CHALIMBANA UNIVERSITY

DIRECTORATE OF DISTANCE EDUCATION

PYS 3200: COUNSELLING

FIRST EDITION 2020

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First Edition

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MODULE OVERVIEW

Introduction

This course provides a framework for understanding different approaches to counselling. It also presents qualities of a good counsellor and ethical considerations in counselling.

Rationale

This course will give you the understanding of different counselling approaches that will enable to be an effective counsellor.

Course aims

The aim of this course is to equip students with an understanding of various counselling approaches.

Learning Outcomes

By the end of the course, you should be able to;

- describe the counseling process.
- explain the professional conduct and ethical issues in the practice of counselling.
- describe theoretical concepts of human behaviour and counselling and how they translate into counselling approaches and techniques.
- apply acquired counselling skills in counselling.
- apply theoretical principles to a variety of presenting issues and client factors.

Summary

This module covers theories of counseling and their application in resolving various human problems.

Study skills

As an adult learner, your approach to learning will be different to that of your school days you will choose when you want to study. You will have professional and/or personal motivation for doing so and you will most likely be fitting your activities around other professional or domestic responsibilities.

Essentially you will be taking control of your learning environment. As a consequence, you will need to consider performance issues related to time management, goals setting, stress management, etc. perhaps you will also need to reacquaint yourself in areas such as essay planning, coping with examinations and using the internet as a learning source.

Your most significant considerations will be time and space i.e. the time you dedicate to your learning and the environment in which you engage in that learning. It is recommended that you take time now before starting your self-study to familiarise yourself with these issues. There are a number of excellent resources on the web. A few suggested links are: http://www.how-to-study.com/ and http://www.ucc.vt.edu/stdysk/stdyhlp.html

Time frame

You are expected to spend at least three terms of your time to study this module. In addition, there shall be arranged contact sessions with lecturers from the University during residential possibly in April, August and December. You are requested to spend your time carefully so that you reap maximum benefits from the course. Listed below are the components of the course, what you have to do and suggestions as to how you should allocate your time to each unit in order that you may complete the course successfully and no time.

Required resources

Text books and module.

Need help

In case you have difficulties in studying this module don't hesitate to get in touch with your lecturers. You can contact them during week days from 08:00 t0 17:00 hours. Mr Moono

Maurice mmoono.75@gmail.com Tutorial Room 3,. You are also free to utilise the services of the University Library which opens from 08:00 hours to 20:00 hours every working day.

Assessment

Continuous Assessment	50%
One Assignment	25%
One Test	25%
Final Examination	50%
Total	100

REFERENCES

Required Readings

Corey, Gerald, (2013), Theory and Practice of Counselling and Psychotherapy, Belmont, California, Brooks/Cole.

Gladding, Samuel T., (2012), Counselling: A Comprehensive Profession MacMillan Publishing Company

Meier S.T and Davis, Susan R., (2010), The Elements of Counselling, Brooks/Cole

Recommended Readings

APA website: http://www.apa.org/ethics/code/index.aspx

APA. (2002). Ethical Principles of Psychologists and Code of Conduct.

Burnard Philip, (2005), Counselling skills for health professionals, London, Chapman.

DeRoad, Robert, (1987), Counselling skills

Ivey, Allen, E., Ivey, Mary, B. & Zalaquett, Carlos P. (2012) Essentials of Intentional Interviewing: counseling in a multicultural world. Brooke /Cole

Mcleod, John, (2009), An Introduction to Counselling, Buckingham, Open University Press.

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Sumarah, J. (2009). Reflection for the beginning counsellor. Toronto: Wolf Ville.

UNIT 1: HISTORY OF COUNSELING

1.1 Introduction

The history of counseling field, though relatively new, is rich. It is important to note the influence of the broad field of psychology, and though much of the history of each is unique, counseling and psychology are branches of the same mental health tree. The counseling field developed from the guidance movement in response to recognition of a need for mental health and guidance counseling for individuals facing developmental milestones. This unit provides a historical context for the development of the counseling profession, the key contributors to the profession, and the development of organizations providing professional context and accountability. An overview focuses on three threads: societal changes that influenced the profession in response to human need, changes in psychological theory, and educational reform.

1.2 Learning Outcomes

By the end of this unit you are expected to;

1. discuss the history of counselling.
2. analyze the contribution of Alfred Adler and Viktor Frankl to the development of counselling.

1.3 Time frame

You need about three (3) hours per week to interact with this material.

1.4 Content

- History Counseling

1.5 Counseling in Early 20th Century

The counseling profession developed in many ways from responses to changes in society. In the early 20th century, when counseling was first emerging, humanistic reform, with an increased emphasis on the value of all human beings, was also emerging. Human qualities such as choice, creativity, self-realization, and ultimately the value of all people became the focus of human change and intervention. During this period of humanistic reform, society saw

changes in conditions of prisons, asylums, and factories based on the humanistic principles noted above. The focus was toward treating all clients, regardless of circumstance, in a way that regarded and supported their potential for success and remediation. Concurrently, the school system was taking a lead in this transformation through its focus on humanistic education, including student-centered learning with the teacher as a facilitator, development of the self-actualized student, and student cooperation. Humanistic reform led to a new way of viewing the individual and the facilitation of human well-being.

Also during this time, America was in the midst of the Industrial Revolution, a time of great change resulting in a shift in human need. One of the primary consequences of the dramatic changes occurring in American society was the movement from farms to the city. As a great influx of people moved to cities to work in industry and in the factories, people were severely overcrowded, which ultimately resulted in an increase in disease and the beginning of slums and poverty. An additional consequence was the disorganization of the family. Before the industrial revolution, families lived close to one another, worked together, and relied on one another for support. Once families moved to the cities to work in the factories, the family structure changed, and the human population became increasingly isolated. These changes created new needs for the individual and the family.

In education, this time period saw the ongoing development of progressive education led by John Dewey. The focus of this movement was child learning through real-world experience and an emphasis on schools reflecting the overall life of society. Also part of this movement was respect for the child and the implementation of a curriculum that allowed for children to develop personal interests; this curriculum included agricultural education, industrial education, and social education with an emphasis on the acculturation of immigrants. Progressive education coupled with the humanistic movement shed light on the growing need to attend to the overall well-being of children, beyond the walls of the school. Another key figure in the change of American schools was Horace Mann, who is often referred to as the father of American education. Mann believed in the development of a system of common schools: universal, free, and nonsectarian education.

These early forerunners (Dewey and Mann) were focused on training and advice, in particular education and vocational guidance, and on interpersonal relationships. To this point in history, the helping professions were dominated by mental health giants such as Sigmund Freud, Alfred

Adler, and Viktor Frankl. Freud's psychoanalytic theory had, and continues to have, a profound impact on counseling and psychotherapy.

The early 1900s saw the beginning of political support for compulsory education. Compulsory education allowed for education for all and is based on the fundamental principle that education is a basic human right. Specifically, compulsory education requires by law that children receive education and that government provide education to all. Educating children decreased the number of children in the labor force and was a primary force in the change of society.

During this time in France, Alfred Binet was part of a commission concerned with retardation in school children. Binet rejected some original tenets of intelligence testing and worked on the development of intelligence scales. With the changes in the educational system driven by education reform in a response to urbanization and industrialization, schools needed assistance to handle diverse learning capabilities. Binet developed a scale to differentiate children struggling to learn from those more capable of school demands. Binet collaborated with Theodore Simon, a physician, and together they developed a measure of intelligence. The primary intent of this 1905 intelligence scale was to discriminate between slightly "retarded" children and the normal school population.

Three key figures influenced the early roots of the counseling profession, specifically Jesse B. Davis, Frank Parsons, and Clifford Beers. A front-runner in the response to educational reform, Jesse B. Davis, was the first person to develop public school counseling and guidance programs. As a principal, Davis required his students to write about their vocational interests on a weekly basis. Davis believed that character development was central to preventing behavioral problems and to creating good relationships with other students. Davis was strongly influenced by Mann qerand Dewey and believed that if children were given proper guidance, the challenges of an increasingly industrialized society could be met. Therefore, he advocated for the infusion of vocational development into traditional curriculum. The goals of the vocational focus were to assist students in understanding their character and in becoming socially responsible workers.

Parsons, often called the father of guidance, founded Boston's Vocational Bureau in 1908. Parsons believed the more people understood themselves and the career choices available to them—specifically their aptitudes, interests, and resources, the more capable they were of

making informed and reasonable occupational choices. In 1909 Parsons wrote Choosing a Vocation, a highly influential book that called for the designation of school teachers as vocational counselors. Other schools took Parsons's example and began implementing their own vocational guidance programs.

During this same time Beers, author of A Mind That Found Itself in 1908, was the impetus for the mental health movement. This book was an autobiographical account of his experience with institutionalization following a suicide attempt. After discovering the condition of these facilities and finding the treatment of mental illness ineffective, Beers committed himself to changing the treatment of the mentally ill. In this book, he exposed the conditions of mental health facilities and eventually prompted national reform in the treatment of persons with mental illness. His work was the forerunner of mental health counseling.

The above professional forces were working toward the development of the counseling profession. Early changes across three professional movements— guidance counseling and educational reform, mental health reform, and the psychometrics movement— came together to create the foundation of the counseling profession.

As the 1900s progressed, several events occurred that impacted the profession. The first event was the founding of the National Vocational Guidance Association (NVGA) in 1913. In 1915, the NVGA published the first National Vocational Guidance Bulletin, and by 1921 it was publishing it regularly. In 1924, the title was changed to the National Vocational Guidance Magazine. The publication evolved over the years to eventually become the Journal of Counseling and Development, the publication's current title. The development of the NCGA signified the first effort toward unifying those invested in the pursuit of scholarly information related to vocational guidance. Also during this time, the Smith Hughes Act of 1917 was passed by Congress. This act provided funding for public schools to provide vocational guidance programs and allowed schools to separate their vocational guidance programs from standard curriculum courses.

The beginning of World War I brought many new challenges to the United States and other countries involved in the war. The U.S. Army, in response to one of their challenges, commissioned the development of the Army Alpha and Army Beta intelligence tests. During this time, counseling became increasingly recognized as the army implemented these

instruments to assist in selection, placement, and training practices for army personnel. After the war ended, these instruments were used with the civilian population; this marked the beginning of the psycho-metrics movement, one of the professional origins on which the counseling field was largely based.

1.6 Counseling in The 1920s

The 1920s saw the emergence of an even greater influence of school guidance. During this time, the profession was becoming increasingly focused, and vocational guidance became the primary focus of training programs, starting with Harvard University. The major influences on the profession at this time were theories of education and governmental support of guidance service for war veterans. Recognition of the importance of vocational assessment and guidance continued to pull the counseling field into more solid development and recognition of the need for increased professionalism. In response to this pull came the development of the first standards for occupational inventories and guidelines for their development and evaluation, providing further impetus for psychometric evaluation. The primary orientation during this time was the medical model and testing.

With the standards for development and evaluation of psychological instruments came an increase in the publication of these materials, most notably the Strong Vocational Interest Blank (SVIB), created and published by Edward Strong in 1927 (now called the Strong Interest Inventory). The Strong Vocational Interest Blank was developed based on the assumption that patterns of individual interests indicate likely occupational choices. The inventory indicated the occupations in which a person will be more likely to be satisfied and perhaps even continue with long-term employment.

1.7 Counseling in The 1930s

The Great Depression in the 1930s had a profound influence on both researchers and practitioners; specifically, there was an increased need for helping processes and counseling for employment placement. During this time period, E. G. Williamson developed the trait-factor theory based on modifications of Parson's theory. Williamson's theory was direct and focused on the counselor's direction, primarily through teaching and mentoring. The focus of trait-factor counseling was to define behavior by traits such as aptitudes, achievements,

personalities, and interest, and based on these and a variety of factors, statistically evaluate them to assist an individual toward becoming an effective and successful individual. Williamson's theory was most popular in the 1930s and 1940s when it was used by the military in World War II for selection.

In addition to the influence of the economic climate, the greatest influence on the counseling profession during this time may have been the government's interest in supporting guidance and counseling efforts. In 1936, the George-Deen Act was approved by Congress; this act allowed for the creation of the Vocational Education Division of the U.S. Office of Education. An extension of this act was the introduction of the position of state supervisor of guidance in state departments of education. The George-Deen Act represented the first time funds were directly allocated for vocational guidance counseling, and guidance counselors saw an increase in support for their work.

Also during this time, the U.S. government instituted the U.S. Employment Service, which published the first edition of the Dictionary of Occupational Titles (DOT). The DOT was the first publication to define jobs of all types. The DOT continues to serve individuals seeking employment to this day.

Despite great strides in the counseling profession during this time, some professionals in the fields of education and psychology were criticizing the narrow focus on the guidance movement. In particular, Edward Thorndike felt that the focus of the guidance movement was too narrow.

1.8 Counseling in The 1940s

The 1940s represented another decade of increased recognition for counseling and the ongoing development and definition of the profession. One of the most significant events was World War II. During the war, the U.S. government employed counselors and psychologists to assist in selection and training of specialists for both the military and industry. The war also brought with it a necessary increase in the number of women in the workforce. With so many men fighting in the military, women were needed to fill the vacant positions. The role of women in the workplace during such an important time for the United States radically changed the traditional sex roles formerly dominating the workforce.

Another significant event for the field of counseling that occurred during the 1940s was a growing interest in psychotherapy. There was an emergence of diverse theories—Carl Rogers's client-centered and nondirective theory in particular. Rogers grew in popularity after the publication of his book Counseling and Psychotherapy. He challenged Williamson's directive way of working with clients and focused on the clients' responsibility for their own growth. As is evident from the history to this point, the focus of counseling and guidance prior to Rogers was on testing, assessment, and vocations. Through Rogers's influence, the focus of counseling shifted to relationship dynamics, counseling technique, training of counselors, and refinement of the goals of the counseling relationship. Rogers's theory came to the forefront of counseling and psychology theories, but new counseling theories emerged as well.

Following the war, several events occurred that further promoted the counseling profession. The George Barden Act of 1946 was passed, which allocated vocational education funds for counselor training programs: This included funding for counselor educators, research, state program supervision, local guidance supervisors, and school counselors. Also during this time, the U.S. Department of Veterans Affairs (VA) gave grants for counselors and psychologists and paid for internships for graduate students. With the combination of the George Barden Act and support from the VA, graduate training programs began defining their curriculum more clearly.

1.9 Counseling in The 1950s

Building on the major changes that occurred during the 1940s, the 1950s saw great changes and the professionalization of counseling. As mentioned previously, the counseling profession developed in the context of historical events. The 1950s were a time of great change with such historical events as the launch of Sputnik, the baby boom, the women's rights movement, and the civil rights movement. While these events were drastically changing the country, additional simultaneous events were occurring that changed the counseling profession. Specifically, these events were the passing of the National Defense Education Act (NDEA), professional developments, the introduction of new guidance and counseling theories, and the emergence of diverse marriage and family counseling theories.

The National Defense Education Act (NDEA) was initiated in response to Sputnik, a space satellite launched by the Soviet Union. The purpose of the NDEA was to promote studies in

math, science, and foreign languages. The NDEA sought to identify children with particular abilities in these academic areas. Although this was the original intent of NDEA, this act also provided funding for improving school counseling programs and for training counselors. This decade saw the greatest increase in the number of school counselors in a decade.

Concurrent to the growing numbers of counselors nationwide, the profession itself was growing and changing. 1952 saw (1) the establishment of the American Personnel and Guidance Association (APGA), (2) the establishment of Division 17, the Division of Counseling Psychology of the American Psychological Association, and (3) the founding of the American School Counselor Association (ASCA). A year after ASCA was founded, it became a division of the APGA.

Finally, the 1950s saw the emergence of many different theories. Prior to this time there were essentially four primary theoretical orientations: psychoanalysis, trait-factor theories, client-centered theories, and behavioral theories. Within these four primary orientations, practitioners worked with either nondirective or directive counseling, but during this time, new theories emerged, including cognitive theories, behavioral theories, learning theories, and career theories. Also, marriage and family therapy emerged to an even greater extent, and major theorists in the marriage and family therapy field, such as Gregory Bateson, Virginia Satir, Jay Haley, Murray Bowen, Carl Whitaker, and Salvador Minuchin were solidifying the marriage and family movement.

1.10 Counseling in The 1960s

In the 1960s, the baby boomers were growing up, and the conservatism of the 1950s was changing to reflect a new way of thinking, thus radically changing American culture. The civil rights movement saw sit-ins, protests, and assassinations. During this time, women were entering the workforce in greater numbers, and the National Organization of Women was exposing the “glass ceiling.” Also during this time, crime and drug use were increasing, and the United States was once again at war, this time in Vietnam. The societal changes of the times contributed to many changes in the counseling profession, in particular a solidification of the profession and a focus on the needs created by the societal changes during this time.

In 1963, the Community Mental Health Act was enacted. This act provided federal funding for community mental health centers and was pivotal in changing the dissemination of services for the mentally ill. It allowed for individuals who would formerly have been institutionalized to live in the community and receive mental health support and services. The Community Mental Health Act also provided funding for building new community mental health centers through the National Institute of Mental Health, thus providing additional support for the provision of community-based care. In addition to major developments in the care for the mentally ill, this act provided employment opportunities for counselors.

This decade also saw increased professionalism in the field of counseling. Specifically, the APGA published its first code of ethics, providing guidelines for ethical practice and ultimately protecting the public and increasing professionalism. Also during this time, an APGA report was edited that defined the role of and the training standards for school counselors. The American Psychological Association, Division 17, continued to clarify the definition of the counseling psychologist and published its first professional journal, The Counseling Psychologist.

Another influence of the government on the development of the counseling profession was the 1966 establishment of the Education Resources Information Clearinghouse (ERIC). Specifically related to the counseling profession was the ERIC section on Counseling and Personnel Services (ERIC/CAPS) at the University of Michigan. The ERIC was funded by the Office of Educational Research and Improvement through the U.S. Department of Education. The ERIC/CAPS provided a comprehensive resource on counseling activities and trends in the United States and internationally. In addition to the development of the database, conferences on counseling were sponsored, bringing together leaders in the profession.

In 1962, Gilbert Wrenn wrote a seminal piece that further defined the role of the school counselor. Specifically, Wrenn wrote that the school counselor should fill four functions: counsel students; consult with parents, teachers, and administrators; study the changing student population and interpret this information for administrators and teachers; and coordinate counseling services in the school and between the school and the community.

As the profession grew and training standards became more rigorous, the provision and regulation of quality services also increased. This decade saw considerable growth in the group

movement and a shift toward small group interaction and interpersonal growth and awareness. Other major influences on the profession during this time were the emergence of Maslow's humanistic counseling theory and of behavioral counseling, which emphasized learning as the root of change.

The counseling profession was paralleling the societal changes of the times. Specifically, counselors were being employed in more diverse settings, such as mental health centers and community agencies. Counselor training programs were also increasing in number, meaning that more counselors were competing for jobs as the programs graduated students. Along with the increased availability of training and more diverse employment opportunities, counselors were seeking and receiving specialized training. The term community counselor began to be used, paralleling the diversification of employment opportunities, with the new title implying a professional with diverse roles and responsibilities.

A pivotal movement in the counseling profession during this decade was for state and national licen-sure. Restrictions on counselors' ability to acquire psychology licensure led to this movement. The APGA started a task force to address licensure for counselors, and a benchmark for its success was the passing of successful licensure legislation in Virginia in 1976. Two additional states, Alabama and Arkansas, also had licensure legislation by the end of the decade.

1.11 Counseling in The 1970s

In the 1970s the profession became increasingly strong. Headquarters for the APGA were established in Alexandria, Virginia, and several strong divisions were chartered, including the Association of Counselor Education and Supervision (ACES), the American Mental Health Counseling Association (AMHCA), the Association for Religious and Value Issues in Counseling (now ASERVIC), the Association for Specialists in Group Work (ASGW), the Association for Non-White Concerns in Personnel and Guidance (ANWC), and the Public Offender Counselor Association. During this time, ACES published its first standards for master's degree programs in counseling, and it approved guidelines for doctoral education in counseling. As the profession became stronger, the APGA began questioning professional identity, as the personnel and guidance focus seemed increasingly outdated and narrow.

1.12 Counseling in The 1980s

The 1980s saw divorce rates increasing, violent crime increasing, and prisons overflowing. Drug use was considered an epidemic with the emergence of crack cocaine, and acquired immunodeficiency syndrome (AIDS) was claiming lives and demanding attention. The counseling profession continued to grow and to become a distinct profession, ultimately changing in response to divergent societal needs.

In 1981, the Council for Accreditation of Counseling and Related Education Programs (CACREP) was formed. CACREP revised the original standards developed by ACES in the 1970s. With those standards, they standardized counselor training (counselor education) programs for both master's and doctoral students in the areas of school, community, mental health, marriage and family counseling, and personnel services.

At the same time, the National Board for Certified Counselors (NBCC) was formed in 1983. The initial intent of the NBCC was to certify counselors on a national level. A large part of this process included developing a standardized test covering eight major subject areas: (1) human growth and development, (2) social and cultural foundations, (3) helping relationships, (4) groups, (5) lifestyle and career development, (6) appraisal, (7) research and evaluation, and (8) professional orientation. Passing the exam, meeting experiential and educational requirements, and character references allowed a person to earn the National Certified Counselor (NCC) credential. Accreditation and certification standards attracted many to the profession.

A conversation continued from the late 1970s became more prevalent during the 1980s, as leaders in the APGA recognized that "personnel and guidance" no longer fit in describing the work of the members. In response, the APGA was changed to the American Association for Counseling and Development (AACD). Professional identity and commitment was increasingly important to members of AACD. Representative of this commitment was the formation of Chi Sigma Iota, the academic and professional honors society for counselors. Chi Sigma Iota was formed by Thomas J. Sweeney to promote excellence in the counseling profession.

AACD saw an increase in membership and an increase in the number of divisions, highlighting the diversification in the counseling field. Throughout this decade, the focus on developmental

issues across the life span was led by developmental theorists such as Erik Erikson and Lawrence Kohlberg. A new division of the AACD, the Association for Multicultural Counseling and Development (AMCD) represented an increased focus on recognizing the challenges of counseling individuals from diverse ethnic and cultural backgrounds.

1.13 Counseling in The 1990s

The technology boom, low unemployment rates, and highly publicized violence (the Los Angeles riots, the World Trade Center bombing, the O. J. Simpson trial, the Oklahoma City bombing, and school shootings) marked the 1990s. During this time the counseling profession was continuing to define itself professionally, was demanding appropriate supervision in response to the diverse needs of counseling consumers, and was dealing with restricted funding. Two primary influences in the 1990s, in addition to advances in technology, were managed care and an increase in accountability.

In 1992, the AACD instituted another name change, this time to the American Counseling Association (ACA). Also in 1992, counseling was included in the healthcare human resource statistics compiled by the Center for Mental Health Services and the National Institute of Mental Health, marking counseling as a primary mental health profession. A final key event that occurred in 1992 was the writing of multicultural counseling standards and competencies by Derald Wing Sue, Patricia Arredondo, and Roderick McDavis.

Finally, during this time there was a return to emphasizing counseling the whole person; this meant counselors took into consideration the importance of societal influences and the context of a client's life, such as his or her spirituality, family, and occupation. Organizations established in the 1970s and 1980s such as CACREP, Chi Sigma Iota, and NBCC experienced continued growth during this time, more states were passing licensure legislation for counselors, and both ACA and APA were publishing articles and books on counseling.

1.14 Terminologies

1. Slums: Unsafe informal settlements.
2. Retarded: Children with learning difficulties.

1.15 Activity

3. Discuss the history of counselling.
4. Analyze the contribution to Alfred Adler and Viktor Frankl to the development of counselling.

1.16 Reflection

What do you think is the difference between counselling and guidance?

1.17 Summary

In this unit, you have learnt about the history of counselling. You have learnt that counselling emerged in the early 20th century, when humanistic reforms with an increasing emphasis on the value of human beings was also emerging. You have also learnt about the contributions of scholars, such as John Dewey, Sigmund Freud, Alfred Adler, and Viktor Frankl to the development of counselling. In the next unit, you will be learning about different theories of counselling.

UNIT 2: ADLERIAN THERAPY

2.1 Introduction

Adlerian therapy is a type of psychoanalysis which broke free from the Freudian school at the beginning of the 20th century. The key belief of Adlerian therapy is that the humans are social beings and actions are driven by social forces. Under Adlerian theory, no one is "sick" with a psychological disorder. Rather, patients are stuck in pathology and they are encouraged to move forward. The role of the therapist in Adlerian therapy is to encourage an optimistic mentality to promote change.

2.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss the history of Adlerian therapy.
- analyse the key concepts of Adlerian therapy.
- discuss the stages of Adlerian therapy.

2.3 Time frame

You need about two (2) hours per week to interact with this material.

2.4 Content

- Brief history of Adlerian therapy
- Key Ideas of Adlerian Therapy
- Goal of Adlerian Therapy
- The role of the therapist
- Process of Adlerian therapy
- Four Stages of Adlerian Therapy
- Subjective Perception of Reality
- Social Interest and Community Feeling
- Birth Order and Sibling Relationships
- Therapeutic Process
- Adlerian Therapy from A Multicultural Perspective
- Adlerian Psychology: 8 Basic Principles

2.5 Brief history of Adlerian therapy

Alfred Adler is one of the three major contributors to psychodynamic therapies. He began his work with Sigmund Freud as part of the psychoanalytic movement. However, Adler disagreed with Freud's principles in many ways. He did not think that human behaviour and personality could be completely summed up as biological. Rather, he believed that social aspects and personal goals were of much more importance.

