorders, and other forms of emotional or psychological issues may be effectively treated by a therapist who embraces the philosophy of eclectic therapy.

Check your progress-2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

2. What are the major approaches to counselling?

11.5 ASSESSMENT TECHNIQUES

Assessment methods include a wide array of formal and informal instruments and strategies, such as standardized and non-standardized tests, questionnaires, inventories, checklists, observations, portfolios, performance assessments, rating scales, surveys, interviews, and other measures.

11.5.1 IMPORTANT FACTORS

Some important factors to consider while using assessments are-

- **Validity**-The extent to which a test measures what it's supposed to measure.
- **Reliability**- The degree to which the result of a measurement, calculation, or specification can be depended on to be accurate.
- **Fairness**- The test/test items should not have any bias.
- **Objectivity**-Assessments that are considered objective have a right and wrong answer that will be evaluated in the same way for every person assessed.

- **Scorability-** It refers to how easy the test is to score and directions provided to score.
- **Adequacy-** The test should contain a large range of sampling of items to determine outcomes or abilities so that the resulting scores are representative of the population.
- **Administrability-** The test should be administered uniformly to all students so that scores obtained will not vary due to other factors.
- **Practicality and efficiency-**It refers to the economy of time, effort and money in testing.
- **Ethics-** It refers to maintaining confidentiality, and distinguishing between right/wrong practices and following them accordingly.
- Counsellors must also be responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the client.
- Counsellors must carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments.
- Counsellors must administer assessments under the same conditions that were established in their standardization.
- In reporting assessment results, counsellors must indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or the inappropriateness of the norms for the person tested.

Check your progress-3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

3. Name some important factors to take into consideration when using assessments.

11.5.2 TOOLS OF ASSESSMENT

- **Achievement tests-** They measure an individual's level of knowledge in a particular area. They mainly focus on an individual's current knowledge and previous learning. They are used for selective purposes in educational institutions and work place. Example: TOEFL
- **Aptitude tests-** Aptitude measures an individual's underlying potential for acquiring skills. These tests have the ability to acquire new information and is used to predict future performance. Common use of aptitude tests is to predict future performance of a client in an educational program or occupational setting. Example: GATB
- **Interest and occupational tests-** Interest is an individual's preference for engaging in one or more specific activities relative to others. These tests are used for measuring and evaluating the level of an individual's interest in, or preference for, a variety of activities. Occupational Tests are procedures used to assess an individual's strengths, weaknesses, values

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and personality traits for different professions. Counsellor sometimes needs to assist his other clients to make distinctions between their interest and occupational realities. The logic is that if the client's preferences matches with the interests of people in his or her target occupation, then he or she might be a suitable candidate for the target occupation. Example: SCII, OSI, Otis Employment Test

- **Personality tests**-Personality refers to enduring characteristics that are unique to an individual. These tests assess these characteristics and predict how the individual would act in the future in a particular situation. They also involve self-report inventories and projective Tests. Example: MMPI, TAT, Rorschach inkblot test.
- **Intelligence tests**-Intelligence refers to the ability to acquire and apply knowledge, adapt to the environment, learn from experience and engage in various forms of reasoning. These tests are broad measures of cognitive ability. They can be individual or group administered. They are used in educational settings or for screening decisions. Example: WISC, Raven's Progressive Matrices.

Check your progress-4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

4. What are the various tools of assessment that are being used in counselling?

11.6 LET US SUM UP

In this unit, you have been introduced to the definitions of guidance and counselling and the difference between the two terms. The unit has also outlined the basic approaches to counselling and the advantages and disadvantages of each approach. Important factors to be considered for assessments and a general outline of various assessment tools has also been discussed.

11.7 UNIT-END EXERCISES

1. Describe the various approaches to counselling.
2. Write a note on the important factors to be taken into consideration regarding assessments.
3. List various tools used of assessment.

11.8 ANSWER TO CHECK YOUR PROGRESS

1.A counsellor directly deals with someone who needs the psychological assistance to free him of minor psychological symptoms, improve his quality

of life and optimize psychological functioning whereas guidance is more universal, gives the individual direction in terms of choosing a particular course of action.

2. Person centered, Gestalt, Psychoanalytic, Cognitive, Trait factor, Behavioral and eclectic approach.

3. Validity, reliability, fairness, scorability, adequacy, administrability, practicality, efficiency and morality.

4. Achievement tests, aptitude tests, interest and occupational tests, personality tests, and intelligence tests.

11.9 SUGGESTED READINGS

7. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
8. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
9. Patterson, L.W. &Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
10. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper’s Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
11. Brammer, L.M. &Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
12. D.John Antony, Skills of Counselling, 2003, Anugraha Publications.

BLOCK IV: COUNSELLING TECHNIQUES

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UNIT 12: GOALS OF COUNSELLING

Structure

- 12.1 Introduction
- 12.2 Objectives
- 12.3 Counselling process
- 12.4 Characteristics of counsellor
- 12.5 Group counselling
- 12.6 Special areas of counselling
- 12.7 Applied areas multicultural counselling
- 12.8 Ethical issues
- 12.9 Let us sum up
- 12.10 Unit-End Exercises
- 12.11 Answer to Check your Progress
- 12.12 Suggested Readings

12.1 INTRODUCTION

People seek the services of professional helpers when their capacities for responding to the demands of life are strained, when desired growth seems unattainable, when important decisions elude resolution, and when natural support systems are unavailable or insufficient. The purpose of counselling is to empower the client to cope with life situations, to reduce emotional stress, to engage in growth-producing activity, and to make effective decisions. As a result of counselling, counsees increase their control over present adversity and present and future opportunity.

12.2 OBJECTIVES

At the end of this unit you will be able to:

- Explain the process of counselling
- Enlist the characteristics of counsellor
- Identify the application of counselling principles to various specialty areas and group setting
- Understand and follow the ethical principles in practice

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12.3 COUNSELLING PROCESS

The process of counselling is a planned, structured dialogue between counsellor and client. It is a cooperative process in which a trained professional helps the client to identify sources of difficulty that he/she is experiencing. Together they develop ways to deal with and overcome these problems so that the person has increased understanding of themselves and others.

There 5 stages in the process of counselling-

1. Relationship building-

The first step involves building a relationship and focusses on engaging clients to explore issues that directly affect them. The first interview is important as the counsellor's verbal and non-verbal behavior communicates a lot to the client. The client will examine two things-

- (a) Empathy- The counsellor must dive into the client's 'inscape' or should be able to accurately sense the feelings and personal meanings the client is experiencing and communicate acceptance to the client.
- (b) Genuineness- The counsellor must exhibit congruence between thoughts and feelings, must be spontaneous and show positive regard.

This is essential to continue and for progress to occur.

The following are some the steps for building a relationship with the client-

- Introduce yourself
- Invite the client to sit down
- Ensure the client is comfortable
- Invite social conversation to reduce anxiety
- Watch for non-verbal behavior as signs of client's emotional state
- Indicate that you are interested in the person
- Allow client time to respond

2. Problem assessment-

While the counsellor and client are in the process of establishing a relationship, a second process is taking place. This is called as problem assessment. This step involves the collection and classification of information about the client's life situation and reasons for seeking

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counselling. These assessments can help the counsellor derive information about the client's current lifestyle, family history and personal history. This information can be used to plan relevant counselling strategies and approaches to use.

3. Goal setting-

Like any other activity, counselling must have a focus. Goals refer to the results or outcomes that the client wants to achieve at the end of counselling. Goals give direction to the counselling process. Goals must be selected and defined with care.

The following are some of the guidelines for proper goal setting-

- Goals should relate to the desired end sought by the client
- It should be feasible
- It should be in explicit and measurable terms
- It should be stated in positive terms that emphasize growth

4. Counselling intervention-

There are different viewpoints regarding intervention depending on the theoretical viewpoint that the counsellor subscribes to. For example, the person-centered approach suggests that the counsellor should get involved rather than intervene in the process; the behavioral approach focuses on activities to change or alter client's behavior.

5. Evaluation, termination or referral-

All counselling aims towards successful termination. The terminating process should be done with extra sensitivity and care. The preparation for termination must begin long before it actually occurs. It is also important to note that termination need not occur only at the end, it can also occur when counselling seems less helpful for the client. In this case, referring the client to another counsellor may also be effective.

Check your progress-1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

1. What are the main stages in the process of counseling?

12.4 CHARACTERISTICS OF COUNSELLOR

The following are some of the characteristics of a counsellor-

- **Self-awareness-** Counsellors should be able to separate their needs, perceptions, and feelings from those of their clients and should be able to help others develop their own self-awareness.
- **Gender and cultural awareness-** Helpers who are sensitive to the influence of gender and culture on their own perceptions, values and attitudes are more likely to be open to the effects of these variables on others. Culturally sensitive helpers are likely to understand and feel

comfortable with these differences and tend to value rather than denigrate these differences.

- **Honesty-** Honesty is more than just being truthful, it is also being open to exploration and being fair in evaluation. Helpers can communicate honesty by being open with clients, answering questions within professional limits, and by admitting mistakes or lack of knowledge. The helper must also invite honest feedback from clients and peers.
- **Congruence-** People have clarified and “own” their value systems are better able to these values and beliefs without imposing them on others, thus allowing a more honest and non-judgmental relationship.
- **Ability to communicate-** Developing and using communication skills can have a positive effect on helping relationships.
- **Knowledge-** Professional helpers need knowledge of psychological, sociological and anthropological theory in order to help their clients effectively. However, experience is also necessary to increase helper adaptability.
- **Ethical integrity-** Ethical dilemmas are complex and challenging and may arise regarding confidentiality, records, and type and length of service. Helpers need the capacity to tolerate ambiguity, uncertainty and ambivalence. They must know to put the client’s welfare over their own needs or those outside of the organization.

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Check your progress-2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

2. Name few of the characteristics of a counsellor.

12.5 GROUP COUNSELLING

Group counselling is a form of counselling where a small group of people meet regularly to discuss, interact, and explore problems with each other and the group leader. Members gain insight into their own thoughts and behavior, and offer suggestions and support to others. In addition, people who have a difficult time with interpersonal relationships can benefit from the social interactions that are a basic part of the group counselling experience. Most groups composed of people of differing ages, backgrounds and experiences. This helps to provide additional perspectives.

Group counselling helps to achieve the following goals-

- Give and receive support

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- Gain understanding of problems and explore possible solutions
- Practice interpersonal skills in a safe group setting
- Learn more about how you come across to others
- Increase observation and feedback skills
- Enhance problem-solving skills
- Improve emotional expressiveness
- Decrease social isolation
- Develop good communication skills

Check your progress-3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

3. What is group counseling?

12.6 SPECIAL AREAS OF COUNSELLING

There are many special areas when counselling is considered. Here we will discuss about a few-

- **Vocational counselling-**It is otherwise called as career counselling. It helps individuals and groups with career, personal goals, social and educational counselling. Many times, counsellors in this field work with individuals who feel unsatisfied with their career choices, but who are afraid to make changes because of emotional issues or family or financial constraints. This type of counsellor can work with people of all ages, from adolescents who want to explore career options to professionals who want to make career changes. Career counsellors typically have a background in vocational, industrial, or organizational psychology.
- **School counselling-** These counsellors help students at all levels to understand and cope with social, behavioral, and personal problems. School or education counsellors emphasize preventive and developmental counselling to enhance students' personal, social, and academic growth and to provide students with the life skills needed to deal with problems before they worsen. School counsellors often provide special services, including alcohol and drug prevention programs, conflict resolution classes, vocational counselling, and also try to identify cases of domestic abuse and other family problems that can affect a student's development. School counsellors help students evaluate their abilities, interests, talents, and personalities to develop realistic academic and career goals.

- **Grief counselling-** These helpers practice a form of psychotherapy that aims to help people cope with grief and mourning following the death of loved ones, or with major life changes that trigger feelings of grief, such as divorce. There is a distinction between grief counselling and grief therapy. Counselling involves helping people move through uncomplicated, or normal, grief to health and resolution. Grief therapy involves the use of clinical tools for traumatic or complicated grief reactions. This could occur where the grief reaction is prolonged or manifests itself through some bodily or behavioral symptom, or by a grief response outside the range of a culturally-defined normality.
- **Financial counselling-**also is known as debt counselling, credit counselling, or financial advising, depending upon the type of financial requirements that a person or family needs. While some counselling may deal with financial troubles, other forms of advisement can point to investments, asset allocation, and portfolio diversification. Counsellors in this field should have some training in investments, banking, and budgets.
- **Genetic counselling-** Genetic counselling is the process of advising individuals and families affected by or at risk of genetic disorders to help them understand and adapt to the medical, psychological and familial implications of genetic contributions to disease. These counsellors not only advise what to do but also provide support through the process, evaluate genetic test results, and also provide information on inheritance patterns in the family.
- **Rehabilitation counselling-** These counsellors provide counselling, guidance and case management services to persons with disabilities to assist them in achieving their psychological, personal, social, and vocational goals. After conferring with the client's physicians, psychologists, occupational therapists, and the employer, a rehabilitation program is initiated. Rehabilitation counsellors are trained to recognize and to help lessen environmental and attitudinal barriers. Such help may include providing education, and advocacy services to individuals, families, employers, and others in the community. Rehabilitation counsellors work toward increasing the person's capacity to live independently by facilitating and coordinating with other service providers.
- **Marital counselling-** These counsellors apply family systems theory, principles, and techniques to address and treat mental and emotional disorders. In doing so, they modify people's perceptions and behaviors, enhance communication and understanding among family members, and help to prevent family and individual crises. They may work with individuals, families, couples, and groups. Marriage and family therapy differs from traditional therapy because less emphasis is placed on an

identified client or internal psychological conflict. The focus is on viewing and understanding their clients' symptoms and interactions within their existing environment.

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Check your progress-4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

4. Name some special areas of counseling.

12.7 APPLIED AREAS IN MULTICULTURAL COUNSELLING

Multicultural counselling is the ability of any professional counsellor to approach counselling through the context of the client's world. In short, the a counsellor's own cultural values or bias must not take precedence that of the client. Competence in multicultural counselling is crucial in societies with multiple representations of cultural groups whose social power and privilege statuses are differentiated based on visible (e.g., race, gender) and invisible (e.g., homosexual/bisexual/trans-gendered orientation, language) attributes.

Multicultural counselling is concerned with the psychological development and psychosocial (mal)adjustment of clients who are ascribed a power-disadvantaged societal status due to their cultural group membership. Regardless of their numerical representation in a given society, these cultural groups are considered minorities in sociopolitical power. Consequently, they are subjected to experiences of discrimination, racism, or oppression. These clients also tend to leave counselling sessions prematurely. To address this problem, therapist competence to establish credibility has been given utmost importance to achieve positive treatment outcome. In other words, therapists and psychotherapy lose credibility when minority clients do not have trust and faith that their counselling concerns will be understood from their cultural belief system. Achieved credibility is related to therapist skills to offer interventions that align with the minority client's belief system, as well as provide strategies that are appropriate and acceptable within the client's cultural system.

Beyond credibility, social justice is the ultimate concern for which therapists and the profession of psychotherapy enable and empower minority clients. Multicultural counselling, therefore, focuses on therapist knowledge of the intricate factors that facilitate and impede the counselling relationship and dynamics between a therapist and client from different cultural groups. It seeks to help clients whose counselling concerns are rooted in their minority status to re-attribute sources of distress to contextual rather than personal causes. In training and supervision, multicultural counselling analyses if the power differential due to counsellor and client's majority-minority group statuses adversely affects the quality of the therapeutic relationship, such as premature termination or conforming minority clients to majority values. Beyond

individual psychotherapy, multicultural counselling engages in advocacy for, and empowerment of, minority clients to achieve social justice.

In sum, multicultural counselling entails therapist competence in the following three domains: (1) empathic knowledge of the impact of societal oppression on the identity development and conflicts of clients who are ascribed a minority status, (2) recognition and confrontation of the therapist's own cultural biases and internalized worldview of the majority group, and (3) skill to discern and apply cultural knowledge to instil trust and credibility in the cross-cultural therapeutic relationship.

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Check your progress-5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

5. What is multicultural counseling?

12.8 ETHICAL ISSUES

Some of the ethical issues that appear to be particularly relevant in the present times are-

(1)Privileged communication and sharing of confidential information- In some cases, the counsellor can be called on to testify in the court of law in which the client's information can be revealed. This is called privileged communication. When confidentiality is considered, counsellors can ask clients to sign an informed consent form and discuss openly what diagnosis will be used. Counsellors are also ethically responsible for ensuring that their employer organization's policies are congruent with their own professional and personal ethical codes.

(2)Conflicts of interest- It is important for the counsellors to remember that their primary responsibility during the helping process is to the client, not to any other individual or group. Thus, if a conflict of interest arises, counsellors must make sure that they do not breach a client's confidentiality because of their own ignorance, insecurity or ineptness, or for the good of some organization or group. The only justification for a breach of confidentiality is that the welfare of the client or some other human being is at stake.

(3)Record keeping- The counsellor must write down only objective, behavioural information and exclude subjective material / interpretations. If the counsellor decides to use any other methods of record keeping (tape recorder, computerized storage etc.), the client must have full knowledge of what is going on.

(4)Use of tests and computerized programs- Counsellors must administer tests only if they have had sufficient training and supervision in the administration of the particular test. They must also explain the rationale and

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purpose for testing to the client. A major issue concerns the use of test data – who receives these data and what use will be made of them. Without client’s specific verbal permission his/her case should not be discussed with anyone.

(5)Dual relationships- Dual relationships happen when the client takes up two varying roles with the client. For example, one as a counsellor and one as a sexual partner. Such a relationship has high potential for exploiting the client, who is in a less powerful position than the counsellor regardless of the circumstances. Setting clear boundaries may be very useful.

(6)Misrepresentation- Misrepresentation can occur when a counsellor directly claims or indirectly infers knowledge, training, experience and or expertise with a particular type of client or a particular type of problem. They can work in such situations with supervision/ consultation from an outside expert, refer to an expert, or use co-therapy with an expert.

(7)Taking a pluralistic approach- Failing to consider other forms of assessment and treatment, such as physical examination, psychopharmacology, or testing is another ethical issue. For example, many clients experience distress that turns out to be related to underlying medical conditions. A pluralistic approach is needed as psychological and sociocultural variables

Check your progress-6

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

6. Name some ethical issues that could arise in counseling.

12.9 LET US SUM UP

In this unit, you have been introduced to the process of counselling and the characteristics of a counsellor. The unit has also outlined the application of counselling principles in special areas and various ethical issues that counsellors may face and how to deal with them.

12.10 UNIT-END EXERCISES

1. Describe the process of counselling in detail
2. Write a note on the special areas of counselling
3. What are some of the ethical issues faced by counsellors?

12.11 ANSWER TO CHECK YOUR PROGRESS

1. Relationship building, problem assessment, goal setting, counselling intervention and evaluation, termination or referral.
2. Self-awareness, gender and culture awareness, honesty, congruence, ability to communicate, knowledge and ethical integrity.

3. Group counselling is a form of counselling where a small group of people meet regularly to discuss, interact, and explore problems with each other and the group leader. Members gain insight into their own thoughts and behavior, and offer suggestions and support to others.

4. Vocational counselling, school counselling, grief counselling, financial counselling, marital counselling, rehabilitation counselling, genetic counselling, geriatric counselling etc.

5. Multicultural counselling is the ability of any professional counsellor to approach counselling through the context of the client's world. In short, the a counsellor's own cultural values or bias must not take precedence that of the client.

6. Maintaining confidentiality, conflicts of interest, record keeping, misrepresentation, having a dual relationship with the client, administering proper tests, and difficulty in taking a pluralistic approach.

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12.12 SUGGESTED READINGS

1. Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.

2. Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.

3. Patterson, L.W. & Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.

4. Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper's Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.

5. Brammer, L.M. & Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.

6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

UNIT 13: COGNITIVE BEHAVIOUR MODIFICATION

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Structure

13.1 Introduction

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13.3 Fundamental Aspects

13.4 Cognitive Restructuring

13.4.1 Role of Cognitive Restructuring in Cognitive Behavioral Therapy

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13.10 Let us sum up

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13.1 INTRODUCTION

Cognitive-behavioral modification (CBM) is an approach to cognitive-behavioral therapy that focuses on changing negative self-talk and life narrative to positive self-talk. The premise of this approach to therapy is that negative self-talk can reflect in a person's behaviors. The goal of CBM is to

change a person's narrative or life story from negative to positive. This is done by focusing on the client's strengths and resilience. CBM also helps clients forgive themselves for misdoings in the past and move forward with hope and positivity for the future. With a favorable change of perspective and life narrative, a client's actions and behaviors will expectantly follow suit. CBM is a form of self-instructional therapy, meaning that clients can do much of the work and learn about themselves on their own time. For change to occur, clients need to interrupt the scripted nature of their behavior so that they can evaluate their behavior in various situations.

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13.2 OBJECTIVES

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

- Identify and modify negative thinking pattern
- Restructure distorted thoughts
- Learn new and better problem solving techniques

13.3 FUNDAMENTAL ASPECTS

- It is based on the cognitive model of emotional disorders. It is brief and time-limited.
- A sound therapeutic relationship is necessary condition for effective cognitive therapy.
- Therapy is collaborative effort between therapist and client. It uses primarily the Socratic Method.
- It is structured & directive.
- It is problem oriented.
- It is based on an educational model.
- The theory & techniques of CT rely on the inductive method.
- Homework is a central feature of cognitive therapy.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

1. What is cognitive behaviour modification?

13.4 COGNITIVE RESTRUCTURING

Cognitive restructuring, also known as cognitive reframing, is a technique drawn from cognitive therapy that can help people identify, challenge and alter stress-inducing thought patterns and beliefs. The end goal of cognitive restructuring is to enable people to replace stress-inducing thoughts with more

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accurate and less rigid (and therefore less stress-inducing) thinking habits. Cognitive restructuring (CR) is a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts known as cognitive distortions, such as all-or-nothing thinking (splitting), magical thinking, over-generalization, magnification, and emotional reasoning, which are commonly associated with many mental health disorders. CR employs many strategies, such as Socratic questioning, thought recording, and guided imagery, and is used in many types of therapies, including cognitive behavioral therapy (CBT) and rational emotive behaviour therapy (REBT).

Cognitive restructuring refers to the process in cognitive behavioral therapy of identifying and changing inaccurate negative thoughts that contribute to the development of depression. This is done collaboratively between the client and therapist, often in the form of a dialogue. For instance, a college student may have failed a math quiz and responded by saying, "That just proves I'm stupid." The therapist might ask if that's really what the test means. In order to help the student recognize the inaccuracy of the response, the therapist could ask what the student's overall grade is in math. If the student answers, "It's a B," the therapist can then point out that his answer shows he's not stupid because he couldn't be stupid and get a B. Then together they can explore ways to reframe what the performance on the quiz actually says. The "I'm stupid" response is an example of an automatic thought. Clients with depression may have automatic thoughts in response to certain situations. They're automatic in that they're spontaneous, negative, and don't come out of deliberate thinking or logic. These are often underpinned by a negative or dysfunctional assumption that is guiding the way patients view themselves, the situation, or the world around them.

Cognitive restructuring teaches us to stop trusting in our automatic tendency to accept the contents of our thoughts as being an accurate assessment of reality. Instead, the goal is to start testing each thought we have for accuracy. It is a very powerful therapy technique which has been adapted to help people cope with all manner of stressful events and conditions. One drawback of this technique is that it is somewhat difficult for people to learn it in a self-help mode (without the assistance of a therapist). It is easy for people to think they are doing it right when they are not and falsely conclude that the technique is of little use.

13.4.1 Role of Cognitive Restructuring in Cognitive Behavioral Therapy

Cognitive Behavioral Therapy, or CBT, is built on the idea that the way we think affects the way we feel. It is easy to see the logic behind this idea, and the implications of faulty ways of thinking. Cognitive restructuring was first developed as a therapeutic tool of CBT and Rational Emotive Behavioral Therapy, or REBT. CBT practitioners quickly found that it was an adaptable and flexible tool that could help a wide range of people dealing with all kinds of problems, whether the problems were due to outside factors, internal issues, or both.

This method of addressing problems and promoting healing makes up the bulk of CBT sessions and offers dozens of techniques and exercises that can be applied to nearly any client scenario. Applied correctly, it will help the client learn to stop automatically trusting his or her thoughts as representative of reality and begin testing his or her thoughts for accuracy.

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13.4.2 Key Components of Cognitive Restructuring

In order to achieve schematic change, an effective Cognitive Restructuring (CR) program has three critical components. Each of these components is necessary for its success. If any component is missing, the intervention would not constitute CR but some other form of intervention. Each component may consist of various intervention strategies, but together collaborative empiricism, verbal intervention, and empirical hypothesis- testing constitute the therapeutic process involved in CR. The following provides an explanation and illustration of these three central elements of CR.

Collaborative empiricism. Beck and his colleagues introduced the term “collaborative empiricism” to describe the therapeutic relationship adopted in CR. The concept has been refined and elaborated by subsequent clinical researchers and is now considered a critical element in the effectiveness of CT or CBT. In essence, collaborative empiricism involves the client and therapist sharing their respective expertise in order to describe, explain, and help resolve the client’s problems. In recognizing their respective contributions to the therapeutic enterprise, the therapist as an expert in the human change process, and the client as having the lived experience of the problem, work together on formulating treatment goals, setting the session agenda, and negotiating homework assignments. Therapist and client share equal responsibility for the direction of therapy, in which the therapist frequently seeks feedback and ensures understanding from the client.

A strong therapeutic alliance and client engagement in the therapy process is a necessary but not sufficient feature of effective CR. To achieve a collaborative atmosphere, the therapist (a) educates the client on the CT model to establish an agreed rationale for achieving change, (b) involves the client in identifying and prioritizing treatment goals, (c) collaborates on setting the session agenda, (d) asks questions and requests client feedback throughout the session, and (e) negotiates homework assignments. This strong emphasis on mutual responsibility and joint involvement in the therapeutic process ensures that CR does not become dictatorial, with the therapist imposing ideas and direction on the client. An authoritarian, overly didactic, and uncompromising therapist style will quickly undermine the effectiveness of CR.

Empiricism is another central feature of the therapeutic process in CR. The therapist encourages the client to take an investigative, questioning approach to long-held beliefs and attitudes. Throughout treatment, an emphasis is placed on observation, experiential evaluation, and learning . The therapist uses

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Socratic questioning of the client's past personal experiences to evaluate the validity of maladaptive beliefs and to introduce the possibility of a more adaptive alternative perspective. In addition, experientially based exercises are formulated that can empirically verify the veracity of the alternative belief and challenge the validity of maladaptive schemas. The cognitive therapist frequently encourages the client to "test this with your experience," or "collect some evidence and see what can be learned." Throughout each session the therapist places a strong emphasis on empiricism to achieve schematic change. Effective collaborative empiricism will encourage clients more readily to attribute behavioral change to their own efforts rather than external forces or the skills of the therapist. This self-determined attribution should result in better and more persistent treatment outcomes.

Verbal interventions. Over the years cognitive behavioral researchers and practitioners have proposed a number of verbal intervention strategies that can be used by therapists directly to modify maladaptive schematic content. These strategies, which in many respects are the essence of CR, are listed below. The first four strategies are the most common verbal interventions used in CR, first introduced by Beck et al. in the original CT treatment manuals and then later refined and elaborated by other cognitive therapists. Evidence gathering, cost/benefit analysis, identifying cognitive errors, and generating alternative explanations are such an integral part of CR that implementing these verbal interventions is what most therapists think of as cognitive restructuring. They are healthy and useful interventions that can be used in most clinical disorders.

Verbal Intervention Strategies Employed in Cognitive Restructuring are listed below:

1. Evidence gathering – Obtaining schema- congruent evidence from the client's past and current experience that enables a more balanced evaluation of schematic content.
2. Consequential analysis – Examining the immediate and long-range costs and benefits of continued acceptance of maladaptive belief.
3. Cognitive Bias Identification – Training clients in greater awareness of the cognitive biases that operate when processing schema-relevant information (eg., dichotomous thinking, catastrophizing, mind reading, magnification/minimization, etc)
4. Generate alternative – Formulating a more adaptive conceptualization of the self/ or some aspects of personal experience that more accurately represents external contingencies and that enhances the client's functional adaptation.
5. Normalization – Reconceptualizing unwanted thoughts, feelings and behaviour as deviations of normal human experience in order to encourage greater acceptance and confidence in dealing with schema-related subjective experience.
6. Decatastrophizing – Developing a hypothetical account of a worst-case scenario, evaluating its realistic and probable effect on quality of life and formulating a coping plan to deal with the catastrophe.