In 1912, Adler formed the Society for Individual Psychology. Under his method of individual psychology, the uniqueness of the person was stressed as well as the holism of the personality. Adler did not prove as influential as Freud or Jung to psychotherapy. However, his methods are still commonly used today and his concept of the inferiority complex is readily recognized.

2.7 Key Ideas of Adlerian Therapy

- The idea that people are naturally social beings is a key belief of the Adlerian approach.

The key beliefs of the Adlerian approach are:

- Humans are social beings
- Humans are motivated by desires to find one's place in society and belong
- Holism – the idea that the personality is complete and indivisible
- Humans are naturally creative, active, and decisional
- Human nature is driven by an unknown creative force to better oneself
- Adler believed that all people formed an individualized approach to life in the first six years of life. Like Freud, Alder believed that perceptions of the past could have lasting influences and that we may not always be conscious of how these perceptions are influencing us. However, Alder was distinctly different than Freud in theory. Adler believed that human nature was driven mostly by social aspects rather than sexual urges. He also believed that all actions were goal oriented in an attempt to better oneself. Under the Adlerian idea of the inferiority complex, all humans feel inferior at birth and then constantly struggle to overcome these feelings throughout life. This is the driving force which causes us to excel.

While Adler believed in the importance of the unconscious, he believed that the conscious was much more important and stressed it during therapy. Thus, Alder stressed therapy which set goals and stressed the importance of successes, choices and responsibilities.

Under Adlerian theory, patients are not sick with a mental illness. Rather, they are viewed as being discouraged and suffering from mistaken ideas about self.

2.8 Goal of Adlerian Therapy

The goal of Adlerian therapy is for the patient to realize his or her mistaken views about self. The patient is then encouraged to think about his/her unique lifestyle and then find ways to incorporate this lifestyle in the social world.

2.9 The role of the therapist

Adlerian therapy depends on a collaborative arrangement between the therapist and the patient. It is important that the patient trusts and respects the therapist and vice versa. It is very important for the therapist to be optimistic throughout the process. When patients present themselves for treatment, they often feel hopeless about their situation. The therapist will encourage ideas that humans are constantly changing beings who strive for perfection. Thus, change can occur.

2.10 Process of Adlerian therapy

Adlerian therapy typically begins with an assessment of the patient which involves interview questions about family and childhood memories. It is common for patients to fill out in-depth questionnaires. The therapist will help identify how family dynamics have influenced the patient's sense of self and the world. Through assessment of personal history, the therapist will help the patient realize where "mistakes" have been made in regards to self and world perception.

In Adlerian psychology, change is sought on multiple levels, including to:

- Views of self/world, belief systems, values, and goals
- Structures of family/relationship dynamics
- Social interest, emotions, and participation
- Behaviours and social skills
- Use of power
- Motivation

There is no set method for invoking these changes. Therapists can use a wide variety of methods which are individualized for the needs of the patient.

2.11 What is Adlerian therapy most effective for treating?

Adlerian principles can be applied to treat all forms of psychological disorders. However, it is especially effective in treating childhood developmental or behavioural problems. Because Adlerian therapy focuses on the goal-oriented nature of humans and the belief that humans are born feeling inferior, it can be useful in treating personality disorders which are linked to feelings of inferiority, such as social anxiety.

2.12 The Stages of Adlerian Therapy

Individual therapy, or Adlerian therapy, is an approach in which a therapist works with a client to identify obstacles and create effective strategies for working towards their goals. Adlerians believe that, by gaining insight into challenges, people can overcome *feelings of inferiority*. Moreover, Adlerians believe that people are most fulfilled when they are working towards the *social interest*; that is, when they are doing things that are beneficial for society as a whole.

2.13 Key Takeaways: Adlerian Therapy

- Adlerian therapy, also known as individual therapy, emphasizes the individual's ability to bring about positive change in his or her own life.
- Adlerian therapy consists of four stages: engagement, assessment, insight, and reorientation.
- In Adler's theory, individuals work to overcome feelings of inferiority and to act in ways that benefit the social interest.

2.14 Four Stages of Adlerian Therapy

In Adler's approach to therapy, termed *individual psychology* or *Adlerian psychology*, therapy progresses through a series of four stages:

1. **Engagement.** The client and therapist begin to establish the therapeutic relationship. The relationship should consist of collaboration towards addressing the client's problems. The therapist should offer support and encouragement.

2. **Assessment.** The therapist works to learn more about the client's background, including early memories and family dynamics. In this part of therapy, the therapist attempts to understand how the client may have developed certain styles of thinking that are no longer helpful or adaptive for them.
3. **Insight.** The therapist offers an interpretation of the client's situation. The therapist suggests theories about how past experiences may have contributed to issues the client is currently experiencing; importantly, the therapist leaves it up to the client to decide whether these theories are accurate and useful.
4. **Reorientation.** The therapist helps the client to develop new strategies that the client can use in daily life.

2.15 Feelings of Inferiority

One of Adler's most well-known ideas is that everyone experiences *feelings of inferiority* (i.e. worries that one is not achieving enough). Among psychologically healthy individuals, these feelings of inferiority encourage the pursuit of goals, providing motivation to strive towards self-improvement. In other words, by developing positive ways of coping with feelings of inferiority, individuals can end up achieving great things and making a positive contribution to society as a whole.

However, some individuals have difficulty coping with feelings of inferiority, which leads them to feel discouraged. Other individuals may cope with feelings of inferiority in unproductive ways, like behaving selfishly in order to feel superior to others. In Adlerian therapy, the therapist works to provide the client the support and encouragement they need in order to cope more effectively with feelings of inferiority and to develop healthy ways of overcoming these feelings.

2.16 Social Interest

One of Adler's other key ideas was the concept of the *social interest*. According to this idea, people are at their best—their psychologically healthiest and most fulfilled—when they act in ways that benefit society. For example, a person high in social interest might go out of their way to help others, while a person with lower levels of social interest may bully others or act in antisocial ways. Importantly, levels of social interest can change over time. A therapist can help their client increase his or her levels of social interest.

2.16 View of Human Nature

Adler abandoned Freud's basic theories because he believed Freud was excessively narrow in his stress on biological and instinctual determination. Adler stressed the unity of personality, contending that people can only be understood as integrated and complete beings. He emphasized that where we are striving to go is more important than where we have come from. Adler believed that people develop a unique style of living that is a movement toward and an expression of their selected goals. In this sense, we create ourselves rather than merely being shaped by our childhood experiences.

Adler holds that the individual begins to form an approach to life somewhere in the first 6 years of living. According to Adler, humans are motivated primarily by social-relatedness rather than by sexual urges; behavior is purposeful and goal-directed; and consciousness more than unconsciousness is the focus of therapy. Unlike Freud, Adler stresses choice and responsibility, meaning in life, and the striving for success, completion and perfection.

Adler's theory focuses on inferiority feelings. He sees these as a normal condition for all people and as a sources of all human striving. Feelings of inferiority can be the wellspring of creativity rather than being considered a sign of weakness or abnormality. They motivate us to strive for mastery, success (superiority) and completion.

According to Adler, at around 6 years of age our fictional vision of ourselves as perfect or complete begins to form into a life goal. The life goal unifies the personality and becomes the source of human motivation; every striving and every effort to overcome inferiority is no in line with this goal.

According to Adler, human behavior is not determined solely by heredity and environment. Instead, we have the capacity to interpret, influence, and create events. Adler asserts that what we were born with is not as important as what we choose to do with the abilities and limitations we possess. Adlerians, however, do not go to the other extreme and maintain that individuals can become whatever they want to be.

The focus of Adlerians is on reeducating individuals and reshaping society. Adler was the forerunner of a subjective approach to psychology that focuses on internal determinants of behavior such as values, beliefs, attitudes, goals, interests, and the individual perception of reality. Adler was also the first systemic therapist, in that he maintained that it is essential to understand people within the system of which they are a part.

2.18 Subjective Perception of Reality:

Adlerians attempt to view the world from the client's subjective frame of reference. This orientation or frame of reference is described as phenomenological. The phenomenological orientation pays attention to the individual ways in which people perceive their world. This "subjective reality" includes the individual's perceptions, thoughts, feelings, values, beliefs, convictions, and conclusions. Behavior is understood from the vantage point of the subjective. Objective reality is less important than how we interpret reality and the meanings we attach to what we experience. Many contemporary theories have incorporated this notion of the client's subjective worldview as a basic factor explaining behavior.

Unity and Patterns of Human Personality:

A basic premise of Adlerian Individual Psychology is that personality can only be understood holistically and systemically. The individual is seen as an indivisible whole, born, reared, and living in specific familial, social, and cultural contexts. People are social, creative, decision-making beings who act with purpose and cannot be fully known outside the contexts that have meaning in their lives.

- Behavior as Purposeful and Goal-Oriented: All Human behavior has a purpose. Humans set goals for themselves, and behavior becomes unified in the context of these goals. The concept of the purposeful nature of behavior is perhaps the cornerstone of Adler's theory.

A basic assumption of Individual Psychology is that we can only think, feel, and act in relation to our perception of our goal. Therefore, we can be fully understood only in light of knowing the purposes and goals toward which we are striving. Decisions are based on the person's experiences, on the present situation, and on the direction in which the person is moving. Continuity is looked for by paying attention to themes running through a person's life.

The term fictional finalism refers to an imagined central goal that guides a person's behavior. Adler ceased using this term and replaced it with "guiding self-ideal" and "goal of perfection" to account for our striving toward superiority or perfection. The guiding self-ideal represents an individual's image of a goal of perfection for which he or she strives in any given situation. We have the creative power to choose what we will accept as truth, how we will behave and how we will interpret events because of our subjective final goal.

- Striving for Significance and Superiority: Adler stresses that striving for perfection and coping with inferiority by seeking mastery are innate. These ideas are called basic inferiority and compensation. From our earliest years, we recognize that we are helpless in many ways, which is characterized by feelings of inferiority. The moment we experience inferiority we are pulled by the striving for superiority. Adler maintains that the goal of success pulls people forward toward mastery and enables them to overcome obstacles. The goal of superiority contributes to the development of human community. "Superiority" refers to moving from a perceived lower position to a perceived higher position. People cope with feelings of helplessness by striving for competence, mastery, and perfection. The unique ways in which people develop a style of striving for competence is what constitutes individuality. The way in which Adler reacted to his childhood and adolescent experiences made him a living example of this aspect of his theory.
- Lifestyle: An individual's core beliefs and assumptions through which the person organizes his or her reality and finds meaning in life events constitutes the individual's lifestyle (or "plan of life, style of life, life movement, strategy for living, or road map"). Lifestyle is the connecting theme that unifies all our actions and our lifestyle consists of all our values and perceptions regarding self, others, and life. It is the characteristic way we move toward our life goal. This concept accounts for why all of our behaviors fit together to provide consistency to our actions. Understanding one's lifestyle is somewhat like understanding the style of a composer. Although events in the environment influence the development of personality, such events are not the causes of what people become.

In striving for the goal of superiority, Adlerians believe some individuals develop their intellect; others, their artistic talent; others, athletic skills; and so on. These styles of life consist of people's views about themselves and the world and their distinctive behaviors and habits as they pursue personal goals. Experiences within the family and relationships between siblings contribute to development of this self-consistent way of perceiving, thinking, feeling, and behaving.

Our unique style is created primarily during the first 6 years of life, however, subsequent events may have a profound effect on the development of our personality. Experiences themselves are not the decisive factors; rather, it is our interpretation of these events that shape

personality. Faulty interpretations may lead to mistaken notions in our private logic, which will significantly influence present behavior.

2.19 Social Interest and Community Feeling:

Social interest and community feeling are probably Adler's most significant and distinctive concepts. These terms refer to individuals' awareness of being part of the human community and to individual's attitudes in dealing with the social world.

Social interest includes striving for a better future for humanity. The socialization process involves finding a place in society and acquiring a sense of belonging and of contributing. Adler equated social interest with a sense of identification and empathy with others. Social interest is the central indicator of mental health according to Adler. Those with social interest tend to direct the striving toward the healthy and socially useful side of life. As social interest develops, feelings of inferiority and alienation diminish.

A central belief of Individual Psychology is that our happiness and success are largely related to our social connectedness. Those who lack community feeling become discouraged and end up on the useless side of life. We seek a place in the family and in society to fulfill basic needs for security, acceptance, and worthiness. Many of the problems we experience are related to the fear of not being accepted by the groups we value. If our sense of belonging is not fulfilled, anxiety is the result.

2.20 Birth Order and Sibling Relationships:

Adler is unique in giving special attention to the relationships between siblings and the psychological birth position in one's family. Actual birth order itself is less important than the individual's interpretation of his or her place in the family.) Birth order and the interpretation of one's position in the family have a great deal to do with how adults interact in the world. Individuals acquire a certain style of relating to others in childhood and form a definite picture of themselves that they carry into their adult interactions. In Adlerian therapy, working with family dynamics – especially relationships among siblings, assumes a key role. He identified five psychological positions:

1. The oldest child – somewhat spoiled as the center of the attention. Depends to be dependable and hard working. Strives to keep ahead. When a newcomer to the family arrives – seen as an intruder who will rob them of the love they are accustomed to receiving.
2. The second child – from the time of birth shares the attention with another child. Behaves as if they were in a race and is generally under full steam at all times. The competitive

struggle between the first two children influence the later course of their lives. The second-born is often opposite to the first-born.

3. The middle child – often feels squeezed out. May become convinced of the unfairness of life and feel cheated. May develop a "poor me" attitude and can become a problem child. In families characterized by conflict, the middle child may become the switchboard and the peacemaker, the person who holds things together. If there are four children in a family, the second child will often feel like a middle child and the third will be more easygoing, more social, and may align with the firstborn.

4. The youngest child – always the baby of the family. Tends to be the most pampered one. Youngest children tend to go their own way. They often develop in ways no others in the family have thought about.

5. The only child – shares some of the characteristics of the oldest child (high achievement drive). May not learn to share or cooperate with other children. Will learn to deal with adults well. May become dependently tied to one or both of them. May want the center stage all of the time, and if their position is challenged will feel it is unfair.

2.21 Therapeutic Process

Therapeutic Goals:

Adlerian counseling rests on a collaborative arrangement between the client and the counselor. This includes forming a relationship based on mutual respect and identifying, exploring, and disclosing mistaken goals and faulty assumptions within the person's style of living. This is followed by a reeducation of the client toward the useful side of life. The main aim of therapy is to develop the client's sense of belonging and to assist in the adoption of behaviors and processes characterized by community feeling and social interest. This is accomplished by increasing the client's self-awareness and challenging and modifying their fundamental premises, life goals, and basic concepts.

Adlerians do not see clients as being "sick" and in need of being "cured." Adlerians assume a nonpathological perspective and thus do not label clients by their diagnoses. Instead of using a medical model to understand their clients, they assume a broader perspective based on a growth model.

They view clients as discouraged. Symptoms are attempted solutions. The counseling process focuses on providing information, teaching, guiding, and offering encouragement to discouraged clients. Encouragement is the most powerful method available for changing a

person's beliefs and stimulating courage. Courage is the willingness to act even when fearful in ways that are consistent with social interest. Without fear there would be no need for courage. The loss of courage, or discouragement, results in mistaken and dysfunctional behavior. The counselor provides clients with a new "cognitive map," which is a fundamental understanding of the purpose of their behavior.

2.22 Adlerian Therapy from A Multicultural Perspective

Adler introduced notions with implications toward multiculturalism that have as much or more relevance today as they did during Adler's time. Adlerian therapists tend to focus on cooperation and socially oriented values as opposed to competitive and individualist values. For example, Native American clients tend to value cooperation over competition. Adlerian therapy is easily adaptable to cultural values that emphasize community. Adler was one of the first psychologists at the turn of the century to advocate equality for women.

Limitations: The Adlerian approach tends to focus on the self as the locus of change and responsibility. This primary emphasis on changing the autonomous self may be problematic for some clients. Many clients who have pressing problems are likely to resent intrusions into areas of their lives that they may not see as connected to the struggles that bring them into therapy. Members of some cultures may believe it is inappropriate to reveal family information.

Contributions of the Adlerian Approach: Flexibility and its integrative nature. Adlerian therapists can be both theoretically integrative and technically eclectic. The Adlerian therapy approach tends to lend itself to short-term formats. One of Adler's most important contribution is his influence on other therapy systems. Many of his basic ideas have found their way into other psychological schools: family systems approaches, Gestalt therapy, learning theory, reality therapy, rational emotive behavior therapy, cognitive therapy, person-centered therapy, existential therapy, and the post-modern approaches to therapy.

Limitations and Criticisms: A large part of the theory still requires empirical testing and comparative analysis. Adlerian theory is of limited use for clients seeking immediate solutions to their problems and for clients who have little interest in exploring early childhood experiences and memories.

2.23 Adlerian Psychology: 8 Basic Principle

What basic principles of Adlerian-Psychology should be accepted by every Adlerian? Before we can answer this question we have to clarify: what is Adlerian Psychology? It is a science

developed by Adler which attempts to understand and explain human behaviour. Not all psychologists try to do this. As a student of psychology, on might be interested in testing or measuring, in animal experimentation in perfecting description of psychoses for the purpose of diagnosing mental illness. All of these approaches will not make you an Adlerian or exclude you from being one.

Adlerian Psychology is interpretative; it is an endeavour to understand human behaviour. There are other psychologies which, like that of Adler, are dynamic, depth psychologies. Principal among these ar the systems of Freud and Jung. However, Adler has developed his science in a direction essentially different from that of Freud and Jung Some of his principles are not exclusive to his psychology nor are they original with Adler. Similar ideas, in some instances, have been expressed either in philosophy centuries ago or even in psychology shortly before the publication of his chief works.

It is rather the totality of Adler's principles, woven together into a workable system, which give a key to the understanding of human behaviour and the possibility of altering it. This is his great contribution, and it is the acceptance of this system in totality which makes an Adlerian.

In all fields where human behaviour, either individually or in group is studied, as in psychology, anthropology, sociology, criminology psychiatry, or where efforts are made to alter behaviour, as in education or psychotherapy, his system is applicable. All principles of his system are interdependent; therefore, the following enumeration of such principles in numerical order is by necessity artificial.

1. Life is directed movement. The moving force is the desire for survival, the goal is security. Life may be interpreted as a movement to compensate for inferiority feelings, as if one wanted to reach a point above from below, where one would be freed from all inferiority feelings.

2. The goal of security determines all our actions, but the concept of security differs in all individuals. This concept of security, or success, is formed in the early years of childhood, about the first five year of age, in accordance with the early experiences in the limited environment of the child.

It is then that the child forms his life plan or life pattern, which is a plan - his own unique creation - for getting along in such a world as he sees and has come to know. He sets his goal, which is his concept of security; he devises methods, choosing some and discarding others. It short, he develops his life style, which is his way of relating himself to life.

His goal of security naturally can never be reached; it is not known to him consciously and could not be expressed by him verbally. This goal determines all expressions of his personality, his actions, feelings words, dreams, what he forgets, and what he remembers.

3. All behaviour is purposeful; we are not driven by a cause, but drawn by our goal, which, however, we were free to set in our childhood. Once the goal is set we are determined by it in all our action' as if "caught in an iron shirt."

4. Adler calls his psychology "Individual Psychology," according to the Latin individere, "do not divide." The organism-as-a-whole acts and reacts always in totality, never only through one of its parts.

5. An individual's behaviour can only be understood in relation to society. Here, his specific unique concept of security causes him to develop either cooperative or other methods in his effort to achieve success, based on his fictitious "private logic." Adler found that early recollections and dreams have a specific meaning to the individual and fit into his purposeful pattern of behaviour.

6. Adler came to his discoveries from the observation of "abnormal behaviour." Thus he found a new approach to psychopathology. Abnormal behaviour, criminal actions, problem children, prostitution, sexual pathology, can be understood by the application of the above mentioned general principles.

7. Furthermore, an Adlerian also believes in the possibility of altering behaviour; this alteration can be achieved by scientific methods developed by Adler. An Alderian applies specific methods of education or psychotherapy in his respective field as teacher, parent, physician etc., based on a framework of general principles. They are essentially an attempt to recognize the goal of the individual, his life plan, the methods he uses to relate himself to life, and to give this knowledge to him. This understanding provides "insight. It is an essentially

Adlerian approach to encourage in order to change the patient's misconceptions of life which he formed in his early childhood. This enables him to give up his efforts to secure himself according to his private concepts and to accept a cooperative goal. Then he can learn to use cooperative methods. Adlerian therapy helps him develop his social feeling which we all have at birth but which, according to Adler, has to be developed.

8. An Adlerian is one who accepts Adler's principles of psychology of psychopathology, and uses his methods, applying his science in all fields of life for the welfare of the people.

2.24 Terminologies

1. Pathology: the study of essential nature diseases and especially of the structure and functional changes produced by them.
2. Perception: interpretation of sensory information.

2.25 Activity

1. Discuss the basic ideas of Adlerian therapy.
2. Discuss the stages of Adlerian therapy.

2.26 Reflection

What are the stages of Adlerian therapy?

2.27 Summary

In this unit, the history, key ideas of the Adlerian therapy, goals of the Adlerian therapy and the role of the therapist in Adlerian therapy have been clearly explained. You have also learnt about the four stages of Adlerian therapy namely; Engagement, Assessment, Insight and Reorientation it is hoped that with the knowledge you have acquired in this unit, you are now able to counsel someone using Adlerian therapy. In the next unit, you will learn about the Reality Therapy.

UNIT 3: REALITY THERAPY

3.1 Introduction

Reality therapy, developed by Dr. William Glasser in 1965, is founded on the principles of choice theory and has developed into a widely recognized form of therapy. Parents as well as many professionals in the fields of education, mental health, and social services have embraced the fundamentals of this therapy, which suggests that all human issues occur when one or more of five basic psychological needs are not met and that an individual can only control their own behavior. Glasser believed that when someone chooses to change their own behavior rather than attempting to change someone else's, they will be more successful at attaining their own goals and desires.

3.2 Learning Outcomes

By the end of this unit, you will be able to;

- discuss the basic Psychological need of human beings according to William Glasser.
- analyze the overview of the therapeutic process of Reality Therapy.
- discuss key concepts of the reality theory.
- discuss the limitation of the reality therapy.

3.3 Time frame

You need about two (2) hours per week to interact with this material.

3.4 Content

- Understanding Reality Therapy
- Overview of The Therapeutic Process
- Role of The Therapist in Reality Therapy
- Application of Reality Therapy
- Concerns and Limitations of Reality Therapy
- The Benefits of Reality Therapy
- Conditions/Disorders Reality Therapy Treats
- Key Concepts of reality theory
- Therapeutic Goals
- Techniques

3.5 Understanding Reality Therapy

The current issues affecting a person seeking treatment rather than the issues the person has experienced in the past, and it encourages that person to use therapy to address any behavior that may prevent them from finding a solution to those issues. This type of therapy encourages problem solving and is based on the idea that people experience mental distress when their basic psychological needs have not been met. These needs are:

- Power: A sense of winning, achieving, or a sense of self-worth.
- Love and belonging: To family, to a community, or to other loved ones.
- Freedom: To be independent, maintain personal space, autonomy.
- Fun: To achieve satisfaction, enjoyment, and a sense of pleasure.
- Survival: Basic needs of shelter, survival, food, sexual fulfillment.

The fact that everyone is constantly striving to meet these basic needs is at the heart of reality therapy. When a person feels bad, reality therapists maintain it is because one of the five needs have not been fulfilled. People participating in reality therapy might learn ways to be more aware of any negative thoughts and actions possibly preventing them from meeting their needs, as according to the tenets of reality therapy, changing one's actions may have a positive effect on the way that individual feels and on their ability to attain their desires. These changes ideally take place through the use of Glasser's choice theory, which uses questions such as "What are you doing/What can you do to achieve your goals?"

3.6 Overview of The Therapeutic Process

In reality therapy, the therapist might begin the therapeutic process by guiding a person's attention away from past behaviors in order to focus on those that occur in the present. Present needs are what are relevant, as they are the needs that can be satisfied. Reality therapists also tend to not focus on a person's symptoms, as Glasser believed symptoms of mental distress manifest as a result of a person’s disconnection from others.

Individuals who enter reality therapy generally have a specific issue of concern, and the therapist may ask them to consider the effects their behavior has on that area, helping that person focus on things they can actually change rather than things beyond their control. In reality therapy, the focal point is what the person in therapy can control. By understanding one's own needs and desires and developing a plan to meet those needs while refraining from

criticizing or blaming others, reality therapists believe that a person may be able to form, reform, or strengthen connections with others.

3.7 Role of The Therapist in Reality Therapy

Because reality therapy seeks to treat individuals who experience difficulty in their relationships with others, forming a connection with the therapist is an important beginning in reality therapy. This connection is considered by reality therapists to be the most important dynamic in facilitating healing. Once this relationship is stable, it can be used as a model to form fulfilling connections outside of the therapeutic environment.

Those in therapy can learn how to best strengthen relationships outside of therapy while in the "safe" therapeutic relationship and as a result, be able to more easily expand on those methods in daily life. Reality therapists hold that when a person in therapy can employ the behaviors, actions, and methods developed through therapy in life successfully, they will often be able to improve external relationships and experience a more fulfilling life.

3.8 Application of Reality Therapy

Reality therapy is considered an effective therapeutic strategy for addressing many issues, but it can be especially valuable in treating difficulties faced by children and young adults at school and in their communities.

Research has shown improvements in overall classroom functioning, cooperation, and a decrease in challenging behaviors when teachers and school counselors are adequately trained in reality therapy. Studies have also indicated that reality therapy is useful when applied to certain issues with behavioral components, including teen pregnancy. Reality therapy works from the perspective that people must assume responsibility for their behavior if they wish to change it.

Reality therapy has also been effective in the broader community, such as when integrated into athletic coaching and in work with juvenile offenders, to facilitate behavioral change. This form of therapy can help bridge the gap between intolerance and ignorance through education and equality, often resulting in a more unified group.

3.9 Concerns and Limitations of Reality Therapy

Findings show that reality therapy has been applied with positive results in schools for problems concerning behavior. However, little long-term research on the effectiveness of this approach in school populations has been conducted. These studies are also limited due to the lack of experimental control in areas such as sample size and training of teachers, as well as questions concerning voluntary participation.

While reality therapy has been found to reduce issues with misbehavior of target groups in schools, findings are limited regarding its capacity for improving the personal experiences of youth, their self-esteem, and self-concept. These findings suggest that reality therapy is effective in addressing symptomatic behavioral issues but not underlying causes and reasons for the behavior.

The goal of reality therapy is to solve problems, rebuild connections and begin working toward a better future. The therapist works with the patient to figure out what they want and how their current behaviors are bringing them closer (or farther) from their goals.

3.10 The Benefits of Reality Therapy

Reality therapy is a highly effective way to solve problems and set and achieve goals. With an emphasis on changing thoughts and actions, reality therapy empowers individuals to improve the present and future. As the patient begins to experience small successes their confidence improves, allowing for more advanced goal-setting and problem-solving.

3.11 What Conditions/Disorders Does Reality Therapy Treat?

Because reality therapy focuses on problem-solving, it can be effective for a variety of mental health disorders, including addiction and eating disorders. It is particularly useful for at-risk or resistant teens struggling with substance abuse, defiance, manipulation, and other emotional and behavioral issues.

3. 12 Key Concepts of reality theory

Guided by concepts of control theory

1. Teach better alternatives of getting wants and needs met.
2. Teach client that he doesn't have to be a victim of past events over which he had no

control.

3. Help client understand the options available for change.

4. Defocus on symptoms such as depression.

5. Suggest client read Glassers book on control theory and discuss and apply to everyday life.

6. Question "Is what you are doing now getting you where you want to be?" Make plans for future.

7. Encourage client to do things, experience success.

*Quality world- The mental file of wants that we build at the core of our life.

*Picture album- The internal storage of wants and ways to satisfy those wants.

*Total behavior- All behavior is made up of acting, thinking, feeling, and physiology.

*Reality therapy emphasizes choice and responsibility, rejects transference, keeps the therapy in the present, avoids focusing on symptoms, and challenges traditional views of mental illness.

3.13 Therapeutic Goals:

*Help clients connect or reconnect with people they want in their quality world.

*"Reality therapists teach clients how to engage in self-evaluation, which is done by raising the question, 'Is what you are choosing to do getting you what you want and need?'" (Corey p. 341).

3.14 Techniques:

*Reality therapy is best viewed as a cycle of counseling with two main components:

1. creating a counseling environment and

2. implementing specific procedures that lead to changes in behavior.

*"WDEP" system- W=wants, needs, and perceptions; D=direction and doing; E=self-evaluation; and P=planning.

*Self-evaluation is the cornerstone of reality therapy.

3.15 Terminology

- Therapeutic process: aspects of interaction in treatment between a various of therapy professionals and their clients.

3.16 Activity

1. Discuss the key concepts of the reality therapy.
2. Explain the basic psychological needs of human being according to William Glasser.

3.17 Reflection

Do you think the psychological needs advanced by William Glasser are exhaustive?

3.18 Summary

In this unit, you have learnt about William Glasser Psychological needs. The overview of the therapeutic process of reality and the limitations of the reality therapy. You have also learnt about the role of the therapist in the reality therapy and how the reality therapy is applied in counselling. In the next unit, you are going to learn about Carl Rogers person - centred approach.

UNIT 4: PERSON-CENTRED THERAPY

4.1 Introduction

Person-cantered therapy uses a non-authoritative approach that allows clients to take more of a lead in discussions so that, in the process, they will discover their own solutions. The therapist acts as a compassionate facilitator, listening without judgment and acknowledging the client's experience without moving the conversation in another direction. The therapist is there to encourage and support the client and to guide the therapeutic process without interrupting or interfering with the client's process of self-discovery.

4.2 Learning Outcomes

By the end of this unit, you are expected to;

- analyze the three conditions necessary in counselling.
- discuss Rogerian Approach to psychotherapy.
- explain goals of client centred therapy.
- discuss client centred techniques.

4.3 Time frame

You need about three (3) hours per week to interact with this material.

4.4 Content

- Carl Rogers' Person-Centred Approach
- The Rogerian Approach to Psychotherapy
- Goals of Client-Centred Therapy
- Client-Centred Therapy Method and Techniques

4.5 Carl Rogers' Person-Centred Approach

4.5.1 When It's Used

Anyone who would be better off gaining more self-confidence, a stronger sense of identity, and the ability to build healthy interpersonal relationships and to trust his or her own decisions could benefit from person-centred therapy. This approach, alone or in combination with other types of therapy, can also be helpful for those who suffer from grief, depression, anxiety, stress, abuse, or other mental health conditions. Person-centred therapists work with

both individuals and groups. Since the client must do a lot of the work in person-centred therapy, those who are more motivated are likely to be more successful.

4.5.2 What to Expect

Person-centred therapy is talk therapy wherein the client does most of the talking. Your therapist will not judge or try to interpret what you say, but may restate your words in an attempt to fully understand your thoughts and feelings. When you hear your own words repeated back to you, you may then wish to self-edit and clarify your meaning. This may happen several times until you decide that you have expressed exactly what you are thinking and how you feel. There may be moments of silence to allow your thoughts to sink in. This client-focused process facilitates your self-discovery, self-acceptance, and a provides a means toward healing and positive growth.

4.5.3 How It Works

Person-centred therapy, also known as Rogerian therapy, originated in the work of the American psychologist, Carl Rogers, who believed that everyone is different and, therefore, everyone's view of his or her own world, and ability to manage it, should be trusted. Rogers believed that all of us have the power to find the best solutions for ourselves and make appropriate changes in our lives. Person-centred therapy was a movement away from the therapist's traditional role—as an expert and leader—toward a process that allows clients to use their own understanding of their experiences as a platform for healing. The success of person-centred therapy relies on three conditions:

Unconditional positive regard, which means therapists must be empathetic and non-judgmental to convey their feelings of understanding, trust, and confidence that encourage their clients to make their own decisions and choices

Empathetic understanding, which means therapists completely understand and accept their clients' thoughts and feelings

Congruence, which means therapists carry no air of authority or professional superiority but, instead, present a true and accessible self that clients can see is honest and transparent.

4.5.4 What to Look for in a Person-Centred Therapist

Licensed mental health professionals from a variety of disciplines who have training and experience in the Rogerian approach can use person-centred interventions in therapy. In

addition to finding someone with the educational background and relevant experience, look for a therapist or counsellor who is especially empathetic and with whom you feel comfortable discussing personal issues.

This term seems redundant now, but when it was first developed, it was a novel idea.

Before the humanistic therapies were introduced in the 1950s, the only real forms of therapy available were behavioural or psychodynamic (McLeod, 2015). These approaches focused on the subconscious or unconscious experience of clients rather than what is "on the surface."

Many of today's popular forms of therapy are more client-centred than the psychotherapy of the early 20th century, but there is still a specific form of therapy that is set apart from others due to its focus on the client and aversion to giving the client any type of direction.

"He who knows others is wise; he who knows himself is enlightened." – Lao Tzu

So, how does this Lao Tzu quote apply to client-centred therapy? Read on to learn about how knowing one's self and others is key to the person-centred approach.

4.6 The Rogerian Approach to Psychotherapy

Rogers' approach to therapy was a simpler one than the earlier approaches in some ways. Instead of requiring a therapist to dig deep into their patients' unconscious mind, an inherently subjective process littered with room for error, he based his approach on the idea that perhaps the client's conscious mind was a better focus.

In Rogers' own words:

"It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely upon the client for the direction of movement in the process." – Carl Rogers

This approach marked a significant shift from the distant, hierarchical relationship between psychiatrist and patient of psychoanalysis and other early forms of therapy. No longer was the standard model of therapy one expert and one layman – now, the model included one expert in the theories and techniques of therapy, and one expert in the experience of the client (the client themselves!).

Rogers believed that every individual was unique and that a one-size-fits-all process would not, in fact, fit all. Instead of considering the client's own thoughts, wishes, and beliefs as secondary to the therapeutic process, Rogers saw the client's own experience as the most vital factor in the process.

Most of our current forms of therapy are based on this idea that we take for granted today: the client is a partner in the therapeutic relationship rather than a helpless patient, and their experiences hold the key to personal growth and development as a unique individual.

In addition to this client-focused approach, Rogerian psychotherapy is also distinct from some other therapies in its assumption that every person can benefit from client-centred therapy and transform from a "potentially competent individual" to a fully competent one (McLeod, 2015).

Rogers' approach views people as fully autonomous individuals who are capable of putting in the effort required to realize their full potential and bring about positive changes in their lives.

4.7 Goals of Client-Centred Therapy

"In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?" – Carl Rogers

Like many current forms of therapy (like narrative therapy or cognitive behavioural therapy, for example), the goals of client-centred therapy depend on the client. Depending on who you ask, who the therapist is, and who the client is, you will likely get a range of different answers – and none of them are wrong!

However, there are a few overarching goals that the humanistic therapies focus on, in general.

These general goals are to:

- Facilitate personal growth and development
- Eliminate or mitigate feelings of distress
- Increase self-esteem and openness to experience
- Enhance the client's understanding of him- or herself

As it is, these goals span an extremely broad range of sub-goals or objectives, but it is also common for the client to come up with his or her own goals for therapy. Client-centred

therapy posits that the therapist cannot set effective goals for the client, due to his or her lack of knowledge of the client. Only the client has enough knowledge of themselves to set effective and desirable goals for therapy.

Other commonly gained benefits include:

- Greater agreement between the client's idea and actual selves
- Better understanding and awareness
- Decreased defensiveness, insecurity, and guilt
- Greater trust in oneself
- Healthier relationships
- Improvement in self-expression
- Improved mental health overall (Person-centered therapy, n.d.)

How Does It Work? The Person-Centered Perspective

"When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness." – Carl Rogers

The quote from Carl Rogers above highlights an important point: the success of this form of therapy rests on the extremely important connection between the client and therapist. If this relationship is not marked by trust, authenticity, and mutual positive feelings, it is unlikely to produce any benefits for either party.

Rogers identified six conditions that are required for success in client-centred therapy:

- The client and counsellor are in psychological contact (a relationship).
- The client is emotionally upset, in a state of incongruence.
- The counsellor is genuine and aware of their own feelings.
- The counsellor has unconditional positive regard for the client.
- The counsellor has an empathic understanding of the client and their internal frame of reference and looks to communicate this experience with the client.
- The client recognizes that the counsellor has unconditional positive regard for them and an understanding of the difficulties they are facing (Person-centred therapy, n.d.).

When these six conditions are met, there is great potential for positive change.

The way client-centred therapy works is a natural extension of these conditions: the therapist and client discuss the client's current problems and issues, the therapist practices active listening and empathizes with the client, and the client decides for themselves what is wrong and what can be done to correct it (McLeod, 2015).

It is clear from Rogers' works that he placed a great deal of value on the firsthand experience of the client, and much less in the "cleverness and learning" or technical expertise of therapists – including himself!

4.8 Client-Centred Therapy Method and Techniques

"We think we listen, but very rarely do we listen with real understanding, true empathy. Yet [active] listening, of this very special kind, is one of the most potent forces for change that I know." – Carl Rogers.

The only technique recognized as effective and applied in client-centred therapy is to listen nonjudgmentally. That's it!

In fact, many client-centred therapists and psychologists view a therapist's reliance on "techniques" as a barrier to effective therapy rather than a boon. The Rogerian standpoint is that the use of techniques can have a depersonalizing effect on the therapeutic relationship (McLeod, 2015).

In the words of Carl Rogers:

"When you are in psychological distress and someone really hears you without passing judgement on you, without trying to take responsibility for you, without trying to mold you, it feels damn good!"

While active listening is one of the only and most vital practices in client-centred therapy, there are many tips and suggestions for client-centred therapists to facilitate successful therapy sessions. In context, these tips and suggestions can be considered client-centred therapy's "techniques."

Saul McLeod (2015) outlines 10 of these "techniques":

1) Set clear boundaries

Boundaries are vital for any relationship, but they are especially important for therapeutic relationships. Both the therapist and the client need healthy boundaries to avoid the

relationship becoming inappropriate or ineffective, such as ruling out certain topics of discussion.

There are also more practical boundaries that must be set, for example, how long the session will last.

2) Remember – the client knows best

As mentioned earlier, this therapy is founded on the idea that clients know themselves, and are the best sources of knowledge and insight about their problems and potential solutions. Do not lead the client or tell them what is wrong, instead let them tell you what is wrong.

3) Act as a sounding board

Active listening is key, but it's also useful to reflect what the client is saying back to them. Try to put what they are telling you into your own words. This can help the client clarify their own thoughts and understand their feelings better.

4) Don't be judgmental

Another vital component of client-centred therapy is to refrain from judgment. Clients are often already struggling with feelings of guilt, low self-worth, and the belief that they are simply not good enough. Let them know you accept them for who they are and that you will not reject them.

5) Don't make decisions for your clients

Giving advice can be useful, but it can also be risky. In client-centred therapy, it is not seen as helpful or appropriate to give advice to clients. Only the client should be able to make decisions for themselves, and they have full responsibility in that respect.

The therapist's job is to help clients explore the outcomes of their decisions rather than guide them to any particular decisions.

6) Concentrate on what they are really saying

This is where active listening can be put to use. Sometimes a client will feel uncomfortable opening up at first, or they will have trouble seeing something just below the surface. In these situations, be sure to listen carefully and keep an open mind – the problem they come in with may not be the real problem.

7) Be genuine

As mentioned earlier, the client-centred therapy must be genuine. If the client does not feel their therapist is authentic and genuine, the client will not trust you. In order for the client to share personal details about their own thoughts and feelings, they must feel safe and comfortable with you.

Present yourself as you really are, and share both facts and feelings with the client. Of course, you don't have to share anything you don't feel comfortable sharing, but appropriate sharing can help build a healthy therapeutic relationship.

8) Accept negative emotions

This is an important technique for any therapist. To help the client work through their issues and heal, it is vital to let them express their emotions – whether positive or negative. The client may even express anger, disappointment, or irritation with you at one point or another.

Learn to accept their negative emotions and practice not taking it personally. They may need to wrestle with some difficult emotions, and as long as they are not abusing you, it is beneficial to just help them through it.

9) How you speak can be more important than what you say

Your tone of voice can have a huge impact on what the client hears, understands, and applies. Make sure your tone is measured, and make sure it matches your non-judgmental and empathetic approach.

You can also use your voice to highlight opportunities for clients to think, reflect, and improve their understanding; for example, you can use your tone to slow down the conversation at key points, allowing the client to think about where the discussion has led and where s/he would like it to go next.

10) I may not be the best person to help

It is vital that you know yourself as a therapist and are able to recognize your own limits. No therapist is perfect, and no mental health professional can give every single client exactly what they need.

Remember, there is no shame in recognizing that the scope of a specific problem or the type of personality you are working with is out of your wheelhouse. In those cases, don't beat

yourself up about it – just be honest and provide any resources you can to help further the client's healing and development.

This PDF from the Australian Institute of Professional Counsellors also lists some useful techniques for client-centred therapy. Some of them overlap with previously mentioned techniques, but all are helpful!

These techniques include:

Congruence: this technique involves therapists being genuine and authentic, and ensuring that their facial expressions and body language match their words.

Unconditional Positive Regard: as described earlier in this piece, unconditional positive regard (UPR) is practice by accepting, respecting, and caring about one's clients; the therapist should operate from the perspective that clients are doing the best they can in their circumstances and with the skills and knowledge available to them.

Empathy: it is vital for the therapist to show clients that s/he understands their emotions rather than just feeling sympathy for them.

Nondirectiveness: a cornerstone of client-centred therapy, non-defectiveness refers to the method of allowing the client to drive the therapy session; therapists should refrain from giving advice or planning activities for their sessions.

Reflection of Feelings: repeating what the client has shared about his or her feelings; this lets the client know the therapist is listening actively and understanding what the client is saying, as well as giving them an opportunity to further explore their feelings.

Open Questions: this technique refers to the quintessential "therapist" question – "How does that make you feel?" Of course, that is not the only open question that can be used in client-centred therapy, but it is a good open question that can encourage clients to share and be vulnerable.

Paraphrasing: therapists can let clients know that they understand what the clients have told them by repeating what they have said back to them in the therapist's own words; this can also help the client to clarify their feelings or the nature of their problems.

Encouragers: these words or phrases, like "uh-huh," "go on," and "what else?" are excellent at encouraging the client to continue; these can be especially useful for a client who is shy, introverted, or afraid of opening up and being vulnerable (J & S Garrett, 2013).

4.9 A Take-Home Message

We hope this information provides you with a better understanding of client-centred therapy, and that it will encourage you to think of yourself as the master and expert of your own experience. You are the only one who understands your problems, issues, needs, desires, and goals, and it is to you that you must turn to solve these problems and reach these goals.

It is an added responsibility when you understand that you are responsible for how your life unfolds, but it can also be extremely liberating.

We encourage all of you to work on building the trust in yourself and in your knowledge and skills that can take your life from "going through the motions" to living a life that is authentic.

As always please let us know your thoughts in the comments! Have you ever tried client-centered therapy, as either a client or a therapist? What did you think of it? We want to hear from you!

4.10 Terminologies

1. Empathetic understanding: means therapists completely understands and accepts their client thoughts and feelings.
2. Congruence: means therapist carry no air of authority or professional superiority but instead present a true and accessible self that clients can see as honest and transparent.

4.11 Activity

1. Discuss the following terms:
   (a) Empathetic understanding.
   (b) Congruence.

4.12 Reflection

What do you think are the weakness of client centred therapy?

4.13 Summary

In this unit. You have learnt about three conditions necessary for successful counselling namely; unconditional positive regards, empathetic understanding and congruence. You have also learnt about goals of client centred therapy, its methods and techniques. In the unit that follow, you will learn about how you can use the Gestalt therapy.

UNIT 5: GESTALT THERAPY

5.1 Introduction

Gestalt therapy, was developed by Fritz Perls, Laura Perls, and Paul Goodman in the 1940s, is an experiential and humanistic form of therapy that was originally designed as an alternative to conventional psychoanalysis. Gestalt therapists and their clients use creative and experiential techniques to enhance awareness, freedom, and self-direction. The word gestalt comes from the German word meaning shape or form, and it references the character or essence of something.

5.2 Learning Outcomes

By the end of this unit you are expected to;

- analyze principles of Gestalt therapy.
- discuss the key concepts of the Gestalt therapy.
- apply Gestalt therapy in counselling.
- discuss strength and weakness of Gestalt therapy.

5.3 Time frame

You need about two (2) hours per week to interact with this material.

5.4 Content

- Principles of Gestalt Therapy
- Working with A Gestalt Therapist
- Gestalt Therapy Techniques
- Key Concepts
- General Ideas about Personality Development
- Applications of Gestalt therapy
- Strengths and weaknesses of Gestalt therapy

5.5 Principles of Gestalt Therapy

At the core of gestalt therapy is the holistic view that people are intricately linked to and influenced by their environments and that all people strive toward growth and balance. Gestalt therapy is similar to person-centered therapy in this way, as well as in its emphasis on

the therapist's use of empathy, understanding, and unconditional acceptance of the client to enhance therapeutic outcomes.

According to gestalt therapy, context affects experience, and a person cannot be fully understood without understanding his or her context. With this in mind, gestalt psychotherapy recognizes that no one can be purely objective—including therapists whose experiences and perspectives are also influenced by their own contexts—and practitioners accept the validity and truth of their clients' experiences.

Gestalt therapy also recognizes that forcing a person to change paradoxically results in further distress and fragmentation. Rather, change results from acceptance of what is. Thus, therapy sessions focus on helping people learn to become more self-aware and to accept and trust in their feelings and experiences to alleviate distress.

5.6 Focus On "Here and Now"

Gestalt therapy emphasis on gaining awareness of the present moment and the present context. Through therapy, people learn to discover feelings that may have been suppressed or masked by other feelings and to accept and trust their emotions. Needs and emotions that were previously suppressed or unacknowledged are likely to surface as well. Through this process, a person gains a new sense of self as overall awareness increases.

The focus on the here and now does not negate or reduce past events or future possibilities; in fact, the past is intricately linked to one's present experience. The idea is to avoid dwelling on the past or anxiously anticipating the future. Experiences of the past may be addressed in therapy sessions, but the therapist and client will focus on exploring what factors made a particular memory come up in this moment, or how the present moment is impacted by experiences of the past.

5.7 Working with A Gestalt Therapist

Gestalt therapy sessions do not follow specific guidelines, in fact, therapists are encouraged to use creativity in their approaches, depending on context and each person's personality. What is consistent is the emphasis on direct contact between therapist and client, direct experience and experimentation, and the focus on the "what and how"—what the client is doing and how he or she is doing it—and the "here and now."

Together, the therapist and the person in therapy will evaluate what is happening now and what is needed as a result. Therapists refrain from interpreting events, focusing only on the immediate, including the physical responses of the client. Remarking on subtle shifts in posture, for example, can bring a person into the present. In this way, gestalt therapy helps people gain a better understanding of how their emotional and physical bodies are connected. Understanding the internal self is the key to understanding actions, reactions, and behaviors. Gestalt therapy helps people take the first steps into this awareness so that they can acknowledge and accept these patterns.

5.8 Gestalt Therapy Techniques

Gestalt therapy is practiced in the form of exercise and experiments. It can be administered in individual or group settings. In general, exercises are somewhat established practices in gestalt therapy designed to arouse action, emotion, or goals from the person in therapy. The therapist and person in therapy can then examine the result of the exercise in order to increase awareness and help the person understand the "here and now" of the experience.

In contrast to exercises, experiments arise throughout the development of the therapeutic process and therapeutic relationship. They are a core component of gestalt therapy and allow the person in therapy to understand different aspects of a conflict, experience, or mental health issue.

The empty chair technique is a quintessential gestalt therapy exercise that places the person in therapy across from an empty chair. He or she is asked to imagine that someone (such as a boss, spouse, or relative), they, or a part of themselves is sitting in the chair. The therapist encourages dialogue between the empty chair and person in therapy in order to engage the person's thoughts, emotions, and behaviors. Sometimes the roles are reversed and the person in therapy assumes the metaphorical person or part of a person in the chair. The empty chair technique can be especially useful for helping people become mindful of the whole situation and forgotten or disengaged pieces of their own self.

Another common exercise in gestalt therapy is the **exaggeration exercise**. During this exercise, the person in therapy is asked to repeat and exaggerate a particular movement or expression, such as frowning or bouncing a leg, in order to make the person more aware of the emotions attached to the behavior.

The empty chair technique and the exaggeration exercise are two of many gestalt therapy techniques used to help people in therapy increase their awareness of immediate experiences. Through exercises and spontaneous experiments, gestalt therapy also allows people reconnect with parts of themselves they may minimize, ignore, or deny.

5.9 Key Concepts

Several key concepts underlie Gestalt Therapy, many of which are similar to that of person-centred and existential therapy. However, what does differentiate Gestalt Therapy from these therapies are some of the ideas added by Perls and associates as well as distinctive therapeutic techniques that will be covered further down (Seligman, 2006). The following are the key concepts of Gestalt Therapy:

Wholeness and Integration: Wholeness refers to the whole person or the individual's mind and body as a unit rather than as separate parts (Seligman, 2006). Integration refers to how these parts fit together and how the individual integrates into the environment. Often people who come to therapy do not have these parts fitting together in their environment, Gestalt Therapy is about facilitating clients to integrate themselves as whole persons and help restore balance in their environment.

Awareness: Awareness is one of the most important elements in Gestalt Therapy as it is seen as a "hallmark of the healthy person and a goal of treatment" (Seligman, 2006). When individuals are "aware", they are able to self-regulate in their environment.

There are two main causes lacking awareness:

Preoccupation with one's past, fantasies, flaws and strengths that the individual becomes unaware of the whole picture.

Low self-esteem.

There are three ways people may achieve awareness through therapy:

Contact with the environment: This is through looking, listening, touching, talking, moving, smelling, and tasting. This enables the individual to grow in his or her environment through reacting to the environment and changing.

Here and now: This is the individual living in and being conscious at the present moment rather than worrying about the past or the future.

Responsibility: This refers to the individual taking responsibility for his or her own life rather than blaming others.

Energy and blocks to energy: Gestalt Therapists often focus on where energy is in the body, how it is used, and how it may be causing a blockage (Corey, 2005). Blocked energy is a form of resistance, for example, tension in a part of the body, not breathing deeply, or avoiding eye contact. Gestalt Therapy is about finding and releasing the blockages that may be inhibiting awareness.

Growth Disorders: Growth disorders refer to emotional problems that are caused by people who lack awareness and do not interact with their environment completely. In doing so, people are unable to cope with the changes in their lives successfully and, instead deal with the problems in a defensive manner (Seligman, 2006).

Unfinished business: Unfinished business refers to people who do not finish things in their lives and is often related to people with a "growth disorder" (Seligman, 2006). People with unfinished business often resent the past and because of this are unable to focus on the here and now. One of the major goals of Gestalt Therapy is to help people work through their unfinished business and bring about closure.

5.10 General Ideas about Personality Development

Gestalt Therapy deems that people cannot be considered as separate from their environment or from interpersonal relations. The individual is seen as being self-regulating and is able to motivate oneself to solve problems. Individuals are able to work towards growth and develop as their environments allow.

A psychologically healthy person is someone who is self-regulating through the changes in life and has developed a sense of "wholeness" between mind and body (Corsini & Wedding, (2000).