7. Problem Solving – Specifying a real-life problem, explaining the pros and cons of various responses to the problem, selecting a course of action, and evaluating the outcome.
8. Imaginal exposure – Guiding the client in repeatedly and systematically generating a schema-related unwanted intrusive thought, image, or emotion in order to enhance clients self-efficacy in dealing with unacceptable emotions.
9. Distancing – Teaching clients to take a “third-party” or observer stance to their unwanted thoughts and emotions; to react to their subjective experience as if it belonged to another person.
10. Reframing or perspective taking – Focussing on current experience as a moment in time and situating it within a longer lifespan time frame
11. Reattribution – Identifying the external or situational causes of the client’s difficulties in order to address exaggerated internal attributions and self-blame.
12. Positivity Reorientation – Refocusing the client on positive, adaptive personal coping experiences that provide schema-incongruent information.

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In order to utilize any of these verbal interventions, clients must be willing to engage in an evaluative process. That is, they must be willing at least to consider the possibility that their maladaptive schematic thinking might be inaccurate, counterproductive, and unrealistic. Clients who insist that their maladaptive beliefs are undeniable facts will not be open to CR. Second, the therapist always begins by inviting clients simply to examine and evaluate their thoughts and beliefs in the light of empirical evidence, that is, their own personal experience. The therapist refrains from cajoling, debating, or trying to convince the client of a more adaptive alternative belief instead of clinging to the maladaptive schematic perspective. Rather, clients are encouraged to generate an alternative view that provides the best fit with “objective” external experience and would be associated with an improvement in their emotional functioning. Third, effective CR will ensure an equal emphasis on questioning the veracity of the maladaptive beliefs and evaluating the relevance of a more adaptive alternative viewpoint. The objective of CR is to raise doubts in the client’s mind about long-held maladaptive beliefs (e.g., “People will notice I’m anxious and think there is something wrong with me”) and to consider the accuracy and utility of an alternative perspective (e.g., “People might notice I’m a little anxious but consider it unimportant”).

Check your Progress - 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

2. What is collaborative empiricism?

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13.4.3. Applications within therapy

There are many methods used in cognitive restructuring, which usually involve identifying and labelling distorted thoughts, such as "all or none thinking, disqualifying the positive, mental filtering, jumping to conclusions, catastrophizing, emotional reasoning, should statements, and personalization". The following methods are commonly used in cognitive restructuring:

Socratic questioning

Socratic questioning is a form of disciplined questioning that can be used to pursue thought in many directions and for many purposes, including: to explore complex ideas, to get to the truth of things, to open up issues and problems, to uncover assumptions, to analyze concepts, to distinguish what we know from what we do not know, to follow out logical consequences of thought or to control discussions. Socratic questioning is based on the foundation that thinking has structured logic, and allows underlying thoughts to be questioned. The key to distinguishing Socratic questioning from questioning per se is that Socratic questioning is systematic, disciplined, deep and usually focuses on fundamental concepts, principles, theories, issues or problems. The purpose is to help uncover the assumptions and evidence that underpin people's thoughts in respect of problems. A set of Socratic questions in cognitive therapy aim to deal with automatic thoughts that distress the patient:

1. Revealing the issue: 'What evidence supports this idea? And what evidence is against its being true?'
2. Conceiving reasonable alternatives: 'What might be another explanation or viewpoint of the situation? Why else did it happen?'
3. Examining various potential consequences: 'What are worst, best, bearable and most realistic outcomes?'
4. Evaluate those consequences: 'What's the effect of thinking or believing this? What could be the effect of thinking differently and no longer holding onto this belief?'
5. Distancing: 'Imagine a specific friend/family member in the same situation or if they viewed the situation this way, what would I tell them?'

Careful use of Socratic questioning enables a therapist to challenge recurring or isolated instances of a person's illogical thinking while maintaining an open position that respects the internal logic to even the most seemingly illogical thoughts.

Thought recording

Keeping thought records is an excellent way to help you or your client become aware of any cognitive distortions that went previously unnoticed or unquestioned, which is the necessary first step to restructuring them. There are several different ways to structure a thought record, but the main idea is to note what recurrent thoughts are coming to mind and the situations in which

they come up. In general, thought record instructs the client to record the situation, thoughts, emotions, behaviors, and alternate thought.

Identifying cognitive errors

The individual is also asked to begin to identify the types of cognitive distortions they engage in which colour their perception of situations. These could include the following:

- Discounting the positive “If I can do it, it doesn’t count”
- All or nothing thinking “I pass or I fail”, “You win or you lose”, “It’s right or it’s wrong”, “I do it all now or do none at all”
- Labelling “I did something bad therefore I am bad”, “I said something silly therefore I am foolish”
- Mind reading “She didn’t look at me therefore I have done something wrong”
- Fortune telling “I just know it will be awful”
- Catastrophising “Oh my God this is SO terrible”
- Personalisation “It’s all my fault”, “I am the one to blame”
- Blame “It’s all his/her/my fault”
- Generalisation “I never get what I want”, “It’s always the same”
- Shoulds, Musts, Have tos and Oughts “I/you/she/he/they must... have to... ought to.”

Decatastrophizing

This technique is basically asking “what’s the worst that can happen?” and following a scenario logically through to completion. People often suffer from assumptions or anxieties about the worst possible outcome that could happen, even if that outcome is (a) not very likely, and (b) not going to ruin our lives even if it does!

Decatastrophizing or asking yourself “what if?” will help you or your client determine what is likely to happen, reduce irrational or unreasonable anxiety, and see that even the worst-case scenario is manageable.

Guided Imagery

Visualization can be a great tool for relaxing, managing pain, getting anxiety under control, and neutralizing anger. It is also an extremely effective method of cognitive restructuring. There are three main categories of guided imagery that a therapist can guide their client through cognitive restructuring:

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- Life Event Visualization-This technique involves having the client identify a specific event or theme that is the focus of the therapy sessions.
- Reinstatement of a Dream or Daytime Image-This imagery technique focuses on a specific image that the client has already had. The image could be one that the client encountered in a dream, daydream, fantasy or previous guided imagery session. Wherever it came from, it will hold some inherent meaning to the client and may cause the client to feel anxious, sad, upset, or another emotion intensely.
- Feeling Focusing-The final imagery type is characterized by the client focusing on a feeling he or she is experiencing in the session, and letting an image arise from the feeling. An image will usually arise spontaneously, but if not, a technique called multisensory evocation can help to clarify an image. For this technique, the therapist will direct the client through an exploration of the senses to help sharpen the image and identify more detail.

13.4.4 Criticisms

Critics of cognitive restructuring claim that the process of challenging dysfunctional thoughts will teach clients to become better suppressors and avoiders of their unwanted thoughts. And that cognitive restructuring shows less immediate improvement because real world practice is often required. Other criticisms include that the approach is mechanistic and impersonal and that the relationship between therapist and client is irrelevant.

13.5 MEICHENBAUM'S SELF STRUCTURAL TRAINING

Donald Meichenbaum is a psychologist noted for his contributions to cognitive behavioral therapy (CBT). He developed a therapeutic technique called cognitive behavior modification (CBM), which focuses on identifying dysfunctional self-talk in order to change unwanted behaviors. Meichenbaum views behaviors as outcomes of our own self-verbalizations. Self-instructional training is a cognitive technique which aims to give clients control over their behavior through guided self talk that gradually becomes covert and self-generated. This is particularly helpful where there are initial cognitive deficits in for example problem solving or verbal mediation contributing to the difficulty. This approach suggests that behaviour change can be brought about if clients are encouraged to change the instructions they give themselves, in the form of 'self-talk', to more adaptive versions. These internal dialogues are externalised during therapy and discussed, then coping strategies are developed to deal with them. These strategies include relaxation, sub-vocal instruction (such as telling yourself to 'stop!' the thoughts, called 'thought-stopping'), and role-playing plans.

Self-instructions are especially important in coping with stressful situations, and have led Meichenbaum to develop 'stress inoculation training'. In this

procedure, people are first asked how they think in stressful situations—for example, they may say ‘I can’t cope’. They are then encouraged to develop and practise more positive self-statements such as ‘worrying won’t help’, ‘one step at a time’ and ‘it could be worse’, and reinforcing self-statements such as ‘that was better’. As well as being used in industry for stress management, such procedures have been applied to the treatment of test and speech anxiety, phobias, schizophrenia, and hyperactivity in children.

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The increasingly important role assigned to cognitive factors not only challenges the traditional tenets of behavior therapy but also augments and expands the highly specific procedures which have characterized the field in recent years. Self—instructional training, first used with hyperactive children to change maladaptive thinking processes, and stress inoculation training, used successfully with both clinical and high risk non—clinical population to help them alter conceptualizations, employ coping skills, and successfully confront stressful situations, illustrate the possibilities of a broad-spectrum approach.

Cognitive restructuring plays a central role in Meichenbaum’s (1977) approach. He describes cognitive structure as the organizing aspect of thinking, which seems to monitor and direct the choice of thoughts. Meichenbaum’s self- instructional training focuses more on helping clients become aware of their self-talk. The therapeutic process consists of teaching clients to make self- statements and training clients to modify the instructions they give to them- selves so that they can cope more effectively with the problems they encounter. Together, the therapist and client practice the self- instructions and the desir- able behaviors in role-play situations that simulate problem situations in the client’s daily life. The emphasis is on acquiring practical coping skills for problematic situations such as impulsive and aggressive behavior, fear of taking tests, and fear of public speaking.

13.5.1 Behavior Changes

Meichenbaum (1977) proposes that “behavior change occurs through a sequence of mediating processes involving the interaction of inner speech, cognitive structures, and behaviors and their resultant outcomes”. He describes a three-phase process of change in which those three aspects are interwoven. According to him, focusing on only one aspect will probably prove insufficient.

Phase 1: Self-observation. The beginning step in the change process consists of clients learning how to observe their own behavior. When clients begin therapy, their internal dialogue is characterized by negative self-statements and imagery. A critical factor is their willingness and ability to listen to themselves. This process involves an increased sensitivity to their thoughts, feelings, actions, physiological reactions, and ways of reacting to others.

If depressed clients hope to make constructive changes, for example, they must first realize that they are not “victims” of negative thoughts and feelings. Rather, they are actually contributing to their depression through the things

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they tell themselves. Although self-observation is necessary if change is to occur, it is not sufficient for change. As therapy progresses, clients acquire new cognitive structures that enable them to view their problems in a new light. This reconceptualization process comes about through a collaborative effort between client and therapist.

Phase 2: Starting a new internal dialogue. As a result of the early client–therapist contacts, clients learn to notice their maladaptive behaviors, and they begin to see opportunities for adaptive behavioral alternatives. If clients hope to change what they are telling themselves, they must initiate a new behavioral chain, one that is incompatible with their maladaptive behaviors. Clients learn to change their internal dialogue through therapy. Their new internal dialogue serves as a guide to new behavior. In turn, this process has an impact on clients’ cognitive structures.

Phase 3: Learning new skills. The third phase of the modification process consists of teaching clients more effective coping skills, which are practiced in real-life situations. (For example, clients who can’t cope with failure may avoid appealing activities for fear of not succeeding at them. Cognitive restructuring can help them change their negative view, thus making them more willing to engage in desired activities.) At the same time, clients continue to focus on telling themselves new sentences and observing and assessing the outcomes. As they behave differently in situations, they typically get different reactions from others. The stability of what they learn is greatly influenced by what they say to themselves about their newly acquired behavior and its consequences.

Check your Progress - 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

3. What is Self- instructional Training?

13.6 BECK’S MODEL

Aaron Beck is considered the father of cognitive therapy. Beck developed cognitive therapy with the belief that a person's experiences result in cognitions or thoughts. These cognitions are connected with schemas, which are core beliefs developed from early life, to create our view of the world and determine our emotional states and behaviors. Cognitive therapy is based on a cognitive theory of psychopathology. The cognitive model describes how people’s perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral (and often physiological) reactions. Individuals’ perceptions are often distorted and dysfunctional when they are distressed. They can learn to identify and evaluate their “automatic thoughts” (spontaneously occurring verbal or imaginal cognitions), and to correct their thinking so that it more closely resembles reality. When they do so, their

distress usually decreases, they are able to behave more functionally, and (especially with anxiety) their physiological arousal identify and modify their distorted beliefs: their basic understanding of themselves, their worlds, and other people. These distorted beliefs influence their processing of information, and give rise to their distorted thoughts.

Thus, the cognitive model explains individuals' emotional, physiological, and behavioral responses as mediated by their perceptions of experience, which are influenced by their beliefs and by their characteristic ways of interacting with the world, as well as by the experiences themselves. Therapists use a gentle Socratic questioning process to help clients evaluate and respond to their automatic thoughts and beliefs—and they also teach them to engage in this evaluation process themselves. Therapists may also help clients design behavioral experiments to carry out between sessions to test cognitions that are in the form of predictions. When clients' thoughts are valid, therapists do problem solving, evaluate patients' conclusions, and work with them to accept their difficulties.

The cognitive model describes how people's thoughts and perceptions influence their lives. Often, distress can distort people's perceptions, and that, in turn, can lead to unhealthy emotions and behaviors. CBT helps individuals learn to identify and evaluate their "automatic thoughts" and shift their thinking to be healthier. The cognitive model is at the core of CBT, and it plays a critical role in helping therapists use gentle Socratic questioning to develop treatments. The Cognitive Triad is a cognitive model developed by Aaron Beck to describe the cause of depression. He proposed that three types of negative thoughts lead to depression: thoughts about the self, the world/environment, and the future. People suffering from depression will attribute negative and unpleasant events to their personal failings (self) and to the unfair and unforgiving world. The future is perceived to be miserable and devoid of hope with their troubles lasting forever.