5.11 Therapeutic Techniques & Methods of Working

The most important goal of Gestalt Therapy is that Gestalt Therapists do not aim to change their clients. The therapist's role is to assist clients in developing their own self-awareness of how they are in the present moment. This will therefore allow them to rectify issues affecting his or her life.

“The therapist’s job is to invite clients into an active partnership where they can learn about themselves by adopting an experiential attitude toward life in which they try out new behaviours and notice what happens” (Perls, Hefferline and Goodman, 1954, in Corey, 2005).

A focus of developing awareness is that of clients’ awareness of their own realities. In order to do this, clients must first accept responsibility for choosing their present situations. Language plays a big part in accepting responsibility. The client may attempt to use avoidance responses or project individual traits onto other people or external causes, for example “She makes me so angry”; “It’s his fault”. Both avoidance responses and projection of traits attempt to displace ownership and responsibility onto an external cause.

Another goal of Gestalt Therapy is that therapists should work to create an “I-thou” relationship with clients in which both the therapist and client are present in the here-and-now rather than focusing on the past or future (Seligman, 2006).

Also, an understanding of the whole of the client’s experience is required by the therapist. This involves considering the client’s verbal and non-verbal communication. In fact, the nonverbal communication is seen to provide more information about the real essence of the person.

Thus, an important function of the Gestalt Therapist is paying attention to the client’s body language such as the client’s posture, movements, gestures, voice, and hesitations as the body language is considered to be reflective of what the client is going through at that point in time.

Experiments: Gestalt Therapists use the technique of experiments or learning experiences with their clients. The experiments are designed for the individual and take the form of an enactment, role play, homework, or other activity which promotes the individual’s self-awareness (Seligman, 2006).

An example of this technique is with a man who feels insecure in social situations. He has a work function to go to in two weeks time so the therapist gives him the experiment of starting a conversation at the function with someone he does not normally speak to. Spending time thinking about what he might say promotes self-awareness and the experiment itself gives him more confidence in social situations.

Use of Language: Gestalt Therapists choose language that will encourage change in the client. The following are ways that this can be accomplished (Seligman, 2006):

Emphasis on statements rather than questions to highlight a collaborative client-therapist relationship.

"What" and "How" questions (when questions are used) to keep the client in the present and promote integration.

"I" statements are used to promote client's ownership of feelings rather than placing blame on others.

The present tense is used so the focus is on the present rather than the past.

Encouraging responsibility for clients of their words, emotions, thoughts, and behaviours so they recognize and accept what they are feeling.

Empty Chair: The empty chair technique is a "method of facilitating the role-taking dialogue between the patient and others or between parts of the patient's personality. It is generally used in a group situation" (Patterson, 1986). Two chairs are placed facing each other: one represents the patient or one aspect of the patient's personality, and the other represents another person or the opposing part of the personality. As the patient alternates the role, he or she sits in one or the other chair.

The therapist may simply observe as the dialogue progresses or may instruct the patient when to change chairs, suggest sentences to say, call the patient's attention to what has been said, or ask the patient to repeat or exaggerate words or actions.

In the process, emotions and conflicts are evoked, impasses may be brought about and resolved, and awareness and integration of polarities may develop — polarities or splits within the patient, between the patient and other persons, or between the patient's wants and the social norms (Patterson, 1986).

Topdog — Underdog: A commonly utilised Gestalt technique is that of the topdog-underdog dialogue. This technique is used when the therapist notices two opposing opinions/attitudes within the client. The therapist encourages the client to distinguish between these two parts and play the role of each in a dialogue between them (Patterson, 1986).

The tyrannical 'topdog' demands that things be a particular way whilst the 'underdog' plays the role of disobedient child. The individual becomes split between the two sides struggling for control.

Dreams: Dreams are used to bring about integration by the client. The focus of a client's dream is not on the unconscious, rather on projections or aspects of the dreamer (Seligman, 2006). The therapist would get clients to talk about their dream/s in terms of the significance of each role in the dream and this allows clients to take responsibility for the dreams and increase awareness of their thoughts and emotions.

Fantasy: Fantasy is used in Gestalt Therapy to increase clients' self-awareness of their thoughts and emotions and to bring about closure to unfinished business (Seligman, 2006). Therapists use guided imagery techniques (fantasy) to encourage clients to imagine situations such as what they would do in a certain situation or by projecting themselves into different roles.

The Body as a Vehicle of Communication: Gestalt Therapy sees that not only are thoughts and emotions important to creating a feeling of "wholeness" for the client, the physical sensations are also important. Seligman (2006) has identified three strategies to help with focusing attention on the physical sensations:

Identification: Gestalt Therapists should be able to recognise physical signs of their clients. For example, a client might be tapping their feet on the ground. The therapist may say "Become your leg and give it a voice?" This creates awareness of the client's physical sensations and emotions.

Locating emotions in the body: Gestalt Therapists may ask clients where they are experiencing the emotion in their body. For example, a client may say they are feeling nervous about something. The therapist may ask where this is coming from in the body and the response from the client may be that the feeling is butterflies in the stomach. This helps the client to bring about more awareness into sensations and their emotions.

Repetition and exaggeration: If there is repetition such as the example of the client tapping their feet on the ground, the therapist would get them to exaggerate the movement and talk about feelings that come up. This in turn focuses on the emotion and should help to release the blocked awareness.

Confusion: The technique of dealing with confusion of the client is about drawing attention to the client's hesitation in talking about something unpleasant. The hesitation can be shown through avoidance, blanking out, verbalism and fantasy (Patterson, 1986). By drawing

attention to the hesitation, it creates self-awareness for the client and allows the client to work through the issue.

Confrontation: In Gestalt Therapy, confrontation means ‘to challenge or frustrate the client’. The client is challenged with sensitivity and empathy on the part of the therapist to face the issues important to them. It is an invaluable tool for bringing clients into clear awareness of their realities, when used appropriately. However, confrontation is not a technique that can be used with all clients.

5.12 Applications of Gestalt therapy

Originally Gestalt Therapy was predominantly used to treat individuals who were anxious and/or depressed and who were not showing serious pathological symptoms. Although still used in the treatment of anxiety and depression, Gestalt Therapy has been effective in treating clients with personality disorders such as borderline personality disorder.

Gestalt Therapy is also effective in counselling groups, couples, and families (Corsini & Wedding, 2000).

5.13 Strengths of Gestalt therapy

There is empirical research to support Gestalt Therapy and its techniques (Corsini & Wedding, 2000). Specifically,

Gestalt Therapy is equal to or greater than other therapies in treating various disorders, Gestalt Therapy has a beneficial impact with personality disorders, and the effects of therapy are stable.

Works with the past by making it relevant to the present (Corey, 2005).

Versatile and flexible in its approach to therapy. It has many techniques and may be applied to different therapeutic issues.

5.14 Weaknesses of Gestalt therapy

For Gestalt Therapy to be effective, the therapist must have a high level of personal development (Corey, 2005).

Effectiveness of the confronting and theatrical techniques of Gestalt Therapy is limited and has not been well established.

It has been considered to be a self-centred approach which is concerned with just individual development.

Potential danger for therapists to abuse the power they have with clients (Corey, 2005).

- Lacks a strong theoretical base.
- Deals only with the here and now.
- Does not deal with diagnosis and testing.

5.15 Conclusion

Gestalt Therapy focuses on the integration between the "whole" person and his or her environment. This therapy sees a healthy individual as being someone who has awareness in his or her life and lives in the here and now rather than focusing on the past or future. Gestalt Therapy has a number of successful techniques that are applicable in therapy today and may be utilised across a broad spectrum of emotional issues.

5.16 Terminologies

1. Gestalt: An organised whole that perceived as more than sum of its parts.
2. Metaphorical: Not using word with their ordinary meaning.

5.17 Activity

1. Discuss the principles of Gestalt therapy.
2. Analyse the strengths and weakness of the Gestalt therapy.

5.18 Reflection

Do you think the empty chair technique is the best way of bringing out a person's thoughts, emotions and behaviours?

5.19 Summary

In this unit, you have learnt about principles of Gestalt therapy, such as focus on "here and now" empty chair techniques and exaggeration exercise, you have also learnt about Gestalt therapy key concepts such as wholeness and integration awareness, contact with environment and unfinished business. In the next unit, you will learn about the transactional analysis therapy.

UNIT 6: TRANSACTIONAL ANALYSIS THERAPTY

6.1 Introduction

Transactional analysis, developed by psychiatrist Eric Berne, is a form of modern psychology that examines a person's relationships and interactions. Berne took inspiration from Sigmund Freud's theories of personality, combining them with his own observations of human interaction in order to develop transactional analysis. In therapy, transactional analysis can be used to address one's interactions and communications with the purpose of establishing and reinforcing the idea that each individual is valuable and has the capacity for positive change and personal growth.

6.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss the development of Transactional analysis.
- examine the ego states of Transactional analysis.
- analyze the key concepts of transactional Analysis
- apply transactional analysis in counselling.

6.3 Time frame

You need about three (3) hours per week to interact with this material.

6.7 Content

- Development of Transactional Analysis
- Examining the Ego States of Transactional Analysis
- Communication Using Transactional Analytic Theory
- Transactional Analysis in Therapy
- Key Concepts in Transactional Analysis
- Benefits of Transactional Analysis

6.8 Development of Transactional Analysis

Dr. Eric Berne developed transactional analysis in the last 1950s, using “transaction” to describe the fundamental unit of social intercourse, with “transactional analysis” being the study of social interactions between individuals. His influences included contemporaries such

as René Spitz, Erik Erikson, Paul Federn, Edoardo Weiss, as well as Freud and Wilder Penfield, a Canadian neurosurgeon.

Inspired by Freud's theory of personality—primarily his belief that the human psyche is multifaceted and that different components interact to produce a variety of emotions, attitudes and complex behaviors—and Penfield's groundbreaking experiments involving the stimulation of specific brain regions with electrical currents, Berne developed an approach that he described as both neo- and extra-Freudian.

upon the philosophical concepts Freud introduced with observable data, Berne developed his own observable ego states of Parent, Adult, and Child, following Freud's proposal of the existence of the Id (emotional and irrational component), Ego (rational component), and Superego (moral component) as different and unobservable factions of personality.

Berne also took special note of the complexities of human communication. He highlighted the fact that facial expressions, gestures, body language, and tone may be regarded as more important by the receiver than any spoken words. In his book Games People Play, he noted that people may sometimes communicate messages underpinned with ulterior motives.

6.9 Examining the Ego States of Transactional Analysis

Like Freud, Berne posited that each individual possesses three ego states. His ego states—the Parent, the Adult, and the Child—do not directly correspond to Freud's Id, Ego, and Superego, however. Instead, these states represent an individual's internal model of parents, adults, and children. An individual may assume any of these roles in transactions with another person or in internal conversation. These roles are not directly associated with their typical English definitions but can be described as follows:

Parent consists of recordings of external events observed and experienced by a child from birth through approximately the first five years of life. These recordings are not filtered or analyzed by the child; they are simply accepted without question. Many of these external events are likely to involve the individual's parents or other adults in parent-link roles, which led Berne to call this ego state "the Parent." Examples of external events recorded in this state:

- Do not play with matches.

- Remember to say “please” and “thank you.”
- Do not speak to strangers.

Child represents all brain recordings of internal events (feelings or emotions) that are directly linked to the external events observed by the child during the first five years of life. Examples of events recorded in this state may include:

- I feel happy when Mom hugs me.
- Dad’s late night movie was very scary.
- I feel sad when Mom is sad.

Adult, the final ego state, is the period in which a child develops the capacity to perceive and understand situations that are different from what is observed (Parent) or felt (Child). The Adult serves as a data processing center that utilizes information from all three ego states in order to arrive at a decision. One important role of the Adult is to validate data which is stored in the Parent:

- I see that Suzie’s house was burnt down. Mom was right—I should not play with matches.

6.10 Communication Using Transactional Analytic Theory

Any indication (speech, gestures or other nonverbal cues) that acknowledges the presence of another person is called a transactional stimulus. All transactions are initiated via the use of a transactional stimulus. When two individuals encounter each other and the receiver reacts in a manner related to the transactional stimulus, that individual has performed a transactional response. The key to successful person-to-person communication generally lies in identifying which ego state (in the speaker) initiated the transactional stimulus and which ego state (in the receiver) provided the transactional response.

Due to the typically rational and reasonable nature of the Adult, Berne believes that the easiest and simplest transactions occur between Adult ego states, but transactions may occur between any of the three ego states. In a complementary transaction, the transaction response from the receiver is directed to the sending ego state in the speaker. For example, if the Adult in the speaker sends a transactional stimulus to the Child in the receiver, then the transaction will be complementary if the Child in the receiver then sends the transactional response to the

Adult in the speaker. According to Berne, communication will continue if the transactions remain complementary.

A crossed transaction occurs when an ego state that did not receive the transactional stimulus sends the transactional response. Crossed transactions may lead to breakdowns in communication, which may sometimes be followed by conflict. For example, the Adult state in an individual may send a transactional stimulus to the Adult in another individual, asking "Have you seen my coat?" But the Child in the second individual may instead send the transactional response to the Parent in the first individual by replying, "You always blame me for everything!"

Not only is communication considered to be an important aspect of everyday life, it is also thought to be an integral part of being human. Even newborns exhibit the need to be recognized and acknowledged. Research conducted by Spitz showed that infants who received less cuddling, handling, and touching were more likely to experience physical and emotional challenges. Berne described this innate need for social recognition as recognition-hunger, defining the fundamental unit of social action or recognition as a stroke.

From Berne's perspective, the adversely affected children in Spitz's studies exhibited physical and emotional deficits due to a lack of strokes. Berne applied this theory to adults, theorizing that men and women also experience recognition-hunger and a need for strokes. However, while infants may desire strokes that are primarily physical, an adult may be contented with other forms of recognition, such as nods, winks, or smiles.

While strokes may be positive or negative, Berne theorized that it is better to receive a negative stroke than no stroke at all. When one person asks another out on a date, for example, and receives a flat refusal, that person may find the refusal to be less damaging than a complete lack of acknowledgment.

6.11 Transactional Analysis in Therapy

The goal of transactional analysis is help the individual in therapy gain and maintain autonomy by strengthening the Adult state. Typically, the individual and the therapist will establish a contract that outlines the desired outcome they wish to achieve in therapy. This may contribute to the person in therapy taking personal responsibility for events that take

place during treatment. The individual will generally then become more able to rely on their Adult ego states to identify and examine various thoughts, behaviors, and emotions which might hinder the ability to thrive.

The atmosphere that supports transactional analysis is one of comfort, security, and respect. When a positive relationship is forged between the therapist and the person

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6.12 Key Concepts in Transactional Analysis

A Brief Overview

Following are some of the most important concepts in transactional analysis.

6.12.1 I'm OK - You're OK

"I'm OK - You're OK" is probably the best-known expression of the purpose of transactional analysis: to establish and reinforce the position that recognizes the value and worth of every person. Transactional analysts regard people as basically "OK" and thus capable of change, growth, and healthy interactions.

6.12.2 Strokes

Berne observed that people need strokes, the units of interpersonal recognition, to survive and thrive. Understanding how people give and receive positive and negative strokes and changing unhealthy patterns of stroking are powerful aspects of work in transactional analysis.

6.12.3 Ego States

Eric Berne made complex interpersonal transactions understandable when he recognized that the human personality is made up of three "ego states". Each ego state is an entire system of thoughts, feelings, and behaviors from which we interact with one another. The Parent, Adult and Child ego states and the interaction between them form the foundation of transactional analysis theory. These concepts have spread into many areas of therapy, education, and consulting as practiced today.

6.12.4 Transactions

Transactions refer to the communication exchanges between people. Transactional analysts

are trained to recognize which ego states people are transacting from and to follow the transactional sequences so they can intervene and improve the quality and effectiveness of communication.

6.12.5 Games People Play

Berne defined certain socially dysfunctional behavioral patterns as "games." These repetitive, devious transactions are principally intended to obtain strokes but instead they reinforce negative feelings and self-concepts, and mask the direct expression of thoughts and emotions. Berne tagged these games with such instantly recognizable names as "Why Don't You, Yes But," "Now I've Got You, You SOB," and "I'm Only Trying to Help You." Berne's book *Games People Play* achieved wide popular success in the early 60's.

6.12.6 Life Script

Eric Berne proposed that dysfunctional behavior is the result of self-limiting decisions made in childhood in the interest of survival. Such decisions culminate in what Berne called the "life script," the pre-conscious life plan that governs the way life is lived out. Changing the life script is the aim of transactional analysis psychotherapy. Replacing violent organizational or societal scripting with cooperative non-violent behavior is the aim of other applications of transactional analysis.

6.12.7 Contracts

Transactional analysis practice is based upon mutual contracting for change. Transactional analysts view people as capable of deciding what they want for their lives. Accordingly, transactional analysis does its work on a contractual basis between the client and the therapist, educator, or consultant.

6.13 Who Can Benefit from Transactional Analysis?

Transactional analysis is frequently applied in the areas of medicine, communications, education, and business management as well as therapy. The mainstream appeal of this technique has attracted parents, professionals, social workers, and others who strive to achieve maximum personal development. Transactional analysis is considered to be one effective method of enhancing relationships with oneself and with others.

Studies show that transactional analysis, often used by counselors and clinicians to address issues currently faced by the person in treatment, can be an effective tool in the treatment of emotional and relationship difficulties that may develop as a result of chronic health challenges.

Transactional analysis is used widely in the educational arena, and this method can serve as a vessel through which educational principles and philosophy can be incorporated into the daily lives of students. This type of therapy can be administered to children and adults of all ages, regardless of social circumstances.

6.14 Terminologies

1. Multifaceted: having one different parts or sides
2. Strokes: an act of hitting or striking someone or something; a blow
3. Transaction: refers to the communication exchanges people between people.

6.15 Activity

1. Examine the Ego states of Transactional analysis.

6.16 Reflection

What do you think are the strengths and weakness of Transactional analysis therapy?

6.17 Summary

In this unit you have learnt that the goal of transactional analysis is to help individuals in therapy to gain and maintain autonomy by strengthening the adult state. You have also examined the three ego states namely, the parent, the adult, and the child. In the next unit you will learn about existential therapy.

UNIT 7: EXISTENTIAL THERAPY

7.1 Introduction

Existential psychotherapy is a style of therapy that places emphasis on the human condition as a whole. Existential psychotherapy uses a positive approach that applauds human capacities and aspirations while simultaneously acknowledging human limitations. Existential psychotherapy shares many similarities with humanistic psychology, experiential psychotherapy, depth psychotherapy, and relational psychotherapy.

7.2 Learning Outcomes

By the end of this unit, you are expected to;

- examine existential psychotherapy ‘givens’
- discuss existential therapeutic process.
- discuss key concepts of existential therapy.
- analyze strengths and weakness of the existential therapy.

7.3 Time frame

You need about three (3) hours per week to interact with this material.

7.4 Content

- Existential Therapy
- Existential Psychotherapy 'Givens'
- Existential Therapists' Process
- Common Concerns and Limitations
- Key Concepts in Existential Therapy
- Strengths and Weaknesses for Multicultural Working

7.5 Timeline of Existential Therapy

Existential therapy developed out of the philosophies of Friedrich Nietzsche and Soren Kierkegaard. As one of the first existential philosophers, Kierkegaard theorized that human discontent could only be overcome through internal wisdom. Later, Nietzsche further developed the theory of existentialism using concepts such as the will to power and personal responsibility. In the early 1900s, philosophers such as Martin Heidegger and Jean-Paul Sartre began to explore the role of investigation and interpretation in the healing process. Over the next several decades, other contemporaries started to acknowledge the importance

of experiencing in relation to understanding as a method to achieving psychological wellness and balance.

Otto Rank was among the first existential therapists to actively pursue the discipline, and by the middle of the 20th century, psychologists Paul Tillich and Rollo May brought existential therapy into the mainstream through their writings and teachings, as did Irvin Yalom after them. The popular approach began to influence other theories, including logotherapy, which was developed by Viktor Frankl, and humanistic psychology. At the same time, British philosophers expanded existentialism further with the foundation of The Philadelphia Association, an organization dedicated to helping people manage their mental health issues with experiential therapies. Other institutions that embody the theory of existentialism include the Society for Existential Analysis, founded in 1988, and the International Community of Existential Counselors, created in 2006.

7.6 Existential Psychotherapy 'Givens'

Existential psychotherapy is based upon the fundamental belief that all people experience intrapsychic conflict due to their interaction with certain conditions inherent in human existence, which are known as givens. The theories recognize at least four primary existential givens:

- Freedom and associated responsibility
- Death
- Isolation
- Meaninglessness

A confrontation with any of the aforementioned conditions, or givens, fills an individual with a type of dread commonly referred to as existential anxiety. This anxiety is thought to reduce a person’s physical, psychological, social, and spiritual awareness, which may lead to significant long-term consequences.

For example, the fact that each one of us and each one of our loved ones must die at some unknown time may be a source of deep anxiety to us, and this may tempt us to ignore the reality and necessity of death in human existence. By reducing our awareness of death, however, we may fail to make decisions that can actually safeguard or even enrich our lives.

At the other end of the spectrum, people who are overly conscious of the fact that death is inevitable may be driven to a state of neurosis or psychosis.

The key, according to existential psychotherapy, is to strike a balance between being aware of death without being overwhelmed by it. People who maintain a healthy balance in this way are motivated to make decisions that can positively impact their lives, as well as the lives of their loved ones. Though these people may not know how their decisions will actually turn out, they do appreciate the need to take action while they can. In essence, the reality of death encourages us to make the most of opportunities and to treasure the things we have.

The perceived meaninglessness of life, and the weighty responsibility of making life-altering decisions may each be a source of acute existential anxiety. According to the theories of existential therapy, the manner in which a person processes these internal conflicts, and the decisions they make as a result, will ultimately determine that person's present and future circumstances.

7.7 Accepting Fears and Overcoming Them

Existential psychotherapy encourages people to not only address the emotional issues they face through full engagement but to also take responsibility for the decisions that contributed to the development of those issues. People who participate in this form of therapy are guided to accept their fears and given the skills necessary to overcome these fears through action. By gaining control of the direction of their life, the person in therapy is able to work to design the course of their choosing. Through this work, people often come to feel both a sense of liberation and the ability to let go of the despair associated with insignificance and meaningless. Thus, existential psychotherapy involves teaching people in therapy to grow and embrace their own lives and exist in them with wonder and curiosity. Developing the ability to view life with wonder can help people be able to view the life experience as a journey rather than a trial and can also help eradicate the fear associated with death.

7.8 Existential Therapists' Process

Therapists who practice existential psychotherapy do not focus on a person's past. Instead, they work with the person in therapy to discover and explore the choices that lie before them. Through retrospection, the person in therapy and therapist work together to

understand the implications of past choices and the beliefs that led those to take place, only as a means to shift to the goal of creating a keener insight into the self. In existential therapy, the emphasis is not to dwell on the past, but to use the past as a tool to promote freedom and newfound assertiveness. By coming to the realization that they are neither unique nor destined for a specific purpose, the person in therapy is able to release the obligatory chains that may have been preventing them from existing in fullness from moment to moment. When that happens, they then achieve the ability to become truly free.

7.9 How Can Existential Psychotherapy Help?

People in therapy who are willing to explore the reasons for their intrapsychic conflicts and the decisions that led to their current circumstances can benefit greatly from existential psychotherapy. There are many behavioral and mental health issues that may be successfully treated with this therapeutic approach, including depression, anxiety, substance dependency, and posttraumatic stress resulting from exposure to military combat, rape, childhood sexual abuse, interpersonal violence, or other life-threatening experiences.

Individuals who respond to treatment tend to find meaning and purpose in their lives and often experience heightened self-awareness, self-understanding, self-respect, and self-motivation. The realization that they are primarily responsible for their own recovery often increases the likelihood that people in treatment will see beyond the limits of a therapy session and view recovery as a therapeutic process.

7.10 Common Concerns and Limitations

Existential psychotherapy, much like other types of therapy, may be misunderstood by people who do not have a thorough grasp of the fundamental principles or scope of the associated theories. It can help to develop awareness of the principles, theories, and givens before and while participating in treatment.

Common misperceptions of existential psychotherapy include the following beliefs:

- One distinctive, united existential theory, free of internal tension, covers all the basic assumptions of existential psychology. In fact, there are at least five categories of the approach, and most scholars view this as a strength of the approach, as it leads to

consistent examination of the basic assumptions of the approach and allows for greater adaptability.

- There is no difference between existential psychology and existential philosophy. Though there are points of agreement between existential philosophy and existential psychology, there are also points of difference, and the variation in perspectives of the leading pioneers and scholars of the two fields help contribute to the development of each approach.
- Existential psychology takes an antireligious or anti-spiritual approach, for example, denying the existence of God**.** Though existential psychology is not innately religious and does discourage people from following one person or religion without question, it is also not anti-religious, and many of the leading scholars and pioneers were Christian theologists.
- Existential and humanistic theories are the same thing. Though there is agreement between the two theories, they are not identical. However, disagreements between these two schools of thought tend to be more degrees of emphasis and less complete divergences.
- Existential psychotherapy takes a negative, dark, or pessimistic view of life**.** Because writings on existential psychology can be read as pessimistic, due to their view that suffering can be embraced as part of the human existence. This is not an encouragement of suffering, though, only recognition of the fact that it is an inescapable part of being human. What existential therapy *does* do is encourage people to embrace the reality of suffering in order to work through and learn from it.
- The approach is fundamentally an intellectual one and, as such, is only beneficial to people of high intellect, who are not experiencing chronic behavioral or mental health conditions. People of any intelligence level are capable of the awareness of their own humanity and able to make meaning of their emotions and anxieties. It is not necessary for a person to be a philosopher or scholar to benefit from the principles of existential therapy, and many people who are actively struggling with mental health issues can also be helped by the approach.

Because existential psychotherapy targets the underlying factors of perceived behavioral and mental health concerns, an existential approach may not directly address the primary issue a person in treatment is experiencing. Because of this, existential therapy, which is quite adaptable, is often used along with other approaches to treatment. Combining approaches can

help maximize the effectiveness of both and promote greater recovery. Additionally, the in-depth, penetrative approach used in existential psychotherapy may not appeal to people who do not wish to explore their intrapsychic processes, or who are solely interested in finding a quick fix for their mental health challenges

7.11 Existential Therapy

Existential therapy focuses on free will, self-determination, and the search for meaning—often cantering on you rather than on the symptom. The approach emphasizes your capacity to make rational choices and to develop to your maximum potential.

7.11.1 The existential approach stresses that:

- All people have the capacity for self-awareness.
- Each person has a unique identity that can be known only through relationships with others.
- People must continually re-create themselves because life's meaning constantly changes.
- Anxiety is part of the human condition.

7.11.2 When It's Used

What else is existential therapy recommended for? Psychological problems—like substance abuse—result from an inhibited ability to make authentic, meaningful, and self-directed choices about how to live, according to the existential approach. Interventions often aim to increase self-awareness and self-understanding. Existential psychotherapists try to comprehend and alleviate a variety of symptoms, including excessive anxiety, apathy, alienation, nihilism, avoidance, shame, addiction, despair, depression, guilt, anger, rage, resentment, embitterment, purposelessness, psychosis, and violence. They also focus on life-enhancing experiences like relationships, love, caring, commitment, courage, creativity, power, will, presence, spirituality, individuation, self-actualization, authenticity, acceptance, transcendence, and awe.

7.11.3 What to Expect

Here's what you can expect from a course of therapy. Existential psychotherapies use a range of approaches, but major themes focus on your responsibility and freedom. Therapists help you find meaning in the face of anxiety by choosing to think and act responsibly and by

confronting negative internal thoughts rather than external forces like societal pressures or luck. Fostering creativity, love, authenticity, and free will are common avenues that help move you toward transformation. Similarly, when treating addiction disorders, the existential therapist coaches you to face the anxiety that tempts you to abuse substances and guides you to take responsibility. The goal: You learn to make more wilful decisions about how to live, drawing on creativity and love, instead of letting outside events determine your behaviour.

7.11.4 How It Works

This practice—due to its focus on existence and purpose—is sometimes perceived as pessimistic, but it's meant to be a positive and flexible approach. At its best, according to 20th-century philosopher Paul Tillich, existential psychotherapy fairly and honestly confronts life's "ultimate concerns," including loneliness, suffering, and meaninglessness. Specific concerns are rooted in each individual's experience, but contemporary existential psychotherapist Irvin Yalom says that the universal ones are death, isolation, freedom, and emptiness. Existential therapy focuses on the anxiety that occurs when you confront these inherent conflicts, and the therapist's role is to foster personal responsibility for making decisions. Yalom, for example, perceives the therapist as a "fellow traveller" through life, and he uses empathy and support to elicit insight and choices. And because people exist in the presence of others, the relational context of group therapy is an effective approach, he says. The core question addressed in this kind of therapy is "how do I exist in the face of uncertainty, conflict, or death?"

7.11.5 What to Look for in an Existential Therapist?

In addition to their mental health training, existential therapists often have a background in philosophy. Licensure varies state by state, but many existential therapists complete graduate degrees in psychology or counselling, for example. They also complete additional supervised fieldwork in existential therapy.

7.12 Key Concepts in Existential Therapy

Existential therapy takes a philosophical/intellectual approach to therapy. It sees humans as:

- having the capacity for self-awareness, experiencing tension between freedom and responsibility
- creating an identity and establishing meaningful relationships
- searching for the meaning, purpose and values of life

- accepting anxiety as a condition of living
- being aware of death and non-being

7.13 Accepting Freedom and Responsibility

Existential therapy posits that we are free to choose among alternatives, and thus we are responsible for our lives, actions and any failure to take action. If clients blame others for their problems, therapists in this modality would help them recognise how they allowed others to decide for them and the price they pay for doing so, and would encourage them to consider the alternative options.

Identity is the courage to be: we must trust ourselves to search within and find our own answers. Our great fear is that we will discover that there is no core or self. Clients who are struggling with their identity need to be challenged, asking them in what ways they have lost touch with their identity and are letting others design their life.

7.14 Relationship to Others

Existential therapy suggests that we are alone. We as humans must therefore give a sense of meaning to life, decide how we will live, have a relationship with ourselves and learn to listen to ourselves. Humans need to create close relationships with others. Therapists might challenge clients on what they get from their relationships, and how and why they avoid close relationships.

7.15 Search for Meaning

Existential therapists encourage clients to ask themselves what they want from life, and where the source of meaning lies for them in life. A trusting therapist–client relationship is important in teaching clients to trust their own capacity to find their way of being. Finding meaning in life is a by-product of engagement, which is a commitment to creating, loving, working and building. Meanwhile, meaninglessness in life leads to emptiness and hollowness (sometimes known as an ‘existential vacuum’).

7.16 Anxiety in Existential Therapy

This modality aims to help clients to expand self-awareness, increase potential choices, accept responsibility for their choices, and experience authentic existence.

Anxiety is seen by existential therapists as being a condition of living, naturally arising from a person's striving to survive. This is known as 'existential anxiety' and is a normal outcome of facing the four ultimate concerns in life: death, freedom, isolation and meaninglessness.

Once existential anxiety is recognised, it can be dealt with constructively. Anxiety can be a stimulus for growth as we become aware of and accept our freedom. If we have the courage to face ourselves and the challenges of human life, we may be frightened but we can change.

7.17 Awareness of Death

Death is seen as providing the motivation for us to live our lives fully and take advantage of each opportunity to do something meaningful.

7.18 How Existential Therapy Works

This modality aims to help clients to expand self-awareness, increase potential choices, accept responsibility for their choices, and experience authentic existence. The therapist seeks to understand the client's subjective world, encourage the client to accept personal responsibility, and get them to take responsibility for their role in any problematic life situations.

Existential therapy is not technique-oriented; instead, the interventions used are based on philosophical views about the nature of human existence, and use the therapist's self. It is particularly well-suited to clients who are bereaved, facing significant decisions or developmental crises, coping with failures in marriage and work, or dealing with physical limitations due to age.

7.19 Strengths and Weaknesses for Multicultural Working

Existential therapy is applicable to diverse clients who are searching for meaning in their lives, including examining whether their behaviour is being influenced by social and cultural factors. Therapists can help clients to weigh up the alternatives and possible consequences, to recognise how they contribute to their situation, and to identify how they can change their external environment.

However, critics of existential therapy see it as excessively individualistic; for many cultures, it is not possible to talk about self and self-determination outside the context of the social network. This modality can also be seen as ignoring the social factors that cause human

problems: even if clients change internally, there may be little hope that the external realities of racism or discrimination will change.

Existential therapy can also be difficult for clients who expect a structured and problem-oriented approach instead of discussion of philosophical questions.

7.20 Terminology

1. existential: a philosophy of relating to or affirming existence.

7.21 Activity

1. Discuss key concepts of existential therapy.
2. Examine strengths and weaknesses of existential therapy.

7.22 Reflection

Explain the role of anxiety the existential therapy.

7.23 Summary

In this unit, you have learnt existential psychotherapy ‘givens’ such as freedom and associated responsibility, dealt, isolation and meaninglessness. You have also learnt about the basic assumption of existential approach. In the next unit, you will be learning about rational emotive therapy.

UNIT 8: RATIONANAL- EMOTIVE THERAPY

8.1 Introduction

Rational emotive behaviour therapy focuses on uncovering irrational beliefs which may lead to unhealthy negative emotions and replacing them with more productive rational alternatives.

8.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss the underlying theory of rational Emotive behaviour theory.
- examine key concepts of Rational emotive theory.

8.3 Time frame

You need about two (2) hours per week to interact with this material.

8.4 Content

- Underlying Theory of Rational Emotive Theory
- Therapeutic Approach of Rational Emotive Behaviour Therapy
- Criticisms of Rational Emotive Behaviour Therapy
- Key Concepts of rational emotive therapy

8.5 Uunderlying Theory of Rational Emotive Behaviour Therapy

Rational emotive behaviour therapy ('REBT') views human beings as 'responsibly hedonistic' in the sense that they strive to remain alive and to achieve some degree of happiness. However, it also holds that humans are prone to adopting irrational beliefs and behaviours which stand in the way of their achieving their goals and purposes. Often, these irrational attitudes or philosophies take the form of extreme or dogmatic 'musts', 'shoulds', or 'oughts'; they contrast with rational and flexible desires, wishes, preferences and wants. The presence of extreme philosophies can make all the difference between *healthy* negative emotions (such as sadness or regret or concern) and *unhealthy* negative emotions (such as depression or guilt or anxiety). For example, one person's philosophy after experiencing a loss might take the form: "It is unfortunate that this loss has occurred, although there is no actual reason why it should not have occurred. It is sad that it has happened, but it is not awful, and I can continue to function." Another's might take the form: "This absolutely

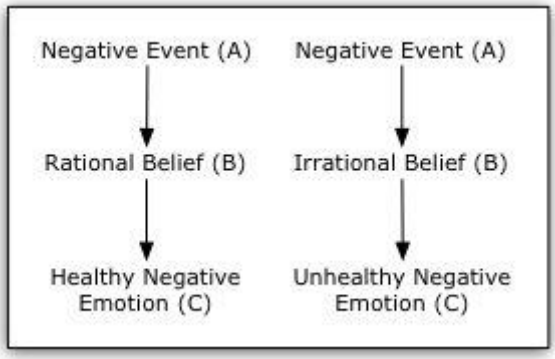
should not have happened, and it is horrific that it did. These circumstances are now intolerable, and I cannot continue to function." The first person's response is apt to lead to sadness, while the second person may be well on their way to depression. Most importantly of all, REBT maintains that individuals have it within their power to change their beliefs and philosophies profoundly, and thereby to change radically their state of psychological health.

REBT employs the 'ABC framework' — depicted in the figure below — to clarify the relationship between activating events (A); our beliefs about them (B); and the cognitive, emotional or behavioural consequences of our beliefs (C). The ABC model is also used in some renditions of cognitive therapy or cognitive behavioural therapy, where it is also applied to clarify the role of mental activities or predispositions in mediating between experiences and emotional responses.

Figure 1: The ABC Module (source, Gerald Corey, 1996, Theory and practice of counselling and Psychotherapy 3rd Ed)

The figure below shows how the framework distinguishes between the effects of rational beliefs about negative events, which give rise to healthy negative emotions, and the effects of irrational beliefs about negative events, which lead to unhealthy negative emotions.

Figure 2: **Frame work of rational beliefs (**Source, Gerald Corey 1996, Theory and practice of counselling and Psychotherapy 3rd Ed).



In addition to the ABC framework, REBT also employs three primary insights:

1. While external events are of undoubted influence, psychological disturbance is largely a matter of personal *choice* in the sense that individuals consciously or unconsciously *select* both rational beliefs and irrational beliefs at (B) when negative events occur at (A)
2. Past history and present life conditions strongly *affect* the person, but they do not, in and of themselves, *disturb* the person; rather, it is the individual's responses which disturb them, and it is again a matter of individual choice whether to maintain the philosophies at (B) which cause disturbance.
3. Modifying the philosophies at (B) requires persistence and hard work, but it can be done.

8.6 Therapeutic Approach of Rational Emotive Behaviour Therapy

The main purpose of REBT is to help clients to replace absolutist philosophies, full of 'musts' and 'shoulds', with more flexible ones; part of this includes learning to accept that all human beings (including themselves) are fallible and learning to increase their tolerance for frustration while aiming to achieve their goals. Although emphasizing the same 'core conditions' as person-centered counselling — namely, empathy, unconditional positive regard, and counsellor genuineness — in the counselling relationship, REBT views these conditions as neither necessary nor sufficient for therapeutic change to occur.

The basic process of change which REBT attempts to foster begins with the client acknowledging the existence of a problem and identifying any 'meta-disturbances' about that problem (i.e., problems about the problem, such as feeling guilty about being depressed). The client then identifies the underlying irrational belief which caused the original problem and

comes to understand both why it is irrational and why a rational alternative would be preferable. The client challenges their irrational belief and employs a variety of cognitive, behavioural, emotive and imagery techniques to strengthen their conviction in a rational alternative. (For example, rational emotive imagery, or REI, helps clients practice changing unhealthy negative emotions into healthy ones at (C) while imagining the negative event at (A), as a way of changing their underlying philosophy at (B); this is designed to help clients move from an intellectual insight about which of their beliefs are rational and which irrational to a stronger 'gut' instinct about the same.) They identify impediments to progress and overcome them, and they work continuously to consolidate their gains and to prevent relapse.

To further this process, REBT advocates 'selective eclecticism', which means that REBT counsellors are encouraged to make use of techniques from other approaches, while still working specifically within the theoretical framework of REBT. In other words, REBT maintains theoretical coherence while pragmatically employing techniques that work.

Throughout, the counsellor may take a very directive role, actively disputing the client's irrational beliefs, agreeing homework assignments which help the client to overcome their irrational beliefs, and in general 'pushing' the client to challenge themselves and to accept the discomfort which may accompany the change process.

8.7 Criticisms of Rational Emotive Behaviour Therapy

As one leading proponent of REBT has indicated, REBT is easy to practice poorly, and it is from this that one immediate criticism suggests itself from the perspective of someone who takes a philosophical approach to life anyway: inelegant REBT could be profoundly irritating! The kind of conceptual disputing favoured by REBT could easily meander off track into minutiae relatively far removed from the client's central concern, and the mental gymnastics required to keep client and therapist on the same track could easily eat up time better spent on more productive activities. The counsellor's and client's estimations of relative importance could diverge rather profoundly, particularly if the client's outlook really does embody significant irrationalities. Having said all that, each of the preceding sentences includes the qualifier '*could* ', and with a great deal of skill, each pitfall undoubtedly could be avoided.

Perhaps more importantly, it would appear that the need to match therapeutic approach with client preference is even more pressing with REBT than with many others. In other words, it seems very important to adopt the REBT approach only with clients who truly are suitable, as it otherwise risks being strongly counter-productive. On this point, however, it is crucial to realize that some clients specifically do appreciate *exactly* this kind of approach, and counsellors who are unable or unwilling to provide the disputation required are probably not right for those clients.

8.8 Best Fit with Clients

REBT is much less empirically supported than some other approaches: the requisite studies simply have not been completed yet, and the relevant data points for determining the best match with clients are therefore thin on the ground. However, one may envision clients responding particularly well who are both willing and able to conceptualize their problems within the ABC framework, and who are committed to active participation in the process of identifying and changing irrational beliefs (including performing homework assignments in support of the latter). Clients will also need to be able to work collaboratively with a counsellor who will challenge and dispute with them directly, and a scientific and at least somewhat logical outlook would seem a pre-requisite. REBT would be less suitable for clients who do not meet one or more of the above. And as hinted above in the section on Criticism, one might also *speculate* that clients who are already highly skilled in philosophical engagement could find the approach less useful. (Perhaps REBT-style self-help could be of more benefit for such clients?)

8.9 Key Concepts

1. Client to minimize self-defeating attitudes and acquire a realistic outlook on life
2. Teach client how to identify thoughts that result in feeling upset
3. Teach client to think more "rationally"
4. Challenge client to examine "Shoulds, Musts and Oughts" that were blindly accepted
5. Examine outcomes. Are they really catastrophic?
6. Homework to deal with specific fears
7. Role playing, humor and modeling
8. Have client read Ellis's book "How to Stubbornly Refuse to Make Yourself 9. 9. 9.
9.Miserable About Anything - Yes Anything"
10. Focus on cognitive and behavioral dimensions

11. Client learn constructive "self-statements", "self-talk"
12. Client learn new coping skills - practice in and out of sessions

8.10 Terminologies

1. Irrational: not logical or reasonable.
2. Hedonistic: engaged in the pursuit of pressure; sensually self-indulgent.

8.11 Activity

1. Discuss the key concepts of rational Emotive therapy.

8.12 Reflection

What do you think are the strengths and weaknesses of rational Emotive therapy?

8.13 Summary

American psychologist Albert Ellis developed Rational Emotive Behaviour Therapy, or REBT for short. REBT is a humanistic approach that focuses on our ability to create our own positive and negative emotions. The goal of this therapy is to make changes to irrational thinking patterns, behaviours and emotional responses, using reasonable and rational thinking. Any irrational belief stems from a core 'should,' 'must,' 'have to' or 'need to' statement regarding demands about the self, others and the world.

Ellis developed an ABCDE format to teach people how their beliefs cause their emotional and behavioural responses: 'A' stands for activating event or adversity. 'B' refers to one's irrational belief about 'A.' That belief then leads to 'C,' the emotional and behavioural consequences. 'D' stands for disputes or arguments against irrational beliefs. 'E' stands for new effect, or the new, more effective emotions and behaviours that result from more reasonable thinking about the original event.

According to REBT therapists, there are three levels of acceptance: unconditional self-acceptance, unconditional other-acceptance and unconditional life-acceptance. By being accepting of ourselves, others and the world, without being overly rigid in our thinking, helps reduce stress and helps us live more fulfilling and meaningful lives.

UNIT 9 :BEHAVIORAL THERAPY

9.1 Introduction

Behavioral therapy is an umbrella term for types of therapy that treat mental health disorders. This form of therapy seeks to identify and help change potentially self-destructive or unhealthy behaviors. It functions on the idea that all behaviors are learned and that unhealthy behaviors can be changed. The focus of treatment is often on current problems and how to change them.

9.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss types of behavioural therapy.
- analyze concepts of cognitive behavioural therapy.
- apply cognitive behaviour therapy in counselling.

9.3 Time frame

You need about two (2) hours per week interacting with is material.

9.4 Content

- Types of behavioral therapy
- Cognitive behavioral therapy
- Cognitive behavioral play therapy
- System desensitization
- Aversion therapy
- Behavioral therapy for children
- The Concepts of Cognitive Behavioural Therapy
- Ethical Issues and Considerations in CBT

9.5 Who can benefit from behavioral therapy?

Behavioral therapy can benefit people with a wide range of disorders.

People most commonly seek behavioral therapy to treat:

- depression
- anxiety
- panic disorders
- anger issues

It can also help treat conditions and disorders such as:

- eating disorders
- post-traumatic stress disorder (PTSD)
- bipolar disorder

ADHD

- phobias, including social phobias
- obsessive compulsive disorder (OCD)
- self-harm
- substance abuse

This type of therapy can benefit adults and children.

9.6 Types of behavioral therapy

There are a number of different types of behavioral therapy:

9.6.1 Cognitive behavioral therapy

Cognitive behavioral therapy is extremely popular. It combines behavioral therapy with cognitive therapy. Treatment is centered around how someone's thoughts and beliefs influence their actions and moods. It often focuses on a person's current problems and how to solve them. The long-term goal is to change a person's thinking and behavioral patterns to healthier ones.

9.6.2 Cognitive behavioral play therapy

Cognitive behavioral play therapy is commonly used with children. By watching children play, therapists are able to gain insight into what a child is uncomfortable expressing or unable to express. Children may be able to choose their own toys and play freely. They might be asked to draw a picture or use toys to create scenes in a sandbox. Therapists may teach parents how to use play to improve communication with their children.

9.7 System desensitization

System desensitization relies heavily on classical conditioning. It's often used to treat phobias. People are taught to replace a fear response to a phobia with relaxation responses. A person is first taught relaxation and breathing techniques. Once mastered, the therapist will slowly expose them to their fear in heightened doses while they practice these techniques.

9.8 Aversion therapy

Aversion therapy is often used to treat problems such as substance abuse and alcoholism. It works by teaching people to associate a stimulus that's desirable but unhealthy with an extremely unpleasant stimulus. The unpleasant stimulus may be something that causes discomfort. For example, a therapist may teach you to associate alcohol with an unpleasant memory.

Is behavioral therapy effective?

Behavioral therapy has successfully been used to treat a large number of conditions. It's considered to be extremely effective.

About 75 percent of people who enter cognitive behavioral therapy experience some benefits from treatment.

One study Trusted Source found that cognitive behavioral therapy is most effective when treating:

- anxiety disorders

- general stress
- bulimia
- anger control problems
- somatoform disorders
- depression
- substance abuse

Studies have shown that play therapy is very effective in children ages 3 to 12. However, this therapy is increasingly being used in people of all ages.

9.9 Behavioral therapy for children

Applied behavior therapy and play therapy are both used for children. Treatment involves teaching children different methods of responding to situations more positively.

A central part of this therapy is rewarding positive behavior and punishing negative behavior. Parents must help to reinforce this in the child's day-to-day life.

It may take children some time to trust their counselor. This is normal.

They'll eventually warm up to them if they feel they can express themselves without consequences.

Children with autism and ADHD often benefit from behavioral therapy.

9.10 How to find a behavioral therapist?

Finding a therapist can feel overwhelming, but there are many resources that make it easier.

When finding a provider, you can choose from:

- social workers
- faith-based counselors
- non-faith-based counselors

- psychologists
- psychiatrists

You should make sure that the provider you choose has the necessary certifications and degrees. Some providers will focus on treating certain conditions, such as eating disorders or depression.

If you don't know how to get started finding a therapist, you can ask your doctor for a recommendation. They may recommend you to a psychiatrist if they think you might benefit from medication. Psychiatrists are able to write prescriptions for medication.

Most insurance plans will cover therapy. Some providers offer scholarships or sliding-scale payment for low income individuals.

A therapist will ask you many personal questions about yourself. You will know you have found the right therapist if you feel comfortable talking to them. You may have to meet with several therapists before you find the right one.

9.11 The Concepts of Cognitive Behavioural Therapy

Introduction

Cognitive Behavioural Therapy (CBT) has been considered a valid psychotherapeutic approach that stems from the branches of behavioural therapy and cognitive therapy. CBT as a treatment focuses on the fundamental premise that negative behaviours arise from faulty cognitions of a person, which can be elicited by stressors from one's self, environment, and/or others. In the following discussion, this paper covers: (1) the general concept of CBT; (2) the focal points of CBT causing the negative cognitions; (3) therapy and techniques used in CBT; (4) the application of CBT; and (5) the ethical issues and concerns arising from the procedure.

a. **Cognitive Behavioural Therapy: The General Concept**

CBT is grounded in a fundamental understanding that an individual's dysfunctional thinking can be derived from the erroneous internal processes, or systematic biases. CBT integrates components of cognitive restructuring approach of cognitive therapy with behavioural modification techniques of behavioural therapy in pursuit of devising a therapeutic structure

that could identify irrational and maladaptive thoughts, assumptions, and core beliefs related to a person's condition. In theory, mental health issues stemming from system bias cognition usually constitute polarized thinking or dichotomous thinking, overgeneralization, labeling and mislabelling, magnification versus minimization, selective abstraction, arbitrary interference, personalization, and mind-reading.

My CBT practice followed its six phases:

(1) psychological assessment usually conducted in forms of interviews dedicated to stimulating the patient's automatic thoughts.

(2) reconceptualization comprising the major part of the treatment that seeks to aid the patient in restructuring his or her views on the subjects causing the negative behaviours.

(3) skills acquisition involves the identification of skill sets the patient may require in resolving the identified maladaptive thoughts.

(4) skills consolidation and application training involves the building of skill sets that shall be used by the patient in confronting stressors and automatic thoughts capable of stimulating maladaptive behaviours.

(5) generalization and maintenance involves the sustenance of the patient's skill sets, usage of these, and the adaptive behavioural outcomes following the therapy; and

(6) post-treatment evaluation and follow-up. In the process of moving through these phases, I securely adhered to the cores of CBT as a therapy that involved the following: (a) I proceeded in teaching the client to prevent from misinterpreting the information acquired; and (b) ultimately, I proceeded in shaping the client's internal cognitive schemas as effective coping mechanism. Therefore, as I followed these components and precepts, my adhered upon CBT therapeutic framework involves the ideals and precepts of behavioural therapy and cognitive therapy that aim to identify irrational and maladaptive thoughts, assumptions, and core beliefs of an individual responsible for one's debilitating negative emotions.

b. Focal Points of CBT: The Negative Cognition

With behaviour-cognitive pathology tracing as the focal point of CBT, automatic thoughts, deviation of schemas, and maladaptive behaviours become the essential targets of the therapy. I followed the three CBT categorization of disturbances in cognition underlying psychological disorders: (1) automatic thoughts derived from the self, the world, other

people, and/or the future arise spontaneously and are not consciously directed, and produce dysphoric affect when associated with psychological disturbance; (2) rules or intermediate beliefs are the thoughts developed by the patient over time that leads the patient to expectations of himself or herself and others and guide behaviour; and lastly, (3) core beliefs or schemas provide the core target for the CBT application. In cognitive psychology, cognitive schemas are considered as the mental components that influence one's personal views, belief systems, internal values, and life assumptions. To further the foundations of my CBT therapeutic framework, I reckoned that the cognitive schemas dealt with should be the non-supportive and dysfunctional behaviours that negatively affect how a person interacts and processes stimuli when challenged by stressors. Additionally, I incorporated the cognitive triad that suggests the etiological connections of negative schemas – the triad involves (1) the self, (2) the world or environment, and (3) the future. Purposively, my incorporation of the triad should allow me to view the patient's faulty cognitive schemas: (a) that tend to perceive themselves as deficient, helpless, and/or unlovable; (b) that may view the world negatively resulting to withdrawn or distancing behaviours; and (c) that may believe future will only bring more hardship, deprivation, and frustration.

c. The Therapy & Techniques in CBT

CBT in my practice follows a problem-focused approach along with action-oriented interventions established on the fundamental premise that rationalization of one's thoughts is capable of resolving one's harmful behaviours. Additionally, my selected CBT intervention comprises various techniques that make use of: (a) cognitive elements grounded on the fundamental belief that an individual's thoughts and beliefs about situation influence the output feelings and behaviours; and (b) exploring the behavioural elements of avoidance, escape, and maladaptive developmental coping behaviours. From the cognitive domain, intervention component used often include: (1) realistic thinking – I engage with the patient in continuously eliciting stressors in an artificial environment in pursuit of letting the patient understand the difference between reality and the cognitive tensions generated by these tensions; (2) self-instruction training – I proceed by helping the patient develop coping skill sets; and/or (3) problem solving – me as the therapist and the patient logically proceed in assessing faulty cognitions and devising appropriate response behaviours to counter its effects. On the other hand, precepts used in behavioural techniques (e.g. classical and operant

conditioning) are combined with social learning theory precepts to support the fundamental premise of the technique domain – the role of thinking or cognitive mediation grounded on the mutual interaction of the individual's behaviours, emotions, and physical reactions. For instance, in the case of occurring anxiety, behavioural premise suggests that maladaptive behaviour may have actually generated from an irrational structure of thoughts prolonged inside one's mind due to the individual's evasive behaviours or fear in confronting the irrational thought.