The components of the triad feed and strengthen each other with negative viewpoints in one area making the other parts of the triad stronger. Attributions of events come from maladaptive beliefs about the self, the world, and the future. Cognitive therapy focuses on changing these pessimistic ways of thinking in order to alleviate bad symptoms. This could be done by pointing out the positive qualities of the depressed patient, the world, and their future.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

4. Explain in brief the cognitive model of Beck.

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13.7 ELLIS'S RATIONAL EMOTIVE THERAPY

Rational Emotive Therapy, sometimes called Rational Emotive Behavioral Therapy, is a form of therapeutic psychology that emerges from behaviorism. It attempts to use reason and rationality to recognize self-defeating cognitive processes, and learn to emote more appropriately. Effectively, the idea is that subconscious destructive behaviors are consciously acknowledged and then subverted in favor of more constructive behavior. Rational-Emotive-Behavior Therapy (REBT), developed by Albert Ellis, is a therapy that consciously uses cognitive, emotive, and behavioral techniques to help clients. REBT theorists stress that human beings have choices. The control of ideas, attitudes, feelings, and actions is specific to the person who arranges a life according to personal dictates. Having little control over what happens or what actually exists, people do have choices and control over how they view the world and how they react to difficulties.

Rational-Emotive-Behavior Therapy (REBT) has emerged from what Albert Ellis considered a limited rational-persuasive therapy into a therapy that consciously uses cognitive, emotive, and behavioral techniques to help clients. Ellis considers himself a philosophical or educational therapist who uses a didactic, cognition-oriented, explicative approach to change.

Founded on the idea that what distresses people is not the event but their judgment of the event, REBT theorists stress that human beings have choices about their thoughts. The control of ideas, attitudes, feelings, and actions is specific to the person who arranges a life according to personal dictates. Having little control over what happens or what actually exists, people do have both choices and controls over how they view the world and react to difficulties.

Ellis viewed humans as naturally irrational, self-defeating individuals who need to be taught to change crooked thinking from self-defeating musts, shoulds, oughts, and demands. People can be helpful and loving as long as they do not think irrationally. The three areas in which people hold irrational beliefs are in thinking that they must be perfect, that others must be perfect, and that the world must be a perfect place in which to live. The goal of the therapy is to teach people to think and behave in a more personally satisfying way by making them realize they have a choice between self-defeating, negative behavior and thought and a more efficient, enhancing, positive behavior. This is accomplished by teaching people to take responsibility for their own logical thinking and the consequences or behaviors that follow it.

Ellis theorized that a belief system - what people tell themselves about an event - determines responses or feelings toward that event. People naturally and easily think crookedly, express emotions inappropriately and behave in a self-defeating manner. REBT teaches how to do otherwise. Irrational beliefs cause trouble. Lists of common irrational beliefs that lead to negative emotions and stress in children, adolescents, and parents are included in the chapter.

Irrational beliefs can form a chain of further irrational beliefs. The categories of those thoughts are self-defeating beliefs, highly rigid and dogmatic beliefs, antisocial beliefs, unrealistic beliefs and contradictory beliefs.

The goal of REBT is to teach people to think and behave in a more personally satisfying way by making them realize they have a choice between self-defeating, negative behavior and efficient, enhancing, positive behavior. The first objective of therapy is to show a person how irrational beliefs or attitudes create dysfunctional consequences such as anger, depression, or anxiety. The second objective is to teach the client how to dispute or crumble the irrational beliefs and replace them with rational thoughts. This will allow the client to escape the cycle of negative feelings and be free to choose behaviors that eliminate the problem or the disappointing impact of the problem.

"A, B, C, D, and E" refer to these ideas. A is the activating event. B is the person's reaction to the event. C represents the consequences or feelings resulting from the person's evaluation of the activating event. D represents the disputing arguments that can be used to attack the irrational self-messages included in the evaluation of the activating event. E is the answers given to the questions raised in D. REBT is direct, didactic, confrontational and verbally active counselling. Several factors help counsellors detect irrational thinking. They can look for overgeneralizations, distortions, deletions, catastrophizing, absolutes, condemning and fortune-telling. Once the irrational beliefs are recognized, the counsellor disputes and challenges them. Ultimately the goal is for young people to recognize their irrational beliefs, think them through and relinquish them.

REBT counsellors use exploration, ventilation, interpretation, confrontation, indoctrination and re-education. Counsellors are didactic and frequently assign homework. With children counsellors may find working on internal verbalization and role reversal techniques helpful. Rational-emotive-behavioral education is an offspring of REBT that focuses on how feelings develop, how to discriminate between valid and invalid assumption, and how to think rationally.

Cognitive behavior treatment (CBT) programs are examples of the integration of cognitive and behavioral approaches. The practice of CBT combines behavior-change methods with thought-screening methods to produce behavior and feeling change in clients. Stress-inoculation methods combined with role-playing provide an example of CBT. For treatment of childhood depression, CBT consists of four levels of treatment: (1) behavioral procedures, such as contingent reinforcement, shaping, prompting, and modeling, to increase social interaction; (2) CBT interventions, which include pairing successful task completion with positive self-statements and reinforcement for those self-statements; (3) cognitive interventions, which are used with social skills training, role-playing, and self-management; and (4) self-control procedures, such as self-evaluation and self-reinforcement. CBT is

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effectively used with treatment of aggression, anxiety, depression, ADHD, obesity, and with children of alcoholics.

13.7.1 KEY CONCEPTS

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1. Rational-emotive-behavioral therapy focuses on present events and the person's reaction to those events.
2. According to REBT, people have almost complete responsibility for their ideas and for their feelings.
3. The role of the counsellor is to attack the false beliefs that cause negative reactions to events.
4. Cognitive-Behavior therapy combines behavior-change methods with thought-restructuring methods to produce behavior and feeling change in clients.
5. Cognitive-behavior therapy involves cognitive restructuring, cognitive behavior modification, and stress inoculation.
6. It is better for people to focus on negating specific behaviors than to develop a negative self-image.
7. The "A, B, C, D, and E" approach shows how problems develop and how to treat them.
8. Effective strategies with children include direct teaching of concepts, such as teaching the child to like oneself, to not take things too seriously, to realize that there is joy in participation, to realize that achievement requires effort, or to realize that one does not have to be perfect.

13.7.2 KEY TERMS AND CONCEPTS

“A,B,C,D, and E” approach – The rational-emotive behavioral approach to counselling. The A, B, C shows how problems develop (A=activating event, B=how the event is evaluated, C=consequences), and the D, E are the treatment steps (D=disputing arguments, E=answers you have developed).

Circle of irrational thinking – A process of thinking that leads to self-hate, which leads to self-destructive behavior, which leads to hatred of others, and eventually causes individuals to act irrationally toward self, thus continuing the cycle.

Contradictory beliefs – An irrational belief that originates from false premises.

Dogmatic beliefs – An irrational belief that leads to unrealistic preferences and wishes.

Irrational beliefs – Statements that individuals tell themselves that create dysfunctional consequences such as anger, depression, or anxiety.

REBE – Rational Emotive Behavior Education. The objectives of REBE include teaching how feelings develop and how to think rationally.

Self-defeating beliefs – An irrational belief that interferes with basic goals and drives.

Stress-inoculation – Cognitive techniques designed to help people master difficult and highly stressful situations and events that they anticipate that they will encounter in the future.

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13.8 THOUGHT STOPPING AND VARIATIONS

The human brain is often full of questions and inner conversation. The ultimate multi-taskers, our minds can simultaneously leap from joys to worries to politics to romance to the price of tea. For some people, negative or fearful thoughts can become a prevalent and repetitive obsession, leading to panic attacks, anxiety, phobias, depression, or obsessive-compulsive disorders. Some psychologists attempt to aid those suffering from such maladies via a technique known as thought stopping.

The basic concept of Thought stopping revolves around the discovery of ways to refocus the mind away from that which causes stress. For instance, in the case of anxiety or panic attacks, a person often realizes that his fear of an object or situation is irrational. However, the more he thinks about not entering a state of panic, the more likely a state of panic becomes. These disorders can become so severe that he may well withdraw from any and all situations that cause stress, leading to even greater anxiety, depression, and social isolation. There are often biological reasons or genetic predispositions to such disorders, and thought stopping is a cognitive tool used most often in conjunction with therapy, pharmaceuticals, or both. The goal is to help the afflicted individual to lead a happy and productive life. Thought stopping is not a complete solution or cure, but it is one way of overcoming.

Thought stopping involves concentrating on an unwanted thought for a short time, then suddenly stopping it and emptying your mind. The internal command “Stop!” or snapping a rubber band on the wrist is generally used to interrupt the unpleasant thought. One of the oldest cognitive techniques still commonly practiced, thought stopping was introduced by Bain in 1928 in his book *Thought Control in Everyday Life*. In the late 1950s it was adapted by Joseph Wolpe and other behavioral scientists for obsessive and phobic thoughts. Thought stopping has proved effective with a wide variety of obsessive and phobic thought processes: sexual preoccupation, hypochondriasis, obsessive thoughts of failure, sexual inadequacy, obsessive memories, and frightening, recurring impulses leading to chronic tension and anxiety attacks. While thought stopping is only effective in approximately 20 percent of cases involving compulsive ritual behavior, it is more than 70 percent effective in controlling thoughts about simple phobias such as fear of snakes, driving, the dark, elevators, someone creep around in the house at night, fear of insanity, and so on. Thought stopping is recommended when the problem behavior is primarily cognitive rather than acted out. It is indicated

when specific thoughts or images are repeatedly experienced as painful or leading to unpleasant emotional states.

13.9 PROBLEM SOLVING TECHNIQUES

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Cognitive behavioral therapy techniques are evidence-based methods to change thoughts, feelings, and behaviors and improve overall life satisfaction and functioning. They are informed by the most current psychology research, having repeatedly demonstrated to be among the most effective interventions for mood disorders and psychological issues. The cognitive behavior therapy techniques listed below represent some of the most common procedures in CBT that are designed to improve mood and behavior.

Cognitive Restructuring Techniques: Cognitive restructuring is a cognitive behavior therapy technique aimed at helping people identify thinking patterns responsible for negative moods and ineffective behavior. There are numerous techniques employed during cognitive restructuring. The most common technique is tracking dysfunctional thoughts on a thought record form, and devising healthier, more psychologically flexible patterns of thinking.

Graded Exposure Assignments: Exposure is a cognitive behavior therapy technique that helps people systematically approach what they fear. Generally, fear causes people to avoid situations. Unfortunately, avoidance of feared situations is what maintains feelings of fear and anxiety. Through systematic exposure, people master feared situations one-by-one, and then tackle increasing difficult exposure assignments. Exposure is one of the most effective psychological treatments that exist, having a 90% effectiveness rate with some anxiety disorders.

Activity Scheduling: Activity scheduling is a cognitive behavior therapy technique designed to help people increase behaviors they should be doing more. By identifying and scheduling helpful behaviors, such as meditating, going for a walk, or working on a project, it increases the likelihood of their getting done. This technique is especially helpful for people who do not engage in many rewarding activities due to depression, or people who have difficulty completing tasks due to procrastination.

Successive Approximation: This cognitive behavior therapy technique works for people who have difficulty completing a task, either due to lack of familiarity with the task, or because the task feels overwhelming for some reason. The technique works by helping people master an easier task that is similar to the more difficult task. It's akin to practicing addition and subtraction before learning long division. Once you are practiced at addition and subtraction, long division isn't as overwhelming. Likewise, by having rehearsed one behavior, one that is slightly more difficult feels more manageable.

Mindfulness Practice: Mindfulness is a cognitive behavior therapy technique borrowed from Buddhism. The goal of mindfulness is to help people

disengage from ruminating or obsessing about negative things and redirect their attention to what is actually happening in the present moment. Mindfulness is the subject of a lot of new research in psychology and represents the cutting edge of psychotherapy practice.

Skills Training: A lot of people's problems result from not having the appropriate skills to achieve their goals. Skills training is a cognitive behavior therapy technique implemented in remedying such skills deficits. Common areas for skills training include social skills training, communication training, and assertiveness training. Usually skills' training take place through direct instruction, modeling, and role-plays.

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13.10 LET US SUM UP

Another major alternative to rational emotive behavior therapy is Donald Meichenbaum's cognitive behavior modification (CBM), which focuses on changing the client's self-verbalizations. A basic premise of CBM is that clients, as a prerequisite to behavior change, must notice how they think, feel, and behave and the impact they have on others. For change to occur, clients need to interrupt the scripted nature of their behavior so that they can evaluate their behavior in various situations. Cognitive restructuring plays a central role in Meichenbaum's (1977) approach. Cognitive restructuring or cognitive reframing refers to the process in cognitive behavioral therapy of identifying and changing inaccurate negative thoughts. It is a psychotherapeutic process of learning to identify and dispute irrational or maladaptive thoughts known as cognitive distortions, such as all-or-nothing thinking (splitting), magical thinking, over-generalization, magnification, and emotional reasoning, which are commonly associated with many mental health disorders. CR employs many strategies, such as Socratic questioning, thought recording, and guided imagery, and is used in many types of therapies, including cognitive behavioral therapy (CBT) and rational emotive behaviour therapy (REBT). A number of studies demonstrate considerable efficacy in using CR-based therapies.

Beck developed cognitive therapy with the belief that a person's experiences result in cognitions or thoughts. These cognitions are connected with schemas, which are core beliefs developed from early life, to create our view of the world and determine our emotional states and behaviors. Cognitive therapy is based on a cognitive theory of psychopathology. The cognitive model describes how people's perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral (and often physiological) reactions.

Rational Emotive Therapy, sometimes called Rational Emotive Behavioral Therapy, is a form of therapeutic psychology that emerges from behaviorism. It attempts to use reason and rationality to recognize self-defeating cognitive processes, and learn to emote more appropriately. Effectively, the idea is that subconscious destructive behaviors are consciously acknowledged and then subverted in favor of more constructive behavior. Rational-Emotive-Behavior

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Therapy (REBT), developed by Albert Ellis, consciously uses cognitive, emotive, and behavioral techniques to help clients. REBT theorists stress that human beings have choices.

13.11 UNIT-END EXERCISE

1. What is Cognitive Behaviour Modification?
2. Explain cognitive restructuring.
3. What does 'A-B-C-D-E' in REBT mean?
4. Explain thought stopping.
5. Narrate a few problem solving techniques of the cognitive approach.

13.12 ANSWER TO CHECK YOUR PROGRESS

1. Cognitive-behavioral modification (CBM) is an approach to cognitive-behavioral therapy that focuses on changing negative self-talk and life narrative to positive self-talk.

2. Collaborative empiricism, which involves a systemic process of therapist and patient working together to establish common goals in treatment, has been found to be one of the primary change agents in cognitive-behavioral therapy

3. Self-instructional training is a cognitive technique which aims to give clients control over their behavior through guided self talk that gradually becomes covert and self-generated. This is particularly helpful where there are initial cognitive deficits in for example problem solving or verbal mediation contributing to the difficulty

4. Cognitive model describes how people's perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral (and often physiological) reaction

13.13 SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper's Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
5. Brammer, L.M. & Shostrom, E.L. (1977). Therapeutic Psychology. New Jersey: Englewood Cliffs.
6. D. John Antony, Skills of Counselling, 2003, Anugraha Publications.

UNIT 14: PROFESSIONAL PREPARATION & TRAINING

*Professional preparation &
training*

Structure

- 14.1 Introduction
- 14.2 Objectives
- 14.3 Selection
- 14.4 Skills
- 14.5 Counselling as a profession
- 14.6 Desirable characteristics
- 14.7 Modern Trends
- 14.8 Career guidance
- 14.9 Functions of counsellor
- 14.10 Values
- 14.11 Assessment
- 14.12 Physical setting
 - 14.12.1 Room
 - 14.12.2 Length of session
- 14.13 Group counselling
- 14.14 Stages of counselling
- 14.15 Techniques
- 14.16 Egan's Model
- 14.17 Interviews
- 14.18 Testing
- 14.19 Let us sum up
- 14.20 Unit-End Exercises
- 14.21 Answer to Check your Progress
- 14.22 Suggested Readings

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14.1 INTRODUCTION

Counselling involves working with a variety of individuals and addressing their everyday problems in individual, family, or group settings. Counselling psychologists typically work by helping clients with a variety of problems, which are not usually severe disturbances. Counselling psychologists are often influenced by the theoretical orientation they adhere to. There are a number of theoretical orientations, each providing a different explanation behind the causes of psychological disorders and their appropriate treatment. The counsellor's objective is to provide support to client's goals by assisting in decreasing their stress, aiding the effort to provide a healthy environment, helping them focus on personal and career goals, thereby contributing to client's motivation, performance, and satisfaction with their life. The counsellor listens, understands, and facilitates a better understanding between the individuals involved. A nonjudgmental attitude and confidentiality agreement is part of the whole process.

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Successful counsellors are those who have a mature and balanced state of mind and disposition, who can place themselves in the shoes of those they are counselling and have the ability to respect their opinions, thoughts, feelings and emotions. There are many considerations that one has to take into account when training to be a counsellor, and educationists have to focus on them when training students to venture into and be successful in this very important profession.

14.2 OBJECTIVES

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

- Comprehend the skills and characteristics required of a counsellor
- Understand the process of counselling
- Prepare yourself for professional practice

14.3 SELECTION

It is being increasingly recognized in any professional field that entrants have to be carefully selected. It is not sufficient to only take into account the intellectual factors or the professed interest in the service to the client. Personality characteristics of the counsellors have great significance. The effectiveness of counsellors is said to depend on the goals which they may be trying to achieve. The counsellor should be sensitive to the situation around him and the needs of the people and above all he should be sincere and genuine.

The first and foremost requirement of professional counsellors is necessary skills and adequate knowledge. Professional training and skills have to be constantly revised and updated. Training can be in basic or general and/or training for different specializations depending on the areas or groups or situations in which they would serve.

All professional fields attach considerable importance to the selection of suitable persons to be trained to become members of a profession. For proper criteria to be laid out it is necessary for the different functions of counsellors to be identified. Primarily counselling is a helping function. Therefore, it is closely related to the needs and characteristics of the social system in which it is to function and operate, and also to the resources; personnel and material; available to the system.

14.4 SKILLS

A balanced and sound training program in counselling should include the following to train the prospective counsellors in appropriate knowledge, skills and competencies required for the profession:

- *Basic theoretical preparation:* Understanding of motivation, psychodynamics of human adjustment, learning principles and other concepts that underlie counselling, psychodiagnostic principles and

procedures, psychopathology, social psychology, principles and process of counselling, and counselling theory.

- *Technical and applied knowledge:* Knowledge of test use and interpretation, interviewing skills and competencies in specialized procedures of intervention.
- *Practical training:* A broad-based practicum and training for enabling the counsellors to meet any exigencies.

Additional training on developing skills to be exercised in multicultural setting, and further training in specialized areas of counselling is also required.

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14.5 COUNSELLING AS A PROFESSION

The master's degree in counsellor education is considered an entry-level preparation for qualification as a professional practitioner. It qualifies them to work and to apply the skills of assessment and clinical intervention in various settings (schools, agencies, universities) and with different modalities (individual, group, and family counselling).

Doctoral training places as much emphasis on research as it does on practice. This degree is intended to prepare professionals to function independently as scholars, supervisors, advanced practitioners, and educators. Doctoral level training is considered a terminal degree, which means the graduate (after completing internship and licensure requirements) may function in an independent position as a supervisor.

14.6 DESIRABLE CHARACTERISTICS

To be effective in their roles, counsellors should enjoy helping others and possess specific attributes and skills.

Communication Skills

Effective counsellors should have excellent communication skills. Counsellors need to have a natural ability to listen and be able clearly explain their ideas and thoughts to others. Some of these skills can be honed during graduate school and are developed and refined over the course of their career.

Acceptance

Being nonjudgmental and accepting are important attributes in any of the helping professions. But professional counsellors must be able to "start where the client is at." This phrase is often used in counselling to describe the ability to relate to clients with an open, nonjudgmental attitude – accepting the client for who he/she is in current situation. Counsellors need to be able to convey acceptance to their clients with warmth and understanding.

Empathy

Counsellors help people through some of the most difficult and stressful times of their lives. They must be able to display empathy – the ability to feel what

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another person is feeling. Empathy means that you are truly able to imagine what it's like to stand in someone else's shoes. Compassion and empathy help the clients feel understood and heard.

Problem-Solving Skills

It's not up to a counsellor to solve the clients' problems, but counsellors must have excellent problem-solving skills to be able to help their clients identify and make changes to negative thought patterns and other harmful behaviors that might be contributing to their issues.

Rapport-Building Skills

Counsellors must possess a strong set of interpersonal skills to help establish rapport quickly with clients and develop strong relationships. They must give their undivided attention to clients and be able to cultivate trust. Counsellors need to be able to place all of their focus on what their clients are saying and avoid being distracted by their own personal problems or concerns when they are in a session.

Flexibility

Flexibility in counselling is defined as the ability to adapt and change the way the counsellor responds to meet the clients' needs. The counsellor does not stay rigid and stick to a predetermined treatment path when the clients require a different approach. Being flexible is one of the most important attributes of a professional counsellor.

Self-Awareness

Self-awareness is the ability to look within and identify one's own unmet psychological needs and desires, such as a need for intimacy or the desire to be professionally competent. This ability prevents the counsellor's issues from affecting or conflicting with those of your clients.

Multicultural Competency

Counsellors help people from all walks of life. They must display multicultural competency which means that the counsellor tries to relate to and understand the clients regardless of their race, ethnicity, religious or political beliefs or socioeconomic background.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. List the desirable characteristics of a counsellor.

14.7 MODERN TRENDS

The approach to counselling is changing into mentoring, coaching, training, consulting, etc as the postmodern generation emerges.

Coaching is a recent phenomenon that has developed from three main streams: 1) Psychotherapy and counselling 2) Business consulting and organizational development 3) Personal development training. In addition it draws from disciplines such as sociology, psychology, positive adult development, career counselling, mentoring and other types of counselling, also sharing similarities with other disciplines, such as organizational consulting, management development, and training. It works on the philosophy that people limit themselves and cap their potential due self-defeating beliefs and patterns.

Mentoring is the process by which an experienced person provides advice, support, encouragement to a less experienced person. A mentor is a teacher or advisor who leads through guidance and example. A mentor provides guidance, wisdom, knowledge and support in a manner in which a ward can receive it and benefit from it. It is a life educational model based on the principle of a more experienced mentor. The need and utility of a mentor is now recognized more and more at all places, especially in the educational institutions and corporate organizations. To help the mentee believe in the self and boost confidence, the mentor generally asks questions and challenges the mentee while providing guidance and encouragement.

A consultant is a professional who provides advice in a particular area of expertise like law, management, medicine, etc. The consultant is usually an expert in the field with a wide knowledge of the subject matter. He/She provides advice to the clients who may be individuals or companies in a particular field or specialty.

The term training refers to the acquisition of knowledge, skills, and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies.

14.8 CAREER GUIDANCE

Career guidance was the central theme of the early guidance movement and consisted of helping the individual choose a suitable vocation. Vocational counselling is concerned with career maturity of the individual within a developmental stream. Towards this end, a counsellor designs intervention strategies to assist his client. The counsellor, both at the elementary and secondary school levels, is emerging as a counsellor to students and consultant to teachers, parents and administrators. As counsellor of students he/she helps resolve the problems of few students and as consultant is able to serve more students by consulting teachers, parents and administrators, thus enhancing sensitivity to teacher problems and deepening their insights into pupil behavior and activities and by initiating them in the basic skills of pupil guidance. This

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enhances the scope of the functioning of the counsellor and helps serve a larger body of pupils, leading to such desirable goals as better scholastic performance and a significant reduction in behavioral and discipline problems.

14.9 FUNCTIONS OF COUNSELLOR

The functions of a counsellor can be succinctly stated as:

1. To identify the problem areas or difficulties of individuals, their potentialities and limitations.
2. To assist people to understand themselves and their situational factors as fully as is practicable.
3. To help develop the potential of individuals through a greater self-understanding, to enable them to take full advantage of the environmental resources.
4. To mitigate suffering, reach appropriate solutions, take responsible decisions and thus enable clients to become self-actualized individuals.

14.10 VALUES

Both the counsellors and counsees bring to the counselling relationship deeply cherished values concerning education, work, marriage and family issues, and the individual's obligations and responsibilities to those in his/her immediate environment as well as those incumbent upon him or her as a citizen.

Value issues become critical in the counselling process when (i) the values of the counselee and the counsellor are different and (ii) the values of the counselee are causing some difficulty in his or her environment. The counsellor must remember that the overall goal of the process is to help the client help himself/herself. Therefore, the counsellor needs to help the client discuss their values in the client's own environment, and help the client resolve the difficulty or cope with the situation in a more effective way. It is important not to impose the counsellor's values on to the client.

14.11 ASSESSMENT

The practice of assessment entails the collection of information in order to identify, analyze, evaluate, and address the problems, issues, and circumstances of clients in the counselling relationship. Assessment is used as a basis for identifying problems, planning interventions, evaluating and/or diagnosing clients, and informing clients and stakeholders. Many novice counsellors may make the mistake of identifying assessment as a means to an end, such as providing a label or diagnosis to a client. Assessment is generally viewed as a process essential to all elements of counselling. Whether practicing in a school, private practice, agency, or other health care setting, assessment plays an integral role. Assessment moves beyond the administration of measures. Assessment involves identifying statements,

actions, and procedures to help individuals, groups, couples, and families make progress in the counselling environment. Although counsellors have the opportunity to limit their scope of practice with respect to modalities, theories, and types of clients, a counsellor cannot function without an understanding of the processes and procedures of assessment in counselling.

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There is a difference between assessment and testing. The focus of assessment is on gathering information; testing refers to the measurement of psychological constructs through instruments or specified procedures. In this sense, a construct refers to a phenomenon that exists but cannot be directly observed. For example, variables such as height and weight can be directly observed. Measurement systems for height and weight are available to minimize errors and guarantee accuracy of results. However, not all variables can be directly observed. Emotional states such as depression or happiness, or cognitive traits such as intelligence, or even psychological states such as stress, cannot be directly observed or measured. Constructs may not be identified so easily. In addition, a construct may vary, depending on the operational definition—how the construct is measured.

The process of assessing, and sometimes testing, is necessary to understand a client. However, differentiating between assessments and testing may be viewed as an academic exercise. Often, these terms may be interchangeable, as the process of testing (i.e., administering, scoring, and interpreting an instrument) cannot be separated from the assessment process. Testing, therefore, is part of assessment. A distinction is made between standardized and nonstandardized assessment. Standardized assessment refers to a formal process in which a specific set of rules and guidelines related to administration, scoring, and interpretation are followed consistently to ensure accurate results over a period of time and across populations. Standardized assessments include instruments developed under a rigorous process and produce results that may be generalizable to a population or meaningful to an individual in the context of a population. Instruments such as achievement tests, aptitude tests, and personality tests fit this description. Nonstandardized assessment refers to a process of gathering information without adherence to a strict set of rules or guidelines. Nonstandardized assessments may include clinical interviews. Even when such interviews follow a formula or pattern, deviations in administrations occur because of the personal nature of the interactions and of addressing the client's personal needs. Such assessments may not adhere to a rigid administration, scoring, and interpretation process.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What are the functions of a counsellor?

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14.12 PHYSICAL SETTING

14.12.1 ROOM

Counselling may take place anywhere but some kind of physical setting may promote and enhance the counselling process better than others. Benjamin (1987) and Shertzer and Stone (1980) emphasize that among the most important factor that influences the counselling process is the place where counselling occurs. Though there is no universal quality that a room should have certain optimal conditions within the room where counselling is to be rendered can provide a conducive environment to both counsellor and counselee. The optimal condition include a room with quiet colors, lighting that is neither too flashy and bright nor too dull and depressing, clutter free with harmonious and comfortable furniture and good ventilation. It should be free from outside disturbances and should radiate a feeling of warmth. In short it should be comfortable such that a relaxed atmosphere is provided in which the client can talk in a relaxed mood.

The sitting arrangement within the room depends on the counsellor. Some counsellors prefer to sit behind a desk. However it has been postulated that a desk can be a physical and symbolic barrier against the development of a rapport between client and counsellor. Benjamin (1987) suggests that counsellors may include two chairs and a nearby table in the setting. The chairs could be at a 90 degree angle from one another so that the clients can look at their counsellors or straight ahead. Counsellors could opt for other variation of physical arrangement as per their comfort level.