Components of intervention utilized in the area of behavioural domain involve: (1) fear exposure – I will create an artificial setting to elicit the patient's automatic thoughts, maladaptive thoughts, and negative schemas ; (2) exposure and ritual prevention – Me as the therapist along with the patient must identify ritual behaviours elicited when confronted by stressors; (3) flooding – I facilitate an imagination or in vivo real life-based technique that leads to the extinction of unlearning of behaviours; (4) systemic desensitization – I shall include relaxation training along with three procedures, particularly (4.a.) training in progressive muscular relaxation, (4.b.) development of a hierarchy of stimulus situations ranging from those that trigger very low levels of anxiety to the one that elicits the phobic reaction; and (4.c.) sequential visualization of the hierarchy of situations while remaining relaxed; and (5) modelling – I shall conduct role-modelling (e.g. symbolic modelling, live modelling, or participant modelling) in order to allow the patient to witness and participate in difficult situations, encourage the trial of alternative ideas for resolving crises, and observe outcomes. The treatment process begins with: (a) the identification of the existing dysfunctional, inaccurate, and unhelpful behaviours in pursuit of establishing common knowledge between the therapist and the patient; and (b) the critical examination on how these behaviours were derived.

d. Application of CBT

Depression, anxiety, and substance abuse are behavioural conditions normally occurring alongside with other maladaptive behavioural patterns interrelated with tensions, stressors, and other components contributing to related morbidity and mortality brought by consequent health risk behaviours. The associated maladaptive behavioural patterns related to the occurrence of depression, anxiety, and substance abusing behaviors normally generate: (1) behaviors that contribute to committing unintentional injuries and violence; (2) substance abuse, particularly of tobacco, alcohol, and drugs; (3) risky sexual behaviors that contribute

to the occurrence of STDs, HIV, and unwanted pregnancy; (4) unhealthy dietary practices; and (5) sedentary lifestyle.

9.12 Depression

Depression is considered a condition: (a) affecting an individual's mood, thinking, behaviour, and biological processes; (b) originating from various internal and external causes; and (c) curable depending on the patient's desire to be cured. Cognitive restructuring is one of the CBT techniques used in treating patients suffering from depression. CBT utilizing cognitive restructuring was able to reduce activities of suicidal ideation among 6.3% of teen participants aged 12 to 17 years old diagnosed with major depressive disorder. Cognitive restructuring involves the eliciting of automatic thoughts, core beliefs, and maladaptive assumptions the patient may possess, and reframing and restructuring of these thoughts in pursuit of reducing depressive symptoms. In my application of cognitive restructuring therapy, I proceeded by: (a) teaching the patient to identify and to challenge irrational unrealistic and/or maladaptive thoughts; (b) encouraging the participation of the patient in recognizing goals and priorities of the treatment; and (c) assisting the identification of potential allies and necessary skills for thought reframing.

Having identified the maladaptive thoughts influencing the occurrence of depression, I aimed to reinforce the patient's skills in social interaction, assertion, communication, and affect regulation by identifying with the patient the key entities (e.g. family and peers) during alliance building. Secondly, me as the therapist along with the client and alliances establish a therapeutic map that: (a) aid the patient in identifying regular symptoms of depression; (b) identify the behaviours requiring the soonest attention; and (c) institute these definitions as goals of the therapy with defined evaluation criteria for post-goal assessment. Finally, skill building proceeds by utilizing self-instruction training activities that aim to aid the patient's problem solving skills utilized whenever confronted by the psychosocial stressors and other triggers of depression. Throughout the treatment, I considered the triggers or activating stimuli responsible for reinforcing faulty behaviours that can either be from internal (e.g. anxiety, boredom, excitement) or external cues (e.g. images from commercials capable of eliciting one's memory). These cues generate anticipatory and relief-oriented beliefs that lead to automatic thoughts producing the dysfunctional behaviours.

9.13 Anxiety

In CBT, anxiety is believed to be: (a) the physical manifestation of biological vulnerability of an individual towards an acute introduction of stressors; (b) the uncontrolled response of an individual when engaged by stressful life events; (c) the manifestation of maladaptive behaviours in response to confronting threats; and (d) the inaccurate, exaggerated, and overly threatening cognitive interpretations of an individual towards a pressing life event. Three most commonly performed CBT programs to treat anxiety include: (a) Virtual Reality Exposure Therapy (VRET); (b) Relaxation Training; and (c) Biofeedback.

VRET has been applied using the so-called CAVE system or Computer Automatic Virtual Environment wherein the patient and me as the therapist are enclosed by a stereoscopic computer-generated images on a cubicle that facilitate experience simulation, or HMD system wherein a head mounted display is placed on the client while I proceed with the simulation and scoring of anxiety levels. VRET concept follows: (a) that virtual environment is capable of eliciting fear and activating anxiety triggers during the process of simulated exposure; and (b) that in the case of in vivo exposure, the introduction of information may disconfirm anxiety beliefs, and may eventually progress towards habituation. Meanwhile, Relaxation Training features the training and strengthening of the individual's relaxation response that counteracts the impacts of anxiety-generating stimuli. The use of relaxation training in treating general anxiety disorders showed consistent and evident efficacy of relaxation training in reducing anxiety. Lastly, Biofeedback makes use of bodily signals in order to identify stress physioresponses, and counter these through relaxation and management of pain. Accordingly, biofeedback procedure displays involuntary or sub-threshold physiological processes via electronic instruments that are exposed to stress-generating stimuli by altering the patient's cognition.

9.14 Substance Abuse

CBT techniques to deal with substance abuse therapeutically focuses on complex behaviours that arise from substance-related beliefs, related automatic thoughts, and maladaptive assumptions. Substance-related beliefs can be constituted (a) by positive or anticipatory beliefs about the eventual outcomes of substance use, such as the anticipation for grandeur feeling from marijuana use, or (b) by negative anticipatory beliefs, such as one's fear of experiencing withdrawal symptoms following rehabilitation for substance abuse. While automatic thoughts can actually occur spontaneously and consciously uncontrollable, these

cognitions often hints the underlying belief system of a person derived from one's personal memory or knowledge system. Permissive beliefs established along with a tolerant environment or self enables the establishment of one's action plans, which in turn produces continued use or relapse of substance abuse. One of the technique I used to apply CBT in treating substance abuse practices involves Dialectical Behavioural Therapy (DBT) that emphasizes two principal premises: (1) behavioural and problem-solving focus; and (2) acceptance-based strategies emphasizing and building on dialectical processes. Functional components of the treatment include: (a) training of skills related to enhancing the patient's behavioural capabilities for relieving from substance abuse; (b) creation of individualized behavioural treatment plans that can be used for motivational enhancement; (c) generalization via in vivo assignment, and phone consultations; (d) reinforcement of sobriety and adaptive behaviours via environment restructuring; and (e) motivational enhancement of therapist.

Utilizing this treatment approach, I was able to observe successful reduction of substance usage of the patient following a post-CBT 12-month follow-up. Meanwhile, I also introduced the client to several CBT techniques aimed at fostering coping skills, and these techniques included (a) contingency contracting, (b) communication skills training, (c) identifying one's distortions, and (d) motivational interview engagement. These techniques are geared in stimulating the person's thoughts on substance use to help them identify core beliefs and relevant automatic thoughts. With motivational interviews during the therapist-patient interaction, the communication aims to develop the odds of the patient entering and actively pursuing the treatment process. Furthermore, open-ended questions I used during the interviews encourage the patient to explore his or her personal belief systems, feelings, and behaviors related to substance usage, whereas reflective listening aids the patient in expressing selective reinforcement of ideas.

9.15 Ethical Issues and Considerations in CBT

The core components of ethical issues surrounding CBT centre on (a) the patient's thinking patterns exposed throughout the treatment, (b) the vulnerability of the patient while under treatment, (c) the risk of the patient experiencing abuse and/or other mental compromises and/or exploitation, and (d) confidentiality of personal information of the patient. During treatment, patient's cognition, thought patterns, and maladaptive behaviours are elicited and are vulnerable to potential outside harm. One of the key ethical concern in this domain involves the maintenance of patient confidentiality following the process of therapy: (a)

protecting, safeguarding, and adequate archiving of patient's records, relevant and important documentations, sensitive responses, and personal verbalized thoughts; (b) maintaining and securing patient privacy during sensitive interviews aimed at stimulating one's core beliefs and automatic thoughts; (c) measuring the welfare of the patient over the wholeness of goals and objectives set for the treatment especially when the therapist encounters resistance from the patient's end, such as in scenarios wherein a patient's treatment process requires disclosing of sensitive thoughts in group participations (e.g. substance abuse forum); and (d) respecting the patient's disclosure readiness towards significant personas involved in the treatment (i.e. parents).

Aside from confidentiality, another ethical concern in CBT involves prevention of harm and abuse from the therapist, the entities involved in the treatment, and other relevant parties. The ethics of non-maleficence or the act of not doing harm to the patient or to others involved in the therapy covers the following considerations: (a) when sociocultural factors involved in the treatment process already conflicts with the patient's understanding of social and/or familial roles (e.g. depression and anxiety brought by non-conventional sexual behaviours, such as homosexuality, that can be taboo in the client's cultural background, but not for the therapist's perspective, or vise versa); and (b) the patient believes the therapy is already interfering to his or her internal motivations for resorting to maladaptive behaviours (e.g. bulimia or anorexia secondary to fear of gaining weight; relapse marijuana addiction symptoms, such as "the shakes"). In responding to the ethical requirement of non-maleficence, therapist-patient initial conversation should be able to establish boundaries with clear definitions of related conditions. First, I must be able to lay down his or her positional role with the patient as well as the involved supporting entities (e.g. parents, siblings, peers) in order to set limitations throughout the course of the therapy. However, it is also essential that ethical consideration of non-maleficence take into consideration the nature of these boundaries, especially when restriction of as such could affect the outcomes of the therapy (i.e. issue concerning family sexual/ physical abuse causing maladaptive behaviours). Lastly, another consideration for non-maleficence involves the probability of countertransference or when my automatic thoughts and schemas are activated by the provided treatment, and in the process, compromises the treatment course. Thus, to prevent this, I must be conscious in assessing self-generated automatic thoughts, such as 'this patient has no interest in the therapy', and must be equip with the proper knowledge on countering such generation of thoughts.

9.16 Terminologies

1. Panic disorder: sudden episode of fear or anxiety and physical symptoms based on a perceived threat rather than eminent danger.
2. Bulimia: is an illness in which a person has a great fear of becoming fat and so they make themselves vomit after eating.

9.17 Activity

1. Discuss types of behavioural therapy.

9.18 Reflection

In your own understanding how can you describe behavioural therapy?

9.19 Summary

CBT as a concept of therapy focuses on identifying problematic thoughts occurring in three forms – automatic thoughts, rules, and schemas – that influence the negative behaviours and maladaptive thoughts of the patient. Using cognitive and behavioural techniques in the process, the therapist engages to the treatment by eliciting the patient's problematic thoughts, enabling reconceptualization of thoughts, aiding in the acquisition of coping skills to confront stressors, guiding the patient in consolidating skills and application training, and securing patient's maintenance of the skills. Lastly, ethical considerations in providing the treatment includes regards on the patient's confidentiality and vulnerability, securing ethics of non-maleficence, preventing countertransference, and boundary settings.

UNIT 10: PSYCHOANALYTIC THERAPY

10.1 Introduction

Psychodynamic therapy is a "global therapy," or form of therapy with a holistic focus on the perspective of the client. The alternative, "problem-based" therapies, such as cognitive behavioural therapy, aim to reduce or eliminate symptoms instead of exploring the client's deep-seated needs, urges, and desires (McLeod, 2014). This translates into significant differences between these therapies in terms of goals, techniques, and general approach.

"In contrast [to behavioural therapy], dynamic psychotherapy, which facilitates a patient's rewriting of his life narrative, his picture of himself, his past, present, and future, seems uniquely positioned to address the depth of an individual's experience." – Richard F. Summers

The global vs. problem-based therapy dichotomy is not the only factor that sets psychodynamic therapy apart from these other, more common forms of therapy. Psychodynamic therapy involves the interpretation of mental and emotional processes rather than focusing on behaviour (Gad, 2017).

10.2 Learning Outcomes

By the end of this unit, you are expected to;

- examine goals of psychodynamic theory.
- discuss key concepts of psychodynamic theory.
- explain the role of the psychodynamic therapist.

10.3 Time frame

You need about three (3) hours per week interacting with is material.

10.4 Content

- Goals of Psychodynamic Therapy
- Psychodynamic Theory, Perspective, and Key Concepts
- Psychoanalysis: The Freudian Approach
- Role of the Psychodynamic Therapist
- Types of Psychodynamic Therapy
- Brief Psychodynamic Therapy

- Psychodynamic Family Therapy
- Psychodynamic Art / Music Therapy
- Psychodynamic Diagnostic Manual (PDM)
- Rorschach Inkblots
- Freudian Slip
- Free Association
- Dream Analysis
- A Take-Home Message
- Psychoanalytic Terms & Concepts
- Confrontation
- Countertransference
- Defence Mechanisms

Psychodynamic therapists attempt to help clients find patterns in their emotions, thoughts, and beliefs in order to gain insight into their current self. These patterns are often found to begin in the client's childhood since psychodynamic theory holds that early life experiences are extremely influential in the psychological development and functioning of an adult (Gad, 2017).

Psychodynamic therapy aims to help the client identify important pieces of the puzzle that makes them who they are and rearrange them in ways that allow the client to form a more functional and positive sense of self:

"We see the central task of psychotherapy as the rewriting of a more complex and useful narrative of the patient's life and experience." – Richard F. Summers.

Psychodynamic therapy sessions are intense and open-ended, dictated by the client's free association rather than a set schedule or agenda. They are typically scheduled once a week and last about an hour. While Freud's psychoanalytic therapy (described in more detail below) demanded a much greater investment of time, current psychodynamic therapy is generally practiced in a less intensive manner (WebMD, 2014).

Modern psychodynamic therapy also substitutes a pair of chairs for the stereotypical couch and usually places the therapist and client face-to-face rather than keeping the therapist hidden from the client's view.

In these sessions, the therapist will encourage the client to talk freely about whatever is on their (conscious) mind. The thoughts and feelings discussed will be probed for recurring patterns in the client's unconscious mind.

This form of therapy is commonly used with clients suffering from depression or anxiety diagnoses, and there is some evidence suggesting that psychodynamic therapy may be as effective in treating depression as other forms of therapy (WebMD, 2014).

10.5 Goals of Psychodynamic Therapy

The main goals of psychodynamic therapy are to (1) enhance the client's self-awareness and (2) foster understanding of the client's thoughts, feelings, and beliefs in relation to their past experiences, especially his or her experiences as a child (Haggerty, 2016). This is accomplished by the therapist guiding the client through the examination of unresolved conflicts and significant events in the client's past.

The assumption in psychodynamic therapy is that chronic problems are rooted in the unconscious mind and must be brought to light for catharsis to occur. Thus, the client must have the self-awareness to discover these unconscious patterns of thought and an understanding of how these patterns came to be in order to deal with them.

10.6 Psychodynamic Theory, Perspective, and Key Concepts

To truly understand psychodynamic therapy, you need to go back to its roots. While this type of therapy has changed over the last century, it is still built on the foundations of some of the earliest work in modern psychology.

In the late 19th century, Sigmund Freud was working on his grand idea of the human mind and the theory of human development. His theories laid the foundation for decades of psychological research and practice. While many of these theories were eventually found to conflict with hard evidence gained through scientific research, they formed the basis for psychodynamic theory and sparked a bold new school of thought that still exists today, in a modified and updated form.

He proposed that the human mind is composed of three parts:

- The id, which consists of instinct and forms the basis of the unconscious mind;
- The superego, or moral component that houses our beliefs of right and wrong;

- The ego, the mediator between the animal instinct of the id and the enlightened moral thought of the superego (Haggerty, 2016).

Freud hypothesized that these components grew out of certain stages in childhood development. He believed humans are born with the id, develop the ego as a toddler, and add the superego around the age of five. Freud's hypothesis led him to the logical conclusion (based on his theory) that one's personality is firmly rooted in their childhood experiences.

While Freud believed that each component formed in each human, the development of each component could be significantly influenced by one's environment and family relationships. These factors could contribute to the development of a healthy sense of self and effective functioning, or they could trigger the development of neuroses and dysfunctional or distressing patterns of thought.

Whether the development led to positive or negative patterns of thoughts and belief, Freud held that that which truly drives human behaviour is buried deep within the human mind, in what he termed the unconscious mind.

Freud theorized three levels of the mind:

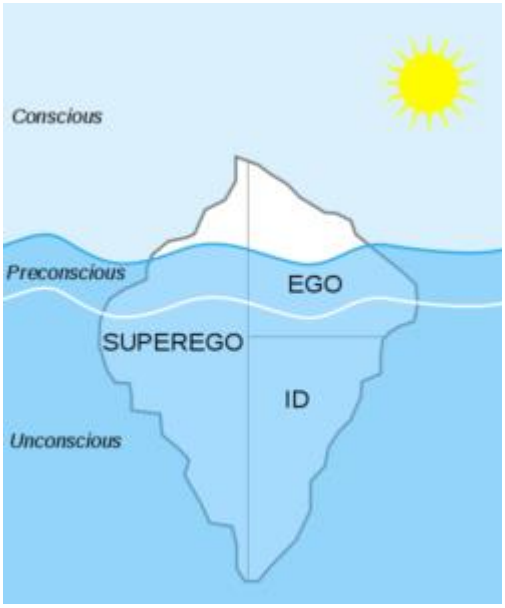
The Unconscious: this level is where our instincts, deeply held beliefs, and many patterns of thought and behaviours reside; we are not consciously aware of anything at this level, but Freud believed the contents of the unconscious mind make up the vast majority of who we are, what we want, and how we behave in order to get what we want.

The Subconscious or Preconscious: this level is between the conscious and unconscious, and can be called up to consciousness with a purposeful effort from the individual; the contents of this level are just below the surface of consciousness.

The Conscious: this is the level at which we are fully aware; Freud believed this was the level with the least defining content, the level that makes up only a tiny sliver of who we are.

Based on this theory, Freud insisted that to truly address our issues and solve our problems, we must dig deep into the unconscious level. This is where we store our unspoken values, the beliefs we do not even realize we have, and the patterns of thought and behaviour developed in our childhood.

Figure 3: **levels of consciousness** (Hedges, 1983, Psychoanalysis)



While psychodynamic theory has outgrown many of Freud's simplistic ideas about human nature, many of the assumptions that underlie the psychodynamic approach are reminiscent of Freud's work:

The unconscious mind is one of the most powerful drivers of human behaviours and emotion;

No behaviours is without cause—all behaviours is determined;

Childhood experiences exert a significant influence on thoughts, emotions, and behaviours as an adult;

Important conflicts during childhood development shape our overall personality as adults (Freud, 1899).

Freud's theories directly support the methods of psychoanalysis, but also help form the basis of psychodynamic theory and inform the methods and techniques used in today's psychodynamic therapy.

10.7 Psychoanalysis: The Freudian Approach

While psychoanalysis and modern psychodynamic therapy grew from the same source, there are several important differences between the two forms of therapy.

First, the timeline and duration of psychoanalysis are far more intensive than modern psychodynamic therapy. Psychoanalysis is generally conducted in two to five sessions per week, lasting several years (McLeod, 2014).

Second, the physical layout of the office or therapy room is significant—in psychoanalysis, the client (or patient, as they are usually called) lies on his or her back on a couch while the therapist sits behind them, out of their line of sight. In modern psychodynamic therapy, it is much more common for therapist and client to face one another, or at least remain in the other's field of vision.

Third, the relationship between therapist and client/patient is much more imbalanced than in modern psychodynamic therapies. The position of the therapist and client suggests a significant imbalance of power, with the therapist acting as a distant and detached expert with techniques and knowledge that will not be shared with the client. Meanwhile, the client acts as a troubled supplicant who relies on the therapist for their expertise in teasing out the dysfunctional thoughts and beliefs that plague them (McLeod, 2014).

Some of the psychoanalytical practices have survived or been adapted for modern use, but this uneven relationship between therapist and client generally does not carry over to current psychodynamic therapy. The therapist's role has been modified over the last century to alter the hierarchy and provide a more equal setting for treatment.

10.8 Role of the Psychodynamic Therapist

Today, the role of the therapist in psychodynamic therapy is to work with the client to discover the bases for their symptoms.

The therapist plays this role by encouraging the client to talk about the emotions they are feeling and helping the client to identify recurring patterns in their thoughts, emotions, and behaviours. They can aid the client in finding the significance of these patterns and discovering the effects they exert upon the client.

One of the most important roles of the therapist is to probe the client's past. Discussion of the client's childhood and early life experiences will likely take up a large portion of psychodynamic sessions, as this form of therapy assumes these experiences have a significant impact on the client's current issues.

The therapist observes how the client interacts within the therapeutic relationship and add their own insight into the client's relationship habits to the discussion. The psychodynamic theory holds that how the client acts in the relationship with the therapist usually mirrors how they act in other relationships, such as with a parent or other important adult from their childhood (WebMD, 2014).

In general, the therapist's role is to aid the client in connecting the dots between their past experiences and their current problems, and leverage their internal resources to address these problems.

10.9 Types of Psychodynamic Therapy

Throughout this piece, I have referred to psychodynamic therapy as a singular entity to make the discussion of psychodynamic therapies easier; but truthfully writing, psychodynamic therapy is more a category of therapies rather than a single type.

All of the therapies below are grounded in the same overarching model of psychodynamic theory, but they apply the tenets of this theory in different ways.

10.10 Brief Psychodynamic Therapy

The aspect of brief psychodynamic therapy that sets it apart from other types of psychodynamic therapies is right in the name: brief.

This type of therapy is generally conducted over the course of only a few sessions, or even just one session in some cases. Sometimes an individual struggling with a specific problem only needs to make a few important connections to overcome that problem. For instance, if a client is suffering from acute anxiety with no known source, the identification of an event or circumstance that gave rise to this anxiety and a strategy for coping can be accomplished in one session.

While the resolution of problems should not be expected in one session for all those seeking treatment, there are several instances where identifying and dealing with a specific problem can be a relatively brief investment.

Brief psychodynamic therapy has been applied to situations like:

- Rape;
- Accident (traffic, physical injury, etc.);

- Act of terrorism;
- Acute psychological disturbances (like anxiety or depression);
- Traumatic family event (discovery of a secret, divorce, etc.).

For more information on brief psychodynamic therapy, visit this link.

10.11 Psychodynamic Family Therapy

This form of psychodynamic therapy is practiced in the context of a family, whether that family is comprised of two adults in a romantic relationship, a parent and child(ren), siblings, grandparents and grandchildren, a traditional nuclear family, or any combination of these family members.

This therapy is usually relatively long-term (versus the shorter term family therapy based on CBT or IPT) and often is instigated by chronic problems in the family (rather than a significant event or the emersion of a specific problem in the Like other psychodynamic therapies, this form focuses on unconscious processes and unresolved conflicts but views them in the context of family relationships. The therapist will lead the family members through an exploration of family history, especially any traumatic family events.

Often, this form of therapy emphasizes the importance of the adult members of the family working out any conflicts with their own parents as a way to better understand the conflicts with their partner(s) and child(ren).

Psychodynamic family therapy can help families to discover and address the deep-seated issues that give rise to family problems, leading to a healthier and happier family dynamic.

10.12 Psychodynamic Art / Music Therapy

This non-traditional form of psychodynamic therapy involves the expression of feelings and emotions through art or music.

Like other types of psychodynamic therapy, this therapy is non-directive and non-structured, allowing the client to lead the session. It does not require any artistic or musical talent or ability, only that clients are able to use music or art to express themselves.

Clients may showcase specific pieces and talk about the emotions they evoke, connect them to events from childhood, or discuss the meaning they find in these pieces. Or, clients might bring in a specific song or album that they feel they can relate to on a deep level.

Alternatively, clients can actually create art or music in the session. It doesn't have to be "good" art or music, it only needs to convey the thoughts or feelings of the clients in a way that makes sense to them.

Through art and/or music, the therapist and client can build an understanding and form an important bond. They may find that art and music are better methods of deep communication than talking.

This type of therapy may be particularly well suited for those who are shy or otherwise find it difficult to talk, as well as clients who are experiencing crippling anxiety or fear which music or art can help to soothe.