The distance between the counsellor and client (the spatial features of the environment) can also affect the relationship. A distance of 30 to 39 inches has been found to be the average range of comfort between counsellor and client of both genders. This optimum distance may vary with room size and furniture arrangement. Benjamin (1987) and Shertzer and Stone (1980) emphasizes that regardless of the arrangement within the room, it is a universal requirement that counsellors should not be interrupted while conducting sessions. All phone calls should be held. If possible counsellors should put do-no-disturb sign on the door to keep others from entering. Auditory and visual privacy are mandated by professional codes of ethics and assure maximum client self-disclosure.

14.12.2 LENGTH OF SESSION

In individual counselling sessions the session will last approximately 50-55 minutes. This 50-55 minutes is referred to as a "therapeutic hour." This is standard practice, although some clinicians will offer 45-minute sessions or 60-minute sessions. A 50-55 minutes session and "block off" for each session will help the counsellor to collect their thoughts, jot some notes (if they haven't been taking them during the session), and 'reset' before their next client comes into the office. The counsellor may

also have to physically stretch and relax between sessions. In some situations, the counsellor may recommend a lengthier session (such as 80-85 minutes). It's hard to get therapeutic work done in a smaller amount of time.

14.13 GROUP COUNSELLING

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Group counselling offer particular advantages for working with a variety of people, for groups can be designed to meet the needs of children, adolescents, young adults, middle-aged persons and the elderly.

The following are the goals and purposes of groups:

- To grow in self-acceptance and learn not to demand perfection.
- To learn how to trust oneself and others.
- To foster self-knowledge and the development of a unique self-identity.
- To lessen fears of intimacy, and learn to reach out to those one would like to be closer to.
- To move away from meeting other's expectations, and decide for oneself the standards by which to live.
- To increase self-awareness, and increase the possibilities for choosing and acting.
- To become aware of choices and to make choices wisely.
- To become more sensitive to the needs and feelings of others.
- To clarify values and decide whether, and how, to modify them.
- To find ways of understanding, and resolving, personal problems.

Forming a group

In forming a group, the place to start is by clarifying the rationale for it. It is well worth devoting considerable time to planning, for if planning is done poorly, and if members are not carefully selected and prepared, groups can fail in their objective.

How a group is announced influences the way it will be received by potential members, as well as the kinds of people who will join the group. Personal contact with potential members is one of the best methods of recruiting members. The leader can, through personal contact, enthusiastically demonstrate that the group has potential value for someone.

The group leader conducts a pre-group interview with each prospective member for the purposes of screening and orientation. He then selects group members whose needs and goals are compatible with the established goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

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In selecting members for a given group, there are some basic factors to keep in mind such as

1. How large should the group be?

The ideal size of a group depends on the age of the members, the counsellor's experience as a leader, the type and purpose of a group, and whether you there is a co-leader. For instance, a group with elementary school children might be kept to four or five members, while a group of adolescents might have eight to ten. The group should be big enough to give ample opportunity for interaction, and small enough for everyone to feel involved in the group.

2. How often should a group meet, and for how long?

With children and adolescents, frequent short meetings may suit their attention span better. If the group is taking place in a school setting, the meeting times can correspond to regularly scheduled class periods. For a group of well-functioning adults, a two-hour weekly session might be preferable. The frequency and duration of a meeting should suit your style of leadership and the type of people in the group.

3. Where should the group meet?

Physical arrangements and setting contribute to, or detract from, the climate of a group. Privacy and freedom from distractions are essential. Group leaders sometimes think that meeting outdoors is a good way to promote informality, but generally such a setting lacks privacy and is a source of distractions.

4. Will membership be voluntary or involuntary?

Although it is ideal to have a group composed only of those who want to be part of the group, some groups consist of clients who are required to attend. Attending a group because one has been ordered to go by someone else greatly curtails the chances of success. The key to successful participation lies in carefully orienting members, and preparing them for being a part of the group, as well as in the leader's belief that the group process has something to offer to prospective members.

5. Should the group be open or closed?

An open group is one characterized by changing membership, while a closed group adds no new members during the lifetime of the group. Closed groups have some distinct advantages, as trust can be developed and work accomplished. If membership changes from week to week, as in some open groups, productive work as a group may be difficult to achieve.

Once the members have been screened, and the group formed, it is useful to conduct a preliminary or pre-group session with all the members selected. The pre-group meeting can be an extension of the individual screening process, for it is an ideal way to present basic information, help members get to know one another, and help them decide whether to commit themselves to the group or not. Depending on the nature of the group, certain ground rules will have to be established early on.

STAGES OF THE GROUP PROCESS

Stage 1:

During the early stages, the central process involves orientation and exploration. At this time, members get acquainted, learn how the group functions, develop spoken and unspoken norms that govern in-group behaviour, discuss fears and hopes pertaining to the group, clarify their expectations, identify personal goals, and determine how safe this group is for them. One of the best ways of creating a trusting climate is for the leader to encourage members to express openly any feelings of mistrust, or absence of trust, they might have. If work is to proceed, mistrust must first be recognized, and then dealt with in the group. If it is not, a hidden agenda develops, the lack of trust is expressed in indirect ways, and the group ceases to progress.

Helping Members Define Goals

One of the tasks at the initial stage for the group leader is to help members establish their own goals. Some members typically come to the group with unclear and abstract goals, e.g., 'I just want to be able to communicate with others,' or 'I hope I can get in touch with my feelings.' These vague ideas need to be translated into specific and concrete goals. Narrow down some statements, e.g., 'I would like to learn to express my feelings.' The leader might ask, 'What are some particular feelings that you have the most difficulty in expressing? With whom do you experience problems in expressing feelings? What are the situations in which you find it most difficult to express a certain feeling? How would you like to be different?' Developing contracts, both orally and in writing, can help members develop concrete goals that guide their participation in the group.

Stage 2: The Transition Stage

Characteristics of the Transition Stage

Some groups remain stuck at the transition stage, because resistance is bypassed or conflict is ignored or passed over. At this point in the evolution of a group, feelings of anxiety and resistance to this anxiety are common, and members often are:

- Experiencing anxiety over what they think of themselves if they open up, as well as concerned at other's acceptance or rejection.
- Testing the leader and other members, to determine how safe the environment is.
- Struggling with wanting to play safe, or risk going beyond safety and becoming involved.
- Experiencing a struggle for control and power. Conflict among members, and between members and leaders, is common.

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- Being challenged with learning how to work through conflict and confrontation.
- Being reluctant to become fully involved in working on personal concerns, because they are not sure that others will care.

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Anxiety

Anxiety grows out of a fear of letting others see us on a level beyond the public image. Anxiety also results from a fear of being judged and misunderstood, from a need for more structure, and from a lack of clarity about goals, norms and expected behaviour in the group. As participants come to trust the other members and the leader more, they become increasingly able to share, and this openness reduces their anxiety about letting others see them as they are.

Common Fears Associated with Resistance

If fears are kept inside, then all sorts of avoidance occur. Although group leaders cannot force members to discuss fears that could inhibit their participation, leaders can invite members sensitively to recognize these fears. Fears often include the fear of making a fool of oneself, the fear of rejection, the fear of hanging, the fear that one will not like what is discovered, the fear of self-disclosure, the fear of being attacked and being left without defenses, and the fear of becoming intimate with others. It is important that the group leader understands, and appreciates, the anxiety and resistance of members. Resistance must be respected, for it is to be expected that members have doubts, reservations, and fears. The central task of the leader at this time is to help the members recognize, and deal with, their resistance and defenses against anxiety.

Learning to Recognize and Deal with Conflict

The transition stage is characterized by conflict, and the expression of negative feelings. Members challenge other members and the leader. Some statements that indicate inter-member conflicts are, 'Why do we focus so much on the negative in this group?' 'I don't belong here because my problems aren't as great as most of the others in here.' 'Some people in here sound as if they are all together.' 'I feel threatened by Ms.X.'

Conflicts with leaders are not uncommon at the transition stage, for a key task of members is to learn how to challenge the leader in a direct and constructive manner. This can be a sign that the members are moving towards greater independence. The way the leader handles this challenge is crucial to the future of a group. If leaders are excessively defensive, and refuse to accept criticism, they inhibit the members from confronting each other in a constructive manner, thus impairing the level of trust within the group.

At this stage of the group's development, the leader's major function is to help members move from conflict to a level of relating openly to one another. Some other tasks are:

- teaching members the value of recognizing, and dealing with, conflict;
- teaching them to respect, and work with, their resistance;
- providing a model for members by dealing directly with any challenges they receive; and
- encouraging members to express their reactions to what is happening within the group.

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Stage 3: The Working Stage

During the initial stage, the group is characterized by tentativeness, for the members are finding out what the group is about and their place in it. During the transition period, there is an expression of feelings regarding interactions within the group, as well as individual personal problems. The working stage is characterized by the commitment of members to explore significant problems they bring to the sessions.

One of the main characteristics of the working stage is that participants have learned how to involve themselves in group interaction, rather than wait to be invited to interact. In a sense, there is a sharing of group leadership functions, for the members are able to assume greater responsibility for the work that is done in the group.

A central characteristic of the working stage is group cohesion, which results when members are willing to become transparent with one another. Some indications of the level of cohesiveness (or 'togetherness') in a group, are the extent of co-operation among group members, the degree of initiative shown by the participants, attendance rates, punctuality, the level of trust shown, and the degree of support, encouragement, and caring that members demonstrate in their interaction.

Group cohesion and authentic positive feelings within a group occur after negative feelings are recognized and expressed, for expressing negative feelings is one way of testing the freedom and trustworthiness of the group. Participants soon discover whether this group is a safe place to disagree openly, and whether they are still accepted in spite of their negative feelings. Cohesion occurs when participants open up and take risks by making themselves known. Cohesion, which is a process of bonding, and genuine trust, are things that the group earns by a commitment to be honest. At this stage the members are able to see common problems, and are struck by the universality of the issues.

Stage 4: The Final Stage

During the final stage a number of characteristics can be expected, all of which are associated with the successful accomplishment of the difficult process of consolidation and termination. These include the possibility of sadness, and

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anxiety over the reality of separation, a tendency of members to pull back and participate in less intense ways in anticipation of the ending of the group, a concern over one's ability to be able to implement in daily life what one learned in the group, and decisions about what courses of action to take, and the development of action programmes. And there may be talk of follow-up meetings or a plan for accountability, so that members are encouraged to carry out their plans to change.

The final stages of group evolution are vital, for during this time members have an opportunity to clarify the meaning of their experiences in the group, consolidate the gains they have made, and revise their decisions about what newly-acquired behaviour they want to transfer to everyday life.

As group members sense that their group is approaching its end, there is a danger that they will begin to distance themselves from the group experience, and fail to examine closely the ways in which their in-group learning might affect their out-of-group behaviour. Other problems that occur at this time include the tendency for some members to avoid reviewing their experience, and failing to put it into some cognitive framework, thus limiting the generalization of what they have learned to their everyday existence. Furthermore, members might consider the group an end in itself rather than a laboratory for interpersonal learning. For these reasons, group leaders must learn to help participants put into a meaningful perspective what has occurred in the group.

Follow-up and Evaluation

A follow-up meeting can take place a couple of months after the end of the group, to assess the impact of the group on each member. Such a session is a way of maximizing the chance that members will receive lasting benefit from the group experience. Many people reported that simply knowing that they would get together as a group in the future, after the group's termination, was the motivation they needed to stick to their commitment to carry out their action programmes.

14.14 STAGES OF COUNSELLING

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

Establish Relationship

Counselling is a relationship. It is further defined as a helping relationship. It therefore, follows that if it is to be a relationship that is helpful, the counsellor

must take the initiative in the initial interview to establish a climate built on trust, mutual respect, free and open communication, and understanding in general of what the counselling process involves. Though the responsibility shifts increasingly to the client, at this stage the responsibility for the counselling process rests on the counsellor primarily. The counsellor uses techniques designed to relieve tension, anxiety, stress and open up communication. Both the counsellor's attitude and verbal communications are significant to the development of a satisfactory relationship. All the counsellors' verbal communication skills are brought into play. These include attentive listening, understanding and feeling with the client. The quality of the counsellor client relationship influences the counselling process outcomes.

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The various factors that are important in the establishment of this counsellor client relationship are positive regard, respect, accurate empathy and genuineness. These conditions imply the counsellor's openness, which is an ability to understand and feel with the client, as well as a valuing of the client. The counsellor client relationship serves not only to increase the opportunity for clients to attain their goals but also to be a potential model of a good interpersonal relationship, one that clients can use to improve the quality of their other relationships outside the therapy setting. Counsellors must keep in mind that the purpose of a counselling relationship is to meet as much as possible the clients' needs and not the counsellor's needs. The counselling process within this relationship seeks to assist the client in assuming the responsibilities for his or her problem and its solution. This will be facilitated by the counsellor's communication skills, the ability to identify and reflect client's feelings, and the ability to identify and gain insights into the clients concerns and needs. Establishing a relationship with the client must be achieved early in the counselling process, in as much as this will often determine whether or not the client will continue.

The initial counselling process has a goal and so has the client a goal. The goals of the initial counselling process are as follows: 1) Establish a comfortable and positive relationship. 2) Explain the counselling process and mutual responsibilities to the client. 3) Facilitate communications. 4) Identify and verify the clients concerns that brought her or him to seek counselling assistance. 5) Plan, with the client, to obtain assessment data needed to proceed with the counselling process. Understand the counselling process and his or her responsibilities in this process. Share and amplify reasons for seeking counselling. Cooperate in the assessment of both the problem and self.