10.13 Psychodynamic Tools and Techniques

Psychodynamic therapy relies less on exercises and activities than most other types of therapy, but there are some very important tools in the psychodynamic toolbox that allow the therapist to delve deep into the unconscious mind with their clients.

The five tools and techniques below are common practice for many types of psychodynamic therapy.

10.14 Psychodynamic Diagnostic Manual (PDM)

The Diagnostic and Statistical Manual, or DSM, is often referred to as the clinical psychologist's Bible. The DSM serves as a framework for understanding and evaluating behaviours within a therapeutic context.

Psychodynamic therapists and theorists sometimes critique the DSM's focus on observable symptoms and omission of more subjective experiences as criteria for diagnosis.

To solve this problem of disagreement over diagnostic criteria, a Psychodynamic Diagnostic Manual (or PDM) was released in 2006 as an alternative or complement to the DSM. Those practicing psychodynamic therapy may find this manual to be more useful in diagnosing and treating their clients than the standard DSM.

10.15 Rorschach Inkblots

While these ambiguous and untidy splotches of ink are closely connected to Freudian psychoanalysis, they are also used in some forms of psychodynamic therapy today.

The Rorschach Inkblot test seems to be a particularly misunderstood tool in the general population. Pop culture has made the test out to be either an end-all, be-all test of an individual's personality, unique psychology, and predictor of all manner of mental health maladies, or a useless exercise in naming unnameable shapes.

In fact, the Rorschach test is neither of these things. It cannot illuminate your entire childhood experience, but it is also not a useless bit of trivia from a psychological era gone by.

The original Rorschach inkblots were developed in the early 1900s by psychologist Hermann Rorschach (Framingham, 2016). At the time, a popular game called Blotto involved a set of inkblots that could be organized into a poem or story or used in a round of charades. Rorschach noticed that patients diagnosed with schizophrenia reacted differently to these inkblots, and began studying their use as a tool for diagnosis and discussion of symptoms.

His work resulted in a set of 10 inkblot images that can be presented to a client with the intention of observing and projecting based on their reactions to the images.

To conduct the Rorschach test, the therapist will present each inkblot to the client individually and ask the client to describe what they see. They are free to use the image as a whole, a piece of the image, or even the blank space surrounding the image to form an interpretation. Rorschach Inkblot Tests. Image Courtesy of Wikimedia Commons.

The therapist will take notes on the client's descriptions and how they interpret the image. They may also ask additional questions to get the client to elaborate on what they see.

While there is controversy over how valid and reliable the results of this test should be considered, many therapists find that they provide valuable qualitative information about how the client is feeling and how they think (Cherry, 2017). It has also been found to be somewhat effective in the diagnosis of thinking disorders (such as schizophrenia and bipolar disorder). Those with these types of disorders tend to see and interpret the images differently than those without such diagnoses.

The important part of this test is the process of interpretation and description undertaken by the client, rather than any specific content seen in the inkblots. As such, the use of this test requires a highly trained professional to conduct, score, and interpret.

10.16 Freudian Slip

This may be the least formal (and perhaps least applied) technique in psychodynamic therapy, but it is certainly not a dead concept yet.

A “Freudian slip” is also known as a slip of the tongue or, more formally, parapraxes. These slips refer to instances when we mean to say one thing but accidentally let “slip” another, specifically when deeper meaning can be attributed to this slip.

For example, you might call it a Freudian slip when someone intends to say “That is your best idea yet!” but accidentally says “That is your breast idea yet!” You may assume that this individual has a certain anatomical feature in mind, or associates the person they are addressing with said feature.

Another example could be when you are feeling frazzled or overwhelmed at work and your boss pops by for a quick discussion. You aren’t really paying attention, and you absentmindedly say “Thanks Mom” instead of using your boss’ name. A psychoanalyst may consider this slip and decide that you have unresolved issues with your mother and that you are trying to fill the void of that parental relationship with your boss.

Freud (and some subsequent psychodynamic theorists) believed that these “accidental” slips of the tongue are not truly accidental, but actually reveal something meaningful about you. The Freudian theory holds that no behaviour is accidental or random; rather, every move you make and every word you say are determined by your mind (conscious, subconscious, or unconscious) and your circumstances.

A psychodynamic therapist may pay special attention to any such slips, whether they occur in session or are simply related by the client during a session, and find meaning in the word substitution. They may conclude that a slip is actually a little piece of your unconscious finding its way to the surface, indicating an unmet desire or unknown association between two concepts.

While most modern psychologists agree that Freudian slips are generally just “slips,” it’s hard to argue that a slip of the tongue can’t occasionally reveal an interesting connection in the speaker’s mind.

10.17 Free Association

Free association may be the single most important and most used tool for psychodynamic therapists. This technique is simple and often effective.

In the context of psychodynamic therapy, there are two meanings attached to "free association:" the more official therapy technique of free association, and the general method of in-session discussion driven by the client's free association between topics.

The more formal technique involves the therapist reading a list of words and the client responding immediately with the first word that comes to mind. This exercise can shed light on some of the associations and connections the client has hidden deep below the surface.

This technique may not be as useful to a client who is resistant to the exercise or to sharing intimate details with the therapist. However, therapists should not assume that a client who pauses before responding is resistant—it may indicate that the client is getting closer to a repressed or highly significant connection.

Free association may provoke an especially intense or vivid memory of a traumatic event, called an abreaction. This can be extremely distressing for the client, but it can also lead to a healing experience of catharsis if the client feels like it helped them work through a significant problem (McLeod, 2014).

The less formal concept of free association is simply the tendency to allow the client to lead the discussion in psychodynamic therapy sessions. This kind of relaxed, non-structured approach to dialogue in therapy is a hallmark of psychodynamics.

Practicing this type of informal free association ensures that the therapist is not leading the client anywhere in particular and that the client is moving authentically from one subject to the next. This is critical in psychodynamic therapy, as it is unlikely to reach the unconscious sources of psychological distress without following the client's lead.

10.18 Dream Analysis

Another vestige of Freudian therapy, this highly subjective technique can prove useful for some, although its efficacy as a treatment technique is not proven via the scientific method.

There are nearly countless ways that therapists, coaches, counsellors, and practitioners of the more mystical arts engage in dream analysis, none of which have been identified as more effective or useful than the others.

However, one popular method of analysing dreams comes from psychologist and author Dr. Patrick McNamara. His theory of the dreaming process can be explored on an individual level, allowing the client to attempt to sort through their own dreams to find meaning.

McNamara's proposed process of dreaming is as follows:

Step One: The dreamer disentangles their consciousness from executive control/personal agency. In other words, the dreamer de-identifies with their usual self and sets up a "liminal state"—a state in which the dreamer is prepared to explore a new identity.

Step Two: The dreamer moves into this liminal space, opening him- or herself up to a world of possibilities in regards to their identity. This step is like taking off your usual "mask" and set it aside in anticipation of finding a new mask.

Step Three: This step typically occupies the most time and material of the dream, in which the dreamer "tries on" a new identity. The dreamer may be experiencing fear or anxiety associated with shedding their identity, and he or she may seek to re-establish a sense of control by searching for another identity or alternate sense of self.

Step Four: The dreamer finds a new, altered identity or resumes their old identity. McNamara believes we are searching for a more unified sense of self, but that we often find an identity that includes aspects of our darker side (McNamara, 2017).

These steps are tied into four literary tropes that some believe we use to make sense of the narratives we encounter and experience: metonymy (breaking up the pieces of a narrative), synecdoche (reorganizing those pieces into a new whole), metaphor (comparison of the pieces or the whole with something familiar), and irony (reflection of the new whole).

Using these tools for understanding narrative, McNamara suggests we can apply this process and the literary tropes to parse the meaning of any dream or dream sequence (2017). Of course, this technique has not been proven through scientific research, but you may find it helpful nonetheless.

10.19 A Take-Home Message

This piece is intended to give you a background in the theory and practice of psychodynamic therapy. This form of therapy paved the way for many of the most popular current forms of therapy and introduced several important ideas to the field of psychology.

While it may not enjoy a place at the top of the therapy hierarchy any longer, it is still a widespread form of therapy that can be effective for many clients, making it a worthwhile topic to explore.

As always, we'd love to hear from you in the comments section! Have you participated in psychodynamic therapy? What was the experience like for you? Did you learn anything significant from your foray into your unconscious mind?

of Form

10.20 Psychoanalytic Terms & Concepts Defined

10.20.1 Confrontation

This is a practice often done prior to an intervention where the patient is encouraged to attend to experiences that they have been avoiding.

10.20.2 Countertransference

This refers to the analyst's feelings and attitudes towards the patient: his/her reaction to the patient's transference, how his/her own experiences impact his/her understanding of the patient, and the analyst's emotional responses to the patient.

10.20.3 Defence Mechanisms

Defence mechanisms are used by the ego as a way to deal with conflict of problems in life. Operating at an unconscious level, defence mechanisms help to reduce negative feelings (e.g. anxiety and guilt). Common defence mechanisms include repression, denial, and projection.

10.20.4 Denial

Denial is an individual's refusal to accept certain or confront (or all) aspects of a given reality in order to avoid potential feelings of discomfort. It exists on a continuum as it can be seen as just a normal reaction to a stressful event or to severe psychosis. While commonly defined as a type of defence mechanism, denial plays a role in all defence mechanisms. Freud also referred to it as disavowal.

10.20.5 Dream

It is a mental event that consists of hallucinations involving imagery and emotions. Dreams occur during the rapid-eye movement (REM) stage during sleep. According to Freud, current concerns and unconscious childhood wishes are present during the day and require gratification and it is dreams that allow us to respond to this demands while continuing to sleep (e.g., a person who is thirsty dreams about drinking water which allows him to continue sleeping rather than having to wake up and satisfy his thirst).

10.20.6 Ego

Sigmund Freud theorized that the mind was divided into three parts: id, ego and superego. The function of the ego can be described as running interference between the id and the superego. It mediates between the drives of the id and the need for self-preservation. The ego is responsible for the development of the skills needed to function in the world, for example, impulse control, perception, evaluation and judgment.

10.20.7 Ego Ideal

This is a part of the superego that contains standards, values and moral ideals. Failure to meet these standards can cause feelings of guilt or shame, while success can enhance self-esteem.

10.20.8 Electra Complex

A term coined by Jung as the female counterpoint to what Freud called the Oedipus complex, it takes its name from the Greek myth of Elektra who, along with her brother Orestes, avenged the murder of their father, Agamemnon, by killing their mother Clytemnaestra and her lover Aegisthus. The term describes the urge of a 3-6-year-old girl to have her father to herself, excluding her mother. Freud did not use this term, but continued to use Oedipus complex to refer to the phenomenon in both genders.

10.20.9 Fantasy

A fantasy loosely refers to an imagined situation that expresses certain desires or aims of the imagining individual. It can occur at the conscious level, also known as a daydream, or unconsciously, sometimes referred to as *phantasy*.

10.20.10 Fixation

Fixation is a state where a person becomes attached to or overly invested in another individual or object. Fixation is the result of conflict occurring during the psychosexual stages of development. Due to frustration or overindulgence occurs, the libido becomes focused on that stage leading to problematic behaviours later on (e.g., an individual with an oral fixation may engage in nail biting).

10.20.11 Id

Sigmund Freud theorized that the mind was divided into three parts: id, ego and superego. The id is the part of the mind that contains one's most basic and instinctive drives. It is governed by sexual and aggressive desires and pleasure seeking. The contents of the id are entirely unconscious; Freud stated that the goal of analysis is to uncover what is repressed in the id so that, "where id was, there ego shall be." (Sigmund Freud, 1933, New Introductory Letters on Psychoanalysis, Standard Edition, 22.

10.20.12 Libido

A term generally used to refer to one's sexual desires or more specifically, the mental energy responsible for one's sex drive. This concept represents Freud's notion that sexual interest exists throughout life and that it is responsible for activities that involve sexual desire and/or affection.

10.20.13 Parapraxis (Freudian Slip)

Revealing an unconscious desire or conflict through a mistake, for example, a slip of the tongue or forgetting someone's name.

10.20.14 Pleasure Principle

The driving force of the id, this refers to one's desire to obtain immediate gratification of needs by obtaining pleasure and avoiding pain. When our basic needs are not met, feelings of anxiety may develop.

10.21 Terminologies

1. Super ego: or moral component that houses our beliefs about what is right and wrong.
2. Freudian slips: these are instances when we mean to say one thing but accidentally say something else.

10.22 Activity

1. Discuss types of psychodynamic therapy.
2. Discuss goals of psychodynamic theory.

10.23 Reflection

Do you think the Freudian slip of the tongue really reveals the hidden intentions of the speaker?

10.24 Summary

In this unit, you have learnt about goals and tools of psychodynamic therapy namely. Freudian slip. Free association, dream analysis. You have also learnt about psychodynamic

terms and concepts such as; confrontation and counter transference. Defence mechanism have also been explained. In the next unit, you will learn about attribute of a good counselling.

UNIT 11: ATTRIBUTE OF A GOOD COUNSLLOR

1.1 Introduction

Some people wonder what makes for a competent career-ready Counsellor? Is it what the Counsellor knows? What qualification they have studied? Where they have studied? What supervised practice the Counsellor has had?

Each one of these factors is part of what makes for an effective Counsellor. But in additional to the theoretical and practical knowledge taught, here are ten characteristics.

11.2 **Learning Outcomes**

By the end of this unit, you are expected to;

- discuss attributes of the good counselling

11.3 Time frame

You need about three (3) hours per week interacting with is material.

11.4 Content

- Counselling skills.
- Active Listening
- Attending Behaviour11.8 Interviewing/Asking Questions
- Reflecting Feelings
- Praise appropriate practices
- Giving Information and negotiating changes
- Use of local language
- Remain neutral and non-Judgmental
- Be consistent in giving advice
- Summarizing and Paraphrasing

1. **Empathy**

   Empathy is the ability to understand and share the feelings of others. As a Counsellor, you need to be able to put yourself in the shoes of your client and understand the

situation from their point of view. Even if you don't agree with their perspective, you still need the ability to understand how it feels to them in order to address their issue effectively.

2. **Discretion**

   Confidentiality is of upmost importance when you are a Counsellor. You must be able to maintain confidentiality so the client can trust you and so that an effective rapport can be built with your client.

3. **Patience**

   As a Counsellor you need to have patience with your clients as they process the discussion. It may take them time to accept certain things and to move towards positive changes. It may also take time for you to see large changes.

4. **Compassion**

   It is very important that your clients sense you truly care about them. You may not be able to relate to every issue that is shared with you, but you need to be able to have compassion for how it feels to be in their shoes.

5. **Encouragement**

   The ability to encourage and instill hope in the client, is important attribute of a Counsellor.

6. **Self-Awareness**

   A Counsellor who is aware of their own feelings and does not react defensively to what a client shares, will be more effective in the therapeutic relationship.

7. **Open Mindedness**

   Counsellors hear all kinds of private information and encounter all types of people. It is important that the client understands that you are not personally judging them but working on improving the outcomes of their behaviors.

8. **Flexibility**

   The competent Counsellor understands the need to remain flexible in their approach often using a variety of conversational responses depending on the needs of the client. Sometimes we ask questions. Other times we are silent.

9. **Good Listener**
   Counsellors spend a significant amount of time listening to their clients. You will need to be intuitive in discerning what the client is really saying and "read between the lines" to translate their dialogue into goals that the client can work towards, in order to reach resolution.
10. **Ability to care for self.**
    Finally, the competent Counsellor recognizes personal limits, boundaries and actively seeks to sustain a life of personal care.

A good counsellor will be one who shares common attributes and is able to offer empathetic support and understanding, in a caring, comforting manner and support.

11.5 The following are some of the skills that you need as a counsellor:

Active Listening

As a health worker, you should listen to what your patient/client says. Show the patient/client that you are p
For example, rather than looking through papers on your desk as the patient/client is talking to you, you sho
face as you listen.

Attending Behaviour

You should greet your patient/client politely and make him/her feel comfortable and relaxed. With facial e
contact, gestures, and posture, show him/her that you are interested in what he/she is telling you.

Interviewing/Asking Questions

As a good counsellor, you should ask open-ended questions as opposed to close-ended questions. You shou
probing questions.
We have used three expressions i.e. close ended, open-ended and probing questions. Before we proceed to
other skills, let's explain what they are.

- *What is a closed ended question?*

A closed ended question is a question that invites a "Yes" or "No" response. For example, "Are you happy are taking?" This is a bad question because it does not provide the client with an opportunity to express his

- *What is an open-ended question?*

An open-ended question is a question that leaves room for a patient/client to give a detailed and complete a example, "tell me about your experience so far with the drug you are taking".

- *What is a probing question?*

A probing question is a question that asks for more details for example, "And what else can you tell me?" o after that?" "Is there anything else you would like to add?" And so on.

NOTE: You should avoid asking why questions because they may elicit feelings or actions that can be com embarrassing.

A good counsellor asks open-ended questions and probing questions because they encourage the patient/cli express his/her feelings. Next time you counsel a patient/client try to use both the open ended and probing q

Reflecting Feelings

By observing and listening, you can imagine how a patient/client feels. You can then tell the patient/client w think. When a patient/client gives a vague answer, you can point this out by saying "You seem not to be cl serves three purposes:

- The patient/client thinks about how he or she feels and why;
- You the health worker can find out whether the patient/client is confused;
- If there is confusion you can clear it up through discussion.

Praise appropriate practices

You should praise a patient/client for any good practice he/she may mention.

11.6 Giving Information and negotiating changes

After the patient/client has told you his/her problem, you should give her/him relevant information and neg should use words that the patient/client understands. Check whether the patient/client understands you by a

repeat the information and instructions you have given. If the feedback shows that the patient/client did not information or cannot remember, explain again.

11.7 Use of local language

Whenever possible use a local language that the client understands best. It is important for both you and the understand each other very well.

11.8 Remain neutral and non-Judgemental

Whenever possible give advice but do not judge.

11.9 Be consistent in giving advice

If you are sure of the facts be consistent.

11.10 Summarising and Paraphrasing

By re-stating in your own words what the patient/client says, you show that you are listening and that you h what the patient/client has said. For example, "What you are saying is that you have no problem with the d It is important to develop skills in counselling so that you can effectively help your patients/clients. Having counselling, let us now discuss the counselling process.

11.11 Terminology

1. Empathy: is the ability to understand and share the feeling of others.

11.12 Activity

1. What do you understand by the term attending behaviour?
2. Define the following:
    (a) Open mindedness.
    (b) Active listening.

11.13 Reflection

Do you think its's possible for counsellor to observe all these attributes discussed in this unit?

11.14 Summary

In this unit, you have learnt the following attributes of the good counsellor; Empathy, discretion, patience, compassion, encouragement, self-awareness, open mindedness, flexibility, good listener, and ability to care for self. You have also learnt about some of the skills that counsellors need.

UNIT 12: ETHICS IN COUNSELLING

12.1 Introduction

In this unit, you are going to learn about Ethics in counselling. You will basically learn about five principles in which therapist's boundaries are based upon.

12.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss ethics in counselling.
- discuss the counselling process.
- examine five stages model for counselling.

12.3 Time frame

You need about three (3) hours per week interacting with is material.

12.4 Content

- Counselling ethics
- Counselling Process
- Five Stage Model for Counselling

Corey (1996) briefly outlines five principles in which therapeutic boundaries are based upon:

1. Beneficence: a counsellor must accept responsibility for promoting what is good for the client with the expectation that the client will benefit from the counselling sessions.

2. Nonmaleficence: "doing no harm". The counsellor must avoid at all times, (even inadvertently) any activities or situations with the client that could cause a conflict of interest.

3. Autonomy: the counsellor's ethical responsibility to encourage client independent thinking and decision-making, and to deter all forms of client dependency.

4. Justice: the counsellor's commitment to provide an equal and fair service to all clients regardless of age, gender, race, ethnicity, culture, disability and socio-economic status.

5, Fidelity: being honest with clients and faithfully honouring the counsellor's commitment to the client's progress.

The confusion caused by boundaries is best described by Corey (1996) as a continuum, ranging from disengagement (rigid, inflexible boundaries/guidelines) to enmeshment (flexibility to the point of diffusement) with a large grey area in between that is notoriously ambiguous and dependent upon the therapist, the situation and the client's changing needs and circumstances.

However, the therapist does not want to empathise with the client to the extent that they hug the client upon meeting them or rant and rave with their client in a mutual expression of anger. Nor would the therapist pop in to visit at the client's home on their own way home from the office. This is the behaviour of a friend, not a therapist. Hence, boundary violation has occurred.

Ambiguous boundaries often arise in the therapeutic relationship, but strict responsibilities do apply to the counsellor in relation to their duty to inform clients of the limitations on client confidentiality. Such information forms a large part of informed consent and informed consent is a fundamental client right.

Contracting a Client

• A contract: deals with individual rights and responsibilities.

• A covenant: addresses commitment to a relationship.

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12.5 Counselling Process

The counselling process is a planned, structured dialogue between a counsellor and a client. It is a cooperative process in which a trained professional helps a person called the client to identify sources of difficulties or concerns that he or she is experiencing. Together they develop ways to deal with and overcome these problems so that person has new skills and increased understanding of themselves and others. Counselling process for example students in a college or university may be anxious about how to study in university, lack of clarity on educational or career direction, have difficulty living with a room-mate of another race or religion, have concerns with self-esteem, feelings with being "stressed out", difficulties in romantic relationships and so forth

Step 1: Relationship Building The first step involves building a relationship and focuses on engaging clients to explore issue that directly affect them. The first interview is important because the client is reading the verbal and nonverbal messages and make inferences about the counselor and the counseling situation. Is the counselor able to empathize with the client? Does the client view the counselor as genuine? There are several lists of non-helpful behaviors. Most common among them include: Advice Giving, Lecturing, Excessive Questioning, Storytelling, Asking "Why?" Asking "How did that make you feel?" Some steps for Relationship Building for the Counsellor are: Introduce yourself, Invite client to sit down, ensure that the client is comfortable, Address the client by name, invite social conversation to reduce anxiety, Watch for nonverbal behaviour as signs of client's emotional state, Invite client to describe his or her reason for coming to talk, allow client time to respond and Indicate that you are interested in the person.

Step 2: Problem Assessment While the counselor and the client are in the process of establishing a relationship, a second process is taking place, i.e. problem assessment. This step involves the collection and classification of information about the client's life situation and reasons for seeking counseling.

Step 3: Goal Setting Like any other activity, counseling must have a focus. Goals are the results or outcomes that client wants to achieve at the end of counselling. Sometimes, you hear both counselor and client complain that the counseling session is going nowhere. This is where goals play an important role in giving direction.

Guidelines for Setting Goals should be selected and defined with care. Below are some guidelines for goal selection that can be used with students:

- Goals should relate to the desired end or ends sought by the student.
- Goals should be defined in explicit and measurable terms.
- Goals should be feasible.
- Goals should be within the range of the counsellor's knowledge and skills.
- Goals should be stated in positive terms that emphasize growth.
- Goals should be consistent with the school's mission and school health policy.

Step 4: Intervention: There are different points of view concerning what a good counselor should do with clients depending on the theoretical positions that the counselor subscribes to. For example, the person-centered approach suggests that the counselor gets involved rather than intervenes by placing emphasis on the relationship.

Step 5: Evaluation, Follow-Up, Termination 0r Referral: For the beginning counselor, it is difficult to think of terminating the counseling process, as they are more concerned with beginning the counseling process. However, all counseling successful termination. aims towards Terminating the counseling process will have to be conducted with sensitivity with the client knowing that it will have to end.

12.6 Five Stage Model for Counselling

The five stages are:

1. Rapport and Therapeutic Alliance
2. Assessment
3. Identification of strengths
4. Interventions
5. Resiliency and Termination

12.7 Terminologies

1. Fidelity: being honest with clients and faithfully honoring the counsellor's commitment to the client's progress.
2. Nonmaleficence: doing no harm to the client.

12.8 Activity

1. Discuss least give ethics in counselling.

2. Explain the counselling process.

12.9 Reflection

Explain ways you can set goals with your client during counselling.

12.10 Summary

In this unit, you have leant about the following principles: Beneficence, Non maleficience, Autonomy, Justice and Fidelity. You have also learnt about stages involved in the counselling process.

UNIT 13: APPLICATION OF COUNSELLING IN OTHER AREAS

13.1 Introduction

In this unit, you are going to learn about the following types of counselling: trauma and crisis counselling, marriage and couple counselling, career counselling, Grief, loss and bereavement counselling. Child abuse counselling, gender based violence counselling will also be discussed.

13.2 Learning Outcomes

By the end of this unit, you are expected to;

- discuss trauma counselling.
- analyze basic of crisis interaction.
- discuss career counselling.
- child abuse counselling.

13.3 Time frame

You need about two (2) hours per week interacting with this material.

13.4 Content

- Trauma and Crisis Counselling
- Leading Crisis Intervention Models
- Roberts' Seven-Stage Crisis Intervention Model
- Marriage Counselling & Couples Therapy
- Different Stages of a Relationship
- Substance Abuse & Addiction
- Child-Rearing Issues
- Career counseling
- Career Counseling Theories
- Trait-and-Factor Theory
- Theory of Person-Environment Fit
- Learning Theory of Career Counseling

- Social Cognitive Career Theory
- The Cognitive Information Processing (CIP) Approach
- Career Counseling Assessments
- Grief, loss, and bereavement
- Models of Grief
- Five stages of grief
- Four tasks of mourning
- Dual process model
- The Process of Recovering from Grief
- Complication of Grief
- Depression and Grief
- Bereavement and Culture
- Disenfranchised Grief
- Counseling techniques for abused children
- Sexual and gender-based violence (SGBV)
- Medical consequences
- Psychological consequences
- Medical care
- Psychological care
- Awareness and access to care

13.5 Trauma and Crisis Counselling

Crisis is a state of emotional turmoil or an acute emotional reaction to a powerful stimulus or demand, trauma expert Jeffrey Mitchell explains. There are three characteristics of crisis:

- The usual balance between thinking and emotions is disturbed.
- The usual coping mechanisms fail.
- Evidence of impairment in an individual or group.