Problem Identification and Exploration

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

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continues to exhibit attending behaviour and may place particular emphasis on such communication skills as paraphrasing, clarifying doubts, perception, checking or giving feedback. The counsellor may question the client, but questions are stated in such a way as to help the client to continue exploring client's problem area. Questions that can embarrass clients are avoided. Throughout this phase the counsellor has to be very conscious about knowing the cultural difference and culturally specific behaviours and responses. Here, the counsellor seeks to distinguish between the surface problems and the problems that are deeper and more complex. The counsellor tries to identify that the problem stated initially is the actual problem or that there could be another more important underlying issue that needs to be attended to and dealt with to the client. This may be a time for information gathering. The more usable information the counsellor has, the greater are the prospects of accurate assessment of the clients' needs. The information is gathered under three headings: the time dimension, the feeling dimension and cognitive dimension are as follows: i) The time dimension: This includes the clients past experiences, especially those which he or she may view as influencing experiences of their lives. ii) The feeling dimension: This includes the emotions and feelings of the client towards himself and herself, as well as significant others, including groups, attitudes, values, and self-concept. iii) The cognitive dimension: This includes how the client solves problems, the coping styles that she or he employs, the rationality used in making daily decisions and the clients capacity and readiness for learning.

The goals of this stage are for counsellors to seek and integrate as much information as possible from the client. The counsellor also shares these perceptions with the client. A goal of this stage is for both the counsellor and the client to perceive the problem and its resolution. One of the counsellor's goals during this stage is to help the client develop a self-understanding that recognizes the need for dealing with the need for change and action. Problem solving is used to promote client understanding of action plans for resolving problems. Steps or stages of problem identification and exploration are as follows: 1) Defining the problem as to what is the issue clearly. 2) Exploring the problem by gathering necessary information and then exploring various alternatives in finding solution to the problem. 3) Integrating the information that has been gathered from the client and then summarising it and putting it down clearly for the possible course of action to be taken in resolving the problem.

Plan for Problem Solving

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

some sequential steps in viewing the processes involved. 1) Define the problem 2) Identify and list all possible solutions 3) Explore the consequences of the suggested solutions. 4) Prioritize the solutions on the basis of priority needs. In the further development of this plan, the counsellor recognizes that the client will frequently not arrive at basic insights, implications, or probabilities as fast as the counsellor will. However, most counsellors will agree that it is better to guide the client toward realizing these understandings by himself or herself, rather than just telling the client outright. To facilitate the clients understanding, the counsellor may use techniques of repetition, mild confrontation, interpretation, information and obviously encouragement.

Solution Application and Termination

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

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

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What are the different stages of counselling?

14.15 TECHNIQUES

There are many different techniques that counsellors can use with their clients. Here is a look at some of the techniques that are felt to be most effective during a counselling session:

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Spheres of Influence: This assessment tool will get the individual to look at areas of their life and see which areas may be impacting and influencing them. The person's job is to figure out which systems in their life give them strength, and which ones give them stress. Some spheres of influence to consider are: themselves, immediate family, friends, husband or wife, extended family, job or school, community, culture or religion, and any external influences.

Clarification: A counsellor should often ask their client to clarify what they are telling them to make sure they understand the situation correctly. This will help the counsellor avoid any misconceptions or avoid them having to make any assumptions that could hinder their feedback.

Client Expectations: When a person enters therapy, they should voice their opinions about counselling and their beliefs about treatment. In the beginning, they should be able to communicate with their counsellor as to what they expect to get out of counselling. This can help the counsellor guide and direct their counselling accordingly.

Confrontation: This does not mean the client confronting the therapist, or vice versa. The confrontation that should happen here is within the client. The client should be able to self-examine themselves during counselling. However, the speed at which they do this should be discussed between the counsellor and the client.

Congruence: This has to do with the counsellor being genuine with their feedback and beliefs about their client's situation and progress. The more authentic and true they are with their counselling, the more that their client and work to grow and benefit from their help.

Core Conditions: This technique in counselling goes over some essential traits that the counsellor needs to integrate for effective counselling, which are: positive regard, empathy, congruence or genuineness, and warmth.

Encouraging: Being encouraging as a counsellor for the client is an essential technique that will help facilitate confidence and respect between both parties. This technique asks that the counsellor focus on the client's strengths and assets to help them see themselves in a positive light. This will help with the client's progression.

Engagement: As a therapist, having a good, yet professional relationship with the client is essential. However, there are bound to be difficult moments in counselling sessions, which will require influential engagement on the counsellor's behalf.

Focusing: This technique involves the counsellor demonstrating that they understand what their client is experiencing by using non-judgmental attention without any words. Focusing can help the counsellor determine what the client needs to obtain next from their services.

Immediacy: This technique features the counsellor speaking openly about something that is occurring in the present moment. This helps the client learn from their real life experiences and apply this to their reactions for other past situations.

Listening Skills: With any relationship, listening skills are needed to show that the counsellor understands and interprets the information that their client gives them correctly. The counsellor should do this by showing attentiveness in non-verbal ways, such as: summarizing, capping, or matching the body language of their clients.

Open-Ended Questions: Open-ended questions encourage people in a counselling session to give more details on their discussion. Therefore, these types of questions are used as a technique by counsellors to help their clients answer how, why, and what.

Paraphrasing: This technique will show clients that the counsellor is listening to their information and processing what they have been telling them. Paraphrasing is also good to reiterate or clarify any misinformation that might have occurred.

Positive Asset Search: A positive technique used by counsellors helps clients think up their positive strengths and attributes to get them into a strong mindset about themselves.

Reflection of Feeling: Counsellors use this technique to show their clients that they are fully aware of the feelings that their client is experiencing. They can do this by using exact words and phrases that their client is expressing to them.

Miracle Question: The technique of asking a question of this sort will help the client see the world in a different way or perspective. A miracle question could be something along the lines of: “What would your world look like if a miracle occurred? What would that miracle be and how would it change things?”

Stages of Change: By assessing a client’s needs, a counsellor can determine the changes that need to occur for their client, and when they should take place. This can be determined by what they believe to be most important.

Trustworthiness: The counsellor must create an environment for their client as such that their client feels that they have the capacity to trust their counsellor. A therapist must be: congruent, warm, empathetic, and speak with positive regard to their client.

Capping: A lot of counsellors use the technique of capping during their sessions. Capping involves changing a conversation’s direction from emotional to cognitive if the counsellor feels their client’s emotions need to be calmed or regulated.

Working Alliance: Creating a working alliance between a counsellor and their client is essential for a successful counselling environment that will work to achieve the client’s needs. This technique involves the client and therapist being active collaborators during counselling and agreeing upon goals of treatment that are necessary, as well as how to achieve those goals.

Proxemics: This technique has the counsellor study the spatial movements and conditions of communication that their client exhibits. By studying their clients’ body orientation, the counsellor can determine mood, feelings, and reactions.

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Self-Disclosure: The counsellor will make note when personal information is disclosed at certain points of therapy. This technique will help the counsellor learn more about the client and use this information only to benefit them.

Structuring: When the individual enters counselling, the counsellor should discuss the agenda for the day with their client, the activities, and the processes that they will go through. This technique in counselling will help the client understand their counsellor's train of thought into determining how this routine will work for them. Soon enough, the client will get used to the routine, and this establishes comfort and trust in counselling.

Hierarchy of Needs: This technique involves the counsellor assessing their client's level of needs as based on the progress that they are making. The needs that they will factor in are: physiological needs, safety needs, love and belonging needs, self-esteem needs, and self-actualization needs. All these will determine if change needs to take place in counselling.

14.16 EGAN'S MODEL

Egan's model is a 3-stage model or framework offered by Egan as useful in helping people solve problems and develop opportunities. The goals of using the model are to help people 'to manage their problems in living more effectively and develop unused opportunities more fully', and to 'help people become better at helping themselves in their everyday lives.' This model emphasizes on empowerment. Also the person's own agenda is central, and the model seeks to move the person towards action leading to outcomes which they choose and value.

This model is not based on a particular theory of personality development, nor on a theory of the ways difficulties develop. It is a framework for conceptualizing the helping process, and is best used in working on issues in the recent past and the present. As with any model, it provides a map, which can be used in exploring, but which is not the territory itself. The model can and should be used flexibly. The model works best if attention is paid to Rogers' 'core conditions', the helpers approach to the speaker being based on genuineness, respect, and empathy, and if principles of good active listening are remembered throughout.

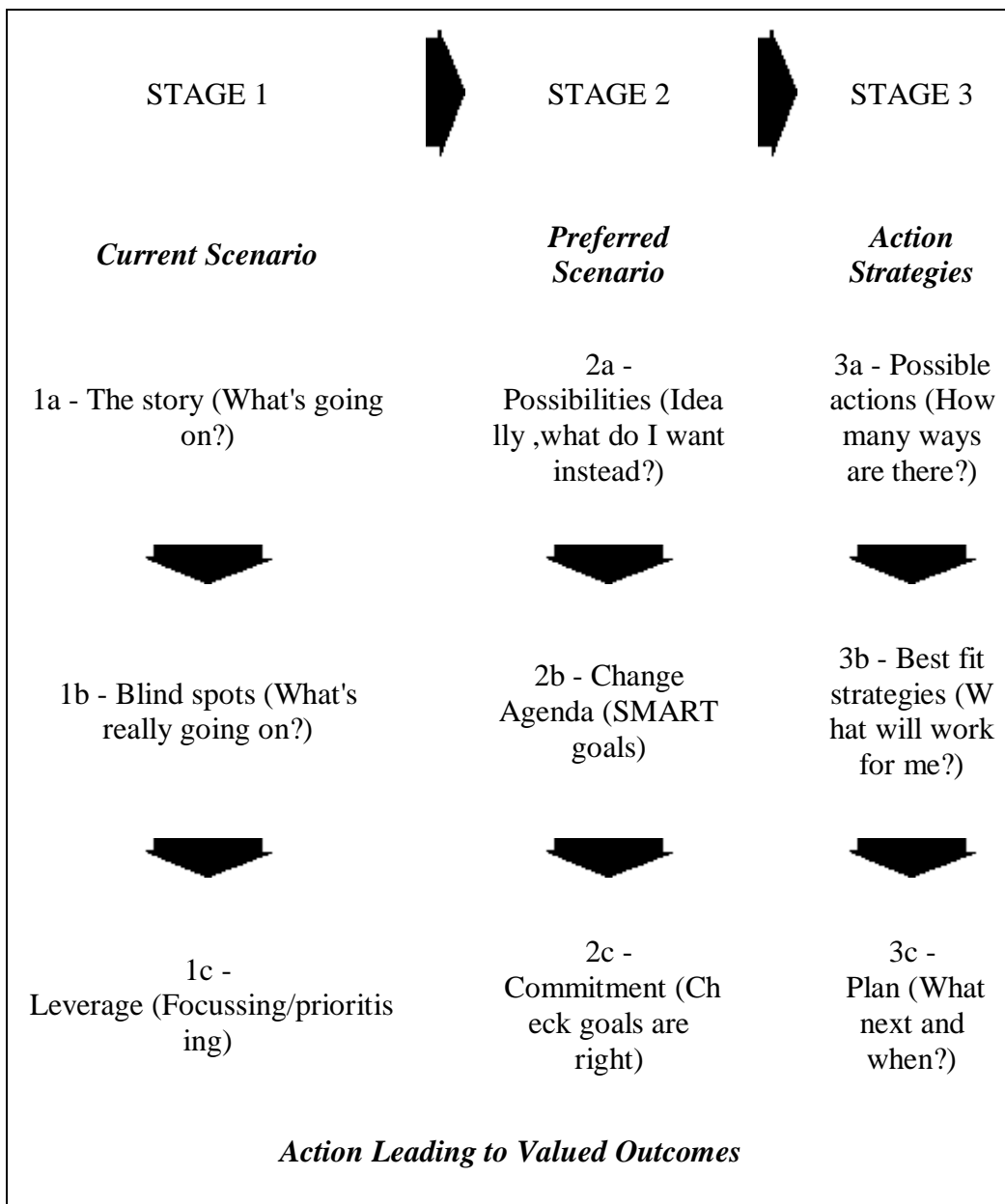
The Egan model aims to help the speaker address 3 main questions:

1. 'What is going on?'
2. 'What do I want instead?'
3. 'How might I get to what I want?'

Not everyone needs to address all 3 questions, and at times people may move back into previously answered ones. The skilled helper will work with the

speaker in all or any of the stages, and move back and forward, as appropriate.

Diagram of the Model



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STAGE 1 - What's going on?

Stage 1 is about providing a safe place for the client to tell their story in their own way, and to be fully heard and acknowledged. It is about a space where a person can hear and understand their own story. It is also about gently helping them lift their head to see the wider picture and other perspectives, and to find a point from which to go forward with hope.

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1a - an expansive part

The helper encourages the client to tell their story, and by using good active listening skills and demonstrating the core conditions, helps them to explore and unfold the tale, and to reflect. For some, this is enough, for others it is just the beginning.

Skills in Stage 1a:- active listening, reflecting, paraphrasing, checking understanding, open questions, summarising.

Useful Questions: How do/did you feel about that? What are/were you thinking? What is/was that like for you? Keep them open! What else is there about that?

1b - a challenging part

Since they are in the situation, it can be difficult for the person speaking to see it clearly, or from different angles. With the help of empathic reflections and challenges, the speaker uncovers blind spots or gaps in their perceptions and assessment of the situation, of others and of themselves - their patterns, the impact of their behaviour on the situation, their strengths. "I'd never thought about how it might feel from my colleague's point of view."

- Skills: Challenging; different perspectives, patterns and connections, shoulds and oughts, negative self-talk, blind spots (discrepancies, distortions, incomplete awareness, things implied, what's not said), ownership, specifics, strengths.
- Useful Questions:
 - How do others see it/you?
 - Is there anything you've overlooked?
 - What does he/she think/feel?
 - What would s/he say about all this?
 - What about all of this is a problem for you?
 - Any other way of looking at it?

1c -Focussing and moving forward

People often feel stuck; that is why they want to talk. In this stage, the helper seeks to move the client from feeling stuck to hope by helping them choose an area that they have the energy to move forward on, that would make a difference and benefit them. "I see now the key place to get started is my relationship with K"

- Skills: Facilitating focussing and prioritising an area to work on.
- Useful Questions:
 - What in all of this is the most important?
 - What would be best to work on now?
 - What would make the most difference?
 - What is manageable?

Stage 2 - What do I want instead?

People often move from problem to action, or problem to solution, without reflecting on what they really want, or in what way their problems might be opportunities. Stage 2 is about this, about helping the speaker to open up a picture of what they really want, and how things could be better. This stage is very important in generating energy and hope.

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2a - a creative part

The helper helps the speaker to brainstorm their ideal scenario; 'if you could wake up tomorrow with everything just how you want it, like your ideal world, what would it be like?' The speaker is encouraged to broaden their horizon and be imaginative, rather than reflect on practicalities. For some people this is scary, for some liberating. "At first it was really difficult but after a while I let my imagination go and began to get really excited about what we could achieve in the department".

- Skills: Brainstorming, facilitating imaginative thinking, i.e.
 - Quantity vs. Quality Anything goes - have fun
 - Write down ideas verbatim, don't analyse or judge
 - Keep prompting - 'what else?'
 - Don't hurry, allow lots of time
- Useful Questions:
 - What do you ideally want instead?
 - What would be happening?
 - What would you be doing/thinking/feeling?
 - What would you have that you don't have now?
 - What would it be like if it were better / a bit better?

2b - a reality testing part

From the creative and visionary brainstorm, the speaker formulates goals which are specific, measurable, achievable/appropriate (for them, in their circumstances), realistic (with reference to the real world), and have a time frame attached, i.e. SMART goals. Goals which are demanding yet achievable are motivating.

"It feels good to be clear that I want a clear understanding with my colleagues about our respective rules and responsibilities."

- Skills: facilitating selecting and reality checking with respect to internal and external landscape.
- Useful Questions:
 - What exactly is your goal?
 - How would you know when you've got there?
 - What could you manage/are you likely to achieve?
 - Which feels best for you?
 - Out of all that, what would be realistic?
 - When do you want to achieve it by?

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2c - moving forward

This stage aims to test the realism of the goal before the person moves to action, and to help the client check their commitment to the goal by reviewing the costs and benefits to them of achieving it. Is it worth it? "It feels risky but I need to resolve this."

- Skills: facilitation of exploring costs and benefits, and checking commitment to goal.
- Useful Questions:
 - What will be the benefits when you achieve this?
 - How will it be different for you when you've done this?
 - What will be the costs of doing this? Any disadvantages/downsides to doing this?

Stage 3 - How will I get there?

This is the 'how' stage... how will the person move towards the goals they have identified in Stage 2? It is about possible strategies and specific actions, about doing something to get started, whilst considering what/who might help and hinder making the change.

3a - another creative part!

The speaker is helped to brainstorm strategies - 101 ways to achieve the goal - again with prompting and encouragement to think widely. What people, places, ideas, organisations could help? The aim is to free up the person to generate new and different ideas for action, breaking out of old mind-sets. "There were gems of possibilities from seemingly crazy ideas".

- Skills: Facilitation of brainstorming
- Useful Questions:
 - How many different ways are there for you to do this?
 - Who/what might help?
 - What has worked before/for others?
 - What about some wild ideas?

3b - focussing in on appropriate strategies

What from the brainstorm might be selected as a strategy that is realistic for the speaker, in their circumstances, consistent with their values? Forcefield analysis can be used here to look at what internal and external factors (individuals and organisations) are likely to help and hinder action and how these can be strengthened or weakened respectively. "I would feel comfortable trying to have a conversation with him about how he sees things".

- Skills for Stage 3b: Facilitation of selecting and reality checking.

- Useful Questions:
 - Which of these ideas appeals most?
 - Which is most likely to work for you?
 - Which are within your resources/control?

3c - moving to action

The aim is to help the client plan the next steps. The strategy is broken into bite-size chunks of action. Here the client is doing almost all the work, producing their action plan. The helper works with them to turn good intention into specific plans with time scales. Whilst being encouraging, it's also important not to push the speaker into saying they'll do things to please the helper. "I will make sure we have time together before the end of the month. I will book a meeting, so that we can be sure of quiet uninterrupted time. I will organise this before Friday".

- Skills: Facilitation of action planning.
- Useful Questions:
 - What will you do first? When?
 - What will you do next? When?

If the end point of producing an action plan has been reached, the experience of trying it out could be the starting point for a follow-up mentoring/co-mentoring session. The work would start in stage I again, telling a new story. If an action plan had not been reached, that's fine too, and the model can be used over a series of sessions.

The key in using the model, as with any theory or model, is to keep the speakers agenda central, the individual in the foreground and theory in the background, and to use the model for the person, rather than vice versa.

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What is a miracle question?

14.17 INTERVIEWS

The counselling interview is a very common type of communication situation. The counsellor performs the counselling role whenever called upon to offer advice on emotional, financial, academic, or personal problems. These situations are very important since they directly influence sensitive aspects of others' lives. Effective counselling skills begin with a thoughtful self-analysis including an assessment of counsellor's own feelings and communication skills.

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Based upon this analysis, the counsellor must be realistic about his own counselling skills and not try to solve every problem encountered. The counsellor must also carefully consider the background of the client so that the counsellor's advice can meet that person's needs.

Based on the counsellor's analysis of own skills as well as the needs of the other person, the counsellor must decide whether to use the directive or nondirective approach. The directive approach is best when it is necessary for the counsellor to control the interview situation and the nondirective approach is best when the interviewee would best control the situation. Although the structure of the interview can vary, four stages are typically followed. First, the counsellor should establish rapport and create a helpful climate. Second, he/she should thoroughly assess the crisis/problem faced by the client. Third, the counsellor should probe more deeply into the client's feelings. Finally, the counsellor should come to some decision and offer potential solutions.

A conducive interview climate must allow for trust, openness, and rapport between the client and the counsellor. The counsellor must also be an effective listener to truly understand the feelings of the client. When appropriate, the counsellor must ask probing questions to gather more information. The counsellor should use a client centered approach and provide either highly directive or highly nondirective responses. Highly nondirective responses encourage the interviewee to continue analysing and communicating ideas. Highly directive responses provide the interviewee with directives and ultimatums. These forms of responses are two ends of a continuum, and can be thought of as extremes. After effective closure of the interview, the counsellor should carefully evaluate the interview so that he/she can further refine their skills.

14.18 TESTING

Counsellors use tests generally for assessment, placements, and guidance and appraisals to assist clients to increase their self-knowledge, practice decision making, and acquire new behaviours. They may be used in a variety of therapies e.g. individual, marital, group, and family and for either gathering of data on clients, assessing the level of some traits, such as stress and anxiety, or measuring clients' personality types.

Steps involved in the process of using tests in counselling include the following: - selecting the test, administering test, scoring the test, interpreting results, communicating the results.

Selecting: Having defined the purpose for testing, the counsellor looks to a variety of sources for information on available tests. Resources include review books, journals, test manuals, and textbooks on testing and measurement (Anastasi, 1988; Cronbach, 1979). The most complete source of information on a particular test is usually the test manual.

Administering: Test administration is usually standardized by the developers of the test. Manual instructions need to be followed in order to make a valid comparison of an individual's score with the test's norm group. Issues of individual versus group administration need to be considered as well. The clients and the purpose for which they are being tested will contribute to decisions about group testing.

Scoring:

Scoring of tests follows the instructions provided in the test manual, the Counsellor is sometimes given the option of having test machine scored rather than hand scored. Both the positive and negative aspects of this choice need to be considered. It is usually believed that test scoring is best handled by a machine because it is free from bias.

Interpreting:

The interpretation of test results is usually the area which allows for the greatest flexibility within the testing process. Depending upon the Counsellor's theoretical point of view and the extent of the test manual guidelines, interpretation may be brief and superficial, or detailed and explicitly theory based (Tinsley & Bradley, 1986). Because this area allows for the greatest flexibility, it is also the area with the greatest danger of misuse. The experience of the counsellor allows for skilled, careful interpretation of results.

Communicating:

Feedback of test results to the client completes the formal process of testing. Here, the therapeutic skills of Counsellors come fully into play. The Counsellor uses verbal and non-verbal interaction skills to convey messages to clients and to assess their understanding of it.

ISSUES IN TESTING

Confidentiality:

The ethical and legal restrictions on what may be disclosed from counselling apply to the use of tests as much as to other private information shared between client and counsellor. The trust issue, which is inherent in confidentiality, is relevant to every aspect of testing. No information can be shared outside the relationship without the full consent of the client. Information is provided to someone outside the relationship only after the specifics to be used from the testing are fully disclosed to the client. These specifics include the when, what, and to whom of the disclosure. The purpose of disclosure is also shared with the client and what the information will be used for is clearly spelled out. Issues of confidentiality are best discussed with the client before conducting any test administration. Clients who are fully informed, before testing takes place, about the issue of confidentiality in relation to testing are more active participants in the counselling process.

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Counsellor Preparation:

Tests are only as good as their construction, proper usage and the preparation of the counsellor intending to use them. The skills and competencies counsellors need or using tests in practice are to: (i) Understand clearly the intended purpose of a test, (ii) Be aware of the client's needs regarding the test to be given (iii) Have knowledge about the test, its validity, reliability and the norm group for which it was developed. (iv) Have personally taken the test before administering it. (v) Have been supervised in administering, scoring, interpreting, and communicating results of the tests to be given. Supervision in the practice of providing testing services ideally encompasses all of the above areas of concern. This supervision needs to be conducted by the knowledgeable practitioner with experience in using tests in clinical practice.

Check your Progress – 5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What are the steps involved in using tests in counselling?

14.19 LET US SUM UP

Counsellor preparation is multifaceted and involves developing trainees' clinical knowledge, skills and competence. Counselling is an activity that can be learned and developed. Most counselling education programmes recognize that a number of factors influence counselling competence. As a result, various types of counsellor training and education are available and counselling training is likely to include various aspects of counselling knowledge, awareness, and skill. Counselling training includes private mentoring and training programmes, and education certificates. The master's degree is considered the entry degree for practice as a professional counsellor. The doctoral degree in counsellor education and supervision expands on the master's degree and is individually tailored to provide emphases in counselling, supervision, teaching, and research. Some individuals pursue a doctoral degree in order to work in colleges and universities teaching and supervising future counsellors and adding to the research base for the counselling profession, while others might pursue the doctoral degree to advance their counselling career through assuming administrative and/or supervisory roles within their organizations. In most circumstances, an individual will need to have a master's degree in counselling and have worked as a counsellor before he or she would be eligible to pursue a doctoral degree in counsellor education and supervision.

14.20 UNIT-END EXERCISES

1. Describe in detail how a counsellor should be prepared and trained for the profession.
2. What factors should be considered while selecting members to be counseled as a group?
3. What are the issues that have to be addressed with regard to use of testing in counselling.
4. Describe Egan's model of counselling.

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14.21 ANSWER TO CHECK YOUR PROGRESS

1. Excellent communication skills, acceptance of the client with warmth, empathy, problem solving skills, rapport building, flexibility, self-awareness, multicultural competency.
2. To identify the problem areas or difficulties of individuals, to assist people to understand themselves and their situational factors completely, To help develop the potential of individuals through a greater self-understanding, to enable them to take full advantage of the environmental resources and to mitigate suffering, reach appropriate solutions, take responsible decisions and thus enable clients to become self-actualized individuals.
3. Establish Relationship, Problem Identification and Exploration, Plan for problem solving, Solution Application and Termination.
4. Miracle question is a technique in counselling of asking a question that sort will help the client see the world in a different way or perspective. For ex., "What would your world look like if a miracle occurred?"
5. Steps involved in the process of using tests in counselling include - selecting the test, administering test, scoring the test, interpreting results, and communicating the results.

14.22 SUGGESTED READINGS

1. Corey, G. (1996). Theory and Practice of Counselling and Psychotherapy. 5th ed. Belmont, CA: Brook/Cole.
2. Nelson, J. (1982). The Theory and Practice of Counselling Psychology. New York: Holt Rinehart & Winston.
3. Patterson, L.W. & Welfel, E. R. (2000). The Counselling Process. 5th ed. Belmont, CA: Brook/Cole.
4. Richard Nelson-Jones (2012). Basic Counselling Skills – a Helper's Manual, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.

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5. Brammer, L.M. & Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
6. D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.
- 7 Corey, G. (1996). *Theory and Practice of Counselling and Psychotherapy*. 5th ed. Belmont, CA: Brook/Cole.
- Nelson, J. (1982). *The Theory and Practice of Counselling Psychology*. New York: Holt Rinehart & Winston.
- 8 Patterson, L.W. & Welfel, E. R. (2000). *The Counselling Process*. 5th ed. Belmont, CA: Brook/Cole.
- 9 Richard Nelson-Jones (2012). *Basic Counselling Skills – a Helper’s Manual*, 3rd Edition, New Delhi: Sage Publication India Pvt Ltd.
- 10 Brammer, L.M. & Shostrom, E.L. (1977). *Therapeutic Psychology*. New Jersey: Englewood Cliffs.
- 11 D.John Antony, *Skills of Counselling*, 2003, Anugraha Publications.

**DISTANCE EDUCATION – CBCS – (2018-19 Academic Year
Onwards)**

Question Paper Pattern (ESE) – Theory

M.Sc Psychology

36332 – COUNSELLING THEORIES AND TECHNIQUES

Time: 3 hours

Max

Marks:75

PART A – (10 x 2 = 20 Marks)

Answer all questions.

1. Define Counselling.
2. What are short-term and long-term goals in the process of counselling?
3. What is informed consent?
4. What are ego-defense mechanisms?
5. What is transference?
6. What is the basic assumption of person-centered approach?
7. What is empathy?
8. What does the acronym 'WDEP' stand for in reality therapy?
9. What are cognitive distortions?
10. What is group counselling?

PART B – (5 x 5 = 25 marks)

Answer all questions choosing either (a) or (b)

11. a. Enlist the characteristics of an effective counsellor.

(or)

b. What fundamental ethical principles have to be observed in the process of counselling?

12. a. Discuss the scope of counselling.

(or)

b. Write a note on the characteristics of a successful counselee.

13. a. Describe Freud's structure of personality.

(or)

b. Describe the characteristics of reality therapy.

14. a. Explain briefly classical conditioning and operant conditioning.

(or)

b. What are the strengths and limitations of behavioural approach?

15. a. Describe Beck's cognitive therapy.

(or)

b. Write a note on assessment techniques used in the process of counselling.

PART C – (3 x 10 = 30 marks)

(Answer any 3 out of 5 questions)

16. Describe the techniques used by psychoanalytic therapists and its underlying assumptions.

17. Describe the techniques used in Gestalt therapy.

18. Elaborate on the techniques used in cognitive behaviour therapy.

19. Explain in detail the process of counselling.

20. What are the various special areas of counselling?