Crises may occur when individuals face actual or threatened death, serious injury or some other threat to their physical integrity, according to the International Journal of Emergency Mental Health. Individuals may also be victimized by witnessing these events occurring to others. Contradictions to some deeply held beliefs can cause crises.

Crisis intervention provides help for individuals or groups during a period of extreme distress. The intervention is temporary, active and supportive. Crisis intervention is most

frequently provided by firefighters, police officers, emergency medical or search and rescue personnel, nurses, physicians and other hospital workers, communications personnel and community members.

13.6 Basics of Crisis Intervention

Three goals guide techniques used in crisis intervention:

- Mitigate impact of event.
- Facilitate normal recovery processes.
- Restore adaptive function.

Crisis intervention techniques should also abide by the following seven principles:

Simplicity: In a crisis, people respond best to simple procedures. Simple things have the best chance of having a positive effect.

Brevity: Psychological first aid needs to remain short, from minutes up to one hour in most cases.

Innovation: Use creativity; specific instructions do not exist for every case or circumstance.

Pragmatism: Keep it practical; impractical suggestions can cause the person to feel more frustrated and out of control.

Proximity: Provide support services close to the person's normal area of function. "The most important thing about proximity is that support must be given in a safe zone," according to the book Prehospital Behavioural Emergencies and Crisis Response.

Immediacy: Provide services right away. Crises demand rapid interaction, and delays can undermine the effectiveness of support services.

Expectancy: Work to set up expectations of a reasonable positive outcome. The person or group in crisis should be encouraged to recognize that help is present, there is hope and the situation is manageable. It may be appropriate to tell the person or group that although the situation is overwhelming right now, most people can and do recover from crisis experiences.

11.7 Leading Crisis Intervention Models

Two leading crisis intervention models are: Albert Roberts' Seven-Stage Crisis Intervention Model, as described in Brief Treatment and Crisis Intervention; and Mitchell's Critical Incident Stress Management intervention system, as described by the International Critical Incident Stress Foundation and International Journal of Emergency Mental Health.

Other widely recognized models include Psychological First Aid, Mental Health First Aid and Stress First Aid.

11.8 Roberts' Seven-Stage Crisis Intervention Model

Roberts identifies seven critical stages that clients typically pass on the road to crisis stabilization, resolution and mastery:

1. Plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment.

The biopsychological assessment should at least include the client's environmental supports and stressors, medical needs and medications, current use of drugs and alcohol, and internal and external coping methods and resources. Assessing lethality must first determine whether a suicide attempt has been initiated and then can continue with the client's potential for self-harm. Imminent danger must establish, for instance, whether the person is now a target of domestic violence, a violent stalker or sexual abuse.

2. Make psychological contact and rapidly establish the collaborative relationship.

Rapport is facilitated by the crisis worker offering conditions such as genuineness, respect and acceptance of the client. Traits, behaviors or character strengths of the crisis worker come to the fore to instill trust and confidence in the client. Strengths include flexibility, positive mental attitude, resiliency, reinforcing small gains, good eye contact, creativity and nonjudgmental attitude.

3. Identify the major problems, including what precipitated the crisis.

The crisis worker should determine what in the client's life led to that person needing help. The worker should also try to determine which problems to work on first; these determinations can help understand the client's coping style.

4. Encourage an exploration of feelings and emotions.

This stage involves the crisis worker allowing the client to express feelings, to vent and heal, and to explain the person's side of the story about the current situation. Skills include active listening, communicating with warmth and reassurance, nonjudgmental statements and validation, and accurate empathetic statements. The crisis worker can, very cautiously, eventually work challenging responses into the dialogue, including giving information, reframing, interpretations and playing "devil's advocate." Challenging responses can help loosen clients' maladaptive beliefs and consider other behavioral options.

5. Generate and explore alternatives and new coping strategies.

This stage can be the most difficult to accomplish. Achieving the goals in stage four means that the client likely has worked through enough feelings to have some emotional balance. Now, the crisis worker and client can put certain options on the table to ensure the client's

safety, such as a no-suicide contract or brief hospitalization, alternatives for finding temporary housing or considering the pros and cons of various programs for treating chemical dependency.

6. Restore functioning through implementation of an action plan.

An action plan helps provide concrete plans for ultimately restoring the client's cognitive functioning. Many clients have trouble mobilizing and following through on an action plan; obviously, the action plan is critical for restoring the client's equilibrium and psychological balance.

7. Plan follow-up and booster sessions.

The crisis worker should plan for a follow-up contact after the initial intervention to ensure the crisis will be resolved and to evaluate the client following the crisis. Follow-up contact should include physical condition, cognitive mastery of the precipitating event, assessment of overall functioning, satisfaction and progress with ongoing treatment, any current stressors and how those are being handled, and need for possible referrals.

Critical Incident Stress Management (CISM)

The CISM is a comprehensive crisis intervention system that may be applied to individuals, small functional groups, large groups, families, organizations and even entire communities. It spans the entire temporal spectrum of a crisis. Mounting empirical evidence demonstrates that the CISM approach provides the tools for prevention and corrective treatment, the International Journal of Emergency Mental Health says.

CISM has seven core components:

- Pre-crisis preparation. This includes stress management education, stress resistance and crisis mitigation training.
- Disaster or large-scale incident, as well as school and community support programs including demobilizations, informational briefings, "town meetings" and advising staff.
- Brief small group discussions called defusing, which are provided within hours of a crisis for assessment, triaging and mitigating acute symptoms.
- Longer small group discussions known as Critical Incident Stress Debriefing (CISD). These structured group discussions are usually provided one to 10 days after a crisis to mitigate acute symptoms, assess the need for follow-up and, if possible, provide a sense of post-crisis psychological closure.

- One-on-one crisis intervention/counselling or psychological support throughout the full range of the crisis spectrum.
- Family crisis intervention and organizational consultation.
- Follow-up and referral mechanisms for assessment and treatment, if necessary.

13.9 What is Marriage Counselling & Couples Therapy?

Well, marriage counselling, also called couples therapy and marriage and family therapy, is a type of psychotherapy that focuses on improving your communication and conflict-resolution skills.

The truth is personal and family relationships can be both fulfilling and challenging. Therefore, the more you understand yourself – your emotions and behaviours – the better you can communicate with loved ones (including your spouse), manage your stress, and effectively function in your daily life.

Truth-be-told, marriage is one of the most monumental relationships you will ever have in your life. But, it's important to be realistic. Every marriage will have its "ups and downs" and "highs and lows." That is normal.

With over 20 years' experience in the helping professions, I can provide the guidance and insight you need to make real changes in the quality of your life. I have helped individuals and families to regain happiness and stability through times of crisis.

Is Marriage and Family Therapy a Type of Marriage Counselling? Yes, marriage and family therapy is a type of marriage counselling. This form of psychotherapy tends to be more involved then marriage counselling, per se. More specifically, marriage and family therapy takes a more holistic approach to marital and family problems. What does that mean? It means that it includes all family members in the therapy process.

What Happens During a Typically Marriage and Family Therapy Session? During a typically marriage and family therapy session, the family may be given role-play tasks and assignments to work on at home. You will also be encouraged to share your true feelings with your counsellor and spouse. Communication and conflict-resolution skills are big focuses on marriage and family therapy. Your therapist will expect you to complete all tasks and assignments. For example, during a session, you and your spouse may be given

communication exercises to practice at home with the expectation that you will share your experiences during the next session.

13.10 What are the Different Stages of a Relationship?

First, relationships are not stagnant. Most, if not all, relationships go through various phases. Moreover, most couples move through these stages at different times. However, "issues" can pop up during any of these stages. The good news is that if you understand them, you can combat issues when they arise.

Listed below are the different stages of being in a relationship:

13.10.1 Stage 1: Passion

The first stage of a relationship typically involves passion. This when you meet your partner and fall in love. Stage #1 is also referred to as the "honeymoon stage," because it involves infatuation and romance.

At the beginning of a relationship, sparks fly and the world is brighter…better. During this time, you begin to establish, respect, intimacy, and a genuine admiration for each other. Keep in mind that this stage is only temporary – for most. Eventually, the passion dwindles and familiarity creeps in. When this occurs, it's important to reignite the passion by changing things up and trying something new.

13.10.1 Stage 2: Realization

Once the initial passion starts to fade, you are "forced" to accept a more realistic vision of what your life could be like as a long-term couple. This is also the time in which you and your partner decide if marriage may be in your future. During this stage, both you and your partner begin to see each other as human beings – complete with flaws and faults.

But, as you begin to really see one another, probably for the first time, you also begin to respect each other on a deeper level. You are more comfortable revealing aspects of yourself and your personality – aspects that you kept hidden during the "honeymoon stage."

It's important to note that this stage comes with challenges. You may experience disappointment, frustration, and a difference of opinion on several topics during Stage #2. However, if you have good communication and conflict-resolution skills, you can successfully navigate any troubled waters together.

13.10.1 Stage 3: Rebellion

During this stage, the focus returns to your own self-interests. This is a hurdle many couples face during the rebellion stage. It becomes “all about me” instead of “all about us.” As a result, conflict can ensue – if you and your partner don’t know how to deal with conflict in a healthy way.

Honestly, these conflicts are bound to happen during Stage #3. Why? Well, because a power struggle typically occurs at this stage. Both you and your partner believe that your way is the best way and that you are always (or most of the time) right.

When this occurs it is important that you and your partner argue the right way. If you blame one another, talk over one another, and/or allow resentment, anger, and frustration to take over, it will cause a rift between you that may be irreparable.

13.10.4 Stage 4: Cooperation

With demanding careers, children, household duties, and monthly mortgages, it’s normal for couples, especially married ones, to find themselves having to cooperate with one another. Truth-be-told, this stage can feel a lot like a business arrangement – one that is devoid of passion, romance, and intimacy.

Many couples put these “essential elements” on the backburner to “deal” with life and it’s many responsibilities. Be prepared though, this stage can last for 20-years or more, especially if you have children.

13.10.5 Stage 5: Reunion

Once your children have flown the coop aka grown up, you and your partner can get reacquainted with each other. In other words, you have an opportunity to enjoy the “quietness,” security, and stability that comes with fewer responsibilities. This is the time to become friends and lovers again. During the reunion stage, you rediscover just how much you like one another and why you got married in the first place and/or chose to stay together so long.

13.10.6 Stage 6: Explosion

Stage #6 is the explosion stage. During this time, you'll probably experience a host of serious life situations – situations that may be challenging to deal with as a couple. For instance, you may experience a death in the family, the loss of a job, financial issues, and/or a life-altering health condition.

But, at the same time, you'll most likely grow closer together, because you are "forced" to tackle these challenges together. In other words, you seek comfort from one another.

On the flip side, this stage could push you farther apart – especially if you have poor communication and conflict-resolution skills. In fact, it could spark resentment, anger, despair, and frustration – ingredients that can destroy a relationship.

Note: The explosion stage can occur at any time in the relationship, causing a major disruption in the current status of your relationship.

13.10.7 Stage 7: Completion

The last stage is the completion stage. During this stage, you have adult children and are preparing to enter retirement. This is the time to focus on you and your partner and begin exploring your new life together. Couples in this stage are normally extremely close, knowing each other inside-and-out.

After having "weathered" the storms of being in a long-term relationship or decades of marriage, the completion stage can feel relaxed and peaceful. The goal of this stage is simply to enjoy each other's company.

Why Might I Need Couples Counselling?

Well, as marriages move through the various stages and experience challenges together, conflict can occur. And, although some minor arguments are to be expected, more complex and deeper ones can drive a wedge between you and your partner. In fact, the more troubling conflicts can cause you to question if a resolution is even possible – or if you really want one.

As a start to drift apart, you may realize that you and your partner want different things in life. In addition, infidelity may enter the mix or you or your partner may feel "stuck" in a relationship with no way out. Well, before seeking couples counselling, you and/or your partner must acknowledge that your marriage is in trouble. Then, you must decide together, if you want to try to "fix" your broken relationship.

In this scenario, marriage and family therapy may be extremely beneficial. In fact, marriage and family therapists can help improve the communication between all of your family members, thus, resolving deep-seated emotional hurt.

Therefore, the decision to seek marriage counselling is an important first step in "saving" your marriage. When you and your partner admit that your marriage is failing, you give it a chance of being repaired.

What are the Various Types of Marriage Counselling?

The truth is, marriage counselling is not just for unhappy or struggling couples. Rather, it also involves couple's therapy for non-married couples. Regardless of your relationship status, marriage counselling aka couples counselling can be used to strengthen bonds and gain a better understanding of one another.

It can also be used to help couples, who are about to be married and those, who are thinking of getting married. This is called premarital counselling. The goal of this type of counselling is to help couples learn how to communicate and resolve issues more effectively and to "iron out differences" before the wedding day.

But, if you are interested in marriage counselling because you are having relationship issues, some of the issues that can be addressed during sessions include:

- Poor Communication – Arguing, Belting, Criticizing, Misunderstanding, etc.
- Financial Problems – Debt, Poor Budgeting, and Overspending
- Sexual Differences & Dysfunctions – i.e. Erectile Dysfunction, Different Sexual Preferences, Low Libido, Premature Ejaculation, etc.
- Parenting Challenges – Defiance, Learning Disabilities, Behavioural Problems, Childhood Mental, and Physical Health Issues
- Substance Abuse – i.e. Addiction
- Anger & Rage
- Infidelity
- Divorce

*If you are experiencing domestic abuse and/or violence, please contact the police, a local shelter, and/or a crisis centre for emergency support – Click here for a list of hotlines that can help!

What is Family Therapy?

Family therapy can teach family members how to handle adversity – before it begins. For instance, newly blended families that include children from previous marriages may benefit from family therapy. Why? Well, because family therapists can help them (all of the members of the newly blended family) learn how to respect one another and live peacefully together.

Because "family" is an important part of a person's social support network, family therapy can be crucial for family's dysfunction or chronic illness. Keep in mind that the better your family functions, the lower the stress level and the better the health for the entire family. In addition, adults, who grew up in dysfunctional families, could also benefit from individual therapy (instead of family or in addition to it) with a focus on family therapy concepts.

Another rarely spoken about aspect of family therapy is parenting counselling. Let's be honest, parenting is hard work and it can involve a host of confusing and conflicting emotions, along with changes within the family. Many of these changes are positive and fulfilling, but some may be trying and difficult to manage. The great thing about a marriage and family therapist is he/she can help you talk through important parenting issues while learning the necessary skills to develop a healthy supportive relationship, as a parent and spouse.

What are the Goals of Marriage Counselling?

For many couples, the primary goal of marriage counselling is to save the marriage and stay together. For others, seeking therapy may be attributed to unresolved issues in the marriage. It's important to understand that marriage counselling isn't a quick fix. Rather, it takes dedication and effort to accomplish goals and repair the relationship.

A marriage counsellor can help you in the following ways:

13.11 Infidelity & Adultery

If either you or your partner is unfaithful, it can seem like your relationship is doomed. However, if both you and your partner are committed to the relationship and willing to try to work it out, there is a chance your relationship can be repaired. The good thing about marriage counsellors is they can help rebuild trust in your relationship. This relationship specialist can also help you understand why the infidelity or adultery occurred.

13.12 Poor Communication

It's common for couples to have different ways of communicating. It's also common for them to have poor communication skills, especially when it comes to voicing how they feel. You may assume your partner should know what you're thinking or feeling – but he/she may not. Regardless, if your partner is not a mind reader, it can hurt your feelings when he/she does not react like you think he/she should.

Moreover, poor communication can cause one or both of you to feel abandoned, ignored, or dismissed. You may even mistake poor communication for a sign that your partner no longer loves you or is attracted to you.

This happens because you assume your partner knows what you need and want, when he/she may have no clue – unless you tell him/her. So, when you remain silent about how you feel, it can cause a breakdown in communication and a disconnect between you and your spouse.

13.13 Substance Abuse & Addiction

Sometimes one or both partners have a substance abuse problem or full-blown addiction. Addiction comes in many forms – i.e. drugs, alcohol, gambling, pornography, overeating, and even shopping. This is a serious issue that must be addressed as soon as possible. But, first the abuser or addict has to admit there is a problem and he/she needs help. The good thing about couple's counsellors is that they can help you address these challenges individually and within your relationship.

13.14 Child-Rearing Issues

Raising children can be hard – really hard. There is no instruction manual on how to raise children or how to combat child-rearing problems when they arise. Most of us simply have to "wing it." Still, children can put a strain on a relationship, especially when the child has behavioural problems, learning difficulties, a chronic illness or disability, and/or mental health issues. Unfortunately, however, when child-rearing issues pop up, the focus usually goes towards the child, leaving the relationship to flounder.

13.14 Passion & Romance

Every couple wants passion and romance in their relationship, especially if they have been together for a long time. So, it is common for couples to seek marriage counselling as a way to become closer to one another. A benefit of marriage counselling is that it can help you and

your partner see the value in reconnecting with one another. The end result? More passion, romance, and a re-emergence of the "honeymoon stage."

13.15 Conflicts & Resentment

It's normal to have conflicts and even resentment from time-to-time in a relationship. You are human after all. A good thing about marriage therapists is that they are trained to teach you important conflict-resolution skills that you can use in your relationship. In other words, they teach you how to "fight fair."

The truth is, when you are unable to or refuse to "fight fair," it can cause deep-seated wounds that are hard to heal. And, when conflicts and resentment are left to simmer, it can do irreparable damage to your relationship.

This is especially true when you and/or your partner are unable to effectively communicate how you feel. As a result, anger, bitterness, and hostility fester, and problems deepen. If you don't take steps to address issues in your relationship and reaffirm your commitment to resolving conflicts and making your marriage work, it will die.

13.16 Career Counseling – Theories, And Assessments

Career counselors use theories and assessments to help others make career choices, think through career problems, find jobs, and explore opportunities. Just like therapists, there are many different types of career counselors who use different theories, interventions, and assessments. One counselor might focus more on helping someone pick a career while another might help someone with job satisfaction or career development.

Choosing a career counselor will depend on what exactly you are looking for. If you are just starting out in your career, you will probably want a counselor who can help you figure out what career path you want to take. If you have been in your field for a while, you might want someone who can help you progress in your field. In order to pick what kind of career counseling is best for you it can be helpful to know exactly what career counseling is, what some different theories are, and what assessments are used.

13.17 Career Counseling Definition

Career counselors help people understand their employment options, find jobs, work on career development. Often career counselors are people who hold a master's degree in counseling or social work. Some career counselors might be therapists, social workers, or life coaches. Because of how varied the work is, there is some debate in the field about the exact definition of career counseling. Therefore, the definition of career counseling changes depending on who you ask. One of the simplest definitions is just: **the counseling activities related to meaningful and purposeful work**. Some other definitions include:

- "A process that will help you to know and understand yourself and the world of work in order to make career, educational, and life decisions." – "Counseling with a focus on issues such as career exploration, career change, personal career development and other career related issues."

- "Counseling that provides career information resources, discusses career development, and administers and interprets aptitude and ability assessments." "Advice and information about what type of job someone could do or how they could progress to a better job." -Cambridge Dictionary

13.18 Career Counseling Theories

There are many different theories of career counseling. These theories date all the way back to Frank Parsons in 1909. He is largely considered the father of modern career counseling and was one of the first people to come up with a theory of career counseling. His theory was very simple, you observe and talk to an individual and then you match them with the best career for them based on what you have observed. This thinking is still the basis for many career counseling theories today. Although there are dozens of theories still in use today, we will cover five that are the most popular.

13.19 Trait-and-Factor Theory

Trait-and Factor theory has been one of the most enduring theories of career counseling. In essence, it focuses on matching people's personalities with careers. In order to determine someone's personality this theory requires taking into consideration someone's abilities or aptitude, personal values, and occupational interests. The process includes three key steps:

1. Studying individuals

2. Surveying career options

3. Using “true reasoning” to match individuals with an occupation

Trait-and-factor theory has been criticized because it assumes that there is one career goal for everyone and because career decisions are based primarily on ability. Many people do not have one career goal as trait-and-factory theory might suggest. Additionally, these career goals might change over time. Also, ability might not be the best way to match someone with a career. Someone who might be interested in a career but not trained in that field. Rather than pushing them away from that field they might just need some encouragement to get training. Critics of this theory would say that it pushed people like this away from things they might be interested in.

13.20 Theory of Person-Environment Fit

The basic foundation of Person-Environment Fit is the idea that if someone has a positive relationship with their work environment, they will have job satisfaction. The theorists Dawis and Lofquist proposed that work includes relationships, interactions, reward, stress and other psychological variables. These psychological variables must be adequately addressed by the work environment. Additionally, the individual must be able to meet the requirements of the work environment. So, it isn’t just that the place needs to fit the individual, the individual must also be able to fit the place. When both of these things happen, it is called consonance.

Four Key Points of Person-Environment Fit:

1. Work personality and work environment should be a good match

2. Individual’s needs more important when deciding if the environment is a good fit

3. How well a person’s needs match the environment and vice versa is a good indicator of satisfaction

4. Job placement is best done by matching the individual’s personality with the requirements of the work environment

13.21 Learning Theory of Career Counseling

Learning Theory was first proposed by Krumboltz, Mitchell, and Gelatt in 1975. You can read their original journal article about the theory here. This theory is broken down into two parts. The first part aims to explain where career choices come from. The second part of the theory addresses how career counselors are supposed to help people solve career or job related problems.

According to Learning theory there are four factors that dictate how someone choices a career. These include, special abilities or genetic endowments, environmental conditions and events, learning experiences, and task approach skills. The main takeaway is that there is not one thing that dictates someone's career choice. This theory also stresses that there is not one career that is best for a person. Instead, the theorists emphasize that someone can grow into a career as long as they are willing to expand their skills and interests.

Here, the role of a career counselor is not so much in job selection as it is helping people deal with career or job problems. It is an approach where individual therapy and career counseling might overlap. This is because career counselors using this theory will address issues like burnout, change, relationships, obstacles to career development and more.

13.22 Social Cognitive Career Theory

Social Cognitive Career Theory was first described by Lent, Brown, and Hackett in 1996. The theory blends some aspects of social learning theory and cognitive theories. There are three key components to this theory.

1. Self-efficacy
2. Outcome expectations
3. Personal goals

Counseling is centered around helping people develop self-efficacy. Outcome expectations are addressed by counselors as well. These are the personal beliefs people have about what will happen as a result of their career actions. Finally, counselors help people address personal goals so that these goals can help guide and sustain someone's behavior. Even just the process of generating goals is thought to be helpful for building up a sense of efficacy.

Essentially, this theory is all about helping clients create a sense of agency related to career choices and issues.

13.23 The Cognitive Information Processing (CIP) Approach

Authors Peterson, Sampson, and Reardon first wrote about CIP in 1999. Florida State University has a great page that describes their theory and research in detail. In a nutshell, the theory is applied to how people make career decisions and use problem solving skills in career decisions. This theory is very cognitive and rational in nature and rests on the assumptions that people make career decisions as a top down process. CIP relies on 10 main assumptions:

1. Career choices come from the interaction of cognition and affect
2. Making career choices is a problem-solving activity
3. How well someone can problem solve depends on their cognitive abilities and knowledge
4. Career problem solving requires a good deal of memory skills
5. Someone must be motivated
6. Career development relies on someone continuing to grow and change their knowledge
7. Career identity depends on self-knowledge
8. Maturing in a career depends on the ability to solve career problems
9. The goal of career counseling is achieved by helping people grow their information-processing skills
10. The aim of career counseling is to help people solve career problems and become better decision makers

One main critique of this theory is that it really only works with people who have full cognitive ability. You could not do this type of career counseling with someone who has a developmental or learning impairment because they probably would not be able to do this kind of thinking. Another issue that it assumes that even people who do have full cognitive abilities are totally rational. As we know from psychology research people rarely make

decisions rationally. Rather they rely on a combination of cognition, emotion, and environmental circumstances when making decisions.

13.24 Career Counseling Assessments

There are many different assessments used by career counselors. Some assessments focus on finding your personality type and then matching that type of personality with a career. Others are more like aptitude tests. These test your abilities and match you with careers based on skills. Still others attempt to assess values and then pick careers for you based on these values. Each theory has different assessments that it uses.

The Self-Directed Search was developed by John Holland and is one of the most widely used career counseling measures. It has been translated into 20 different languages and can be administered online. If you are interested you can take the assessment here. You can also view a copy by clicking the button below.

Myers-Briggs Type Indicator is an assessment that attempts to understand your personality type by looking at individual preferences. After answering the questions, it gives you a personality type based on extraversion or introversion, sensing or intuition, thinking or feeling, and judging or perceiving. There are 16 possible personality combinations and each one is described on the scoring sheet for your convenience. You can read more about this assessment on the official MyersBriggs.org website. You can view or download a pdf copy by clicking on the button below.

Temperament and Values Indicator is a measure assesses how someone's values might relate to career choice. The test has two parts, the first are temperament questions that relate to personality and career choice, the second part is related to values and work rewards. The scores help you figure out if your career goals are congruent with your values and temperament. This test was specifically developed for people who are high school aged or older. This assessment is not publicly available.

Kuder Occupational Interest Survey consists of 77 occupational scales and 29 college majors. It usually Takes about 30-40 minutes to complete and is best used for helping people with job placement. It is generally used with college aged students. This measure is not publicly available. Many career counselor or career centers will have access to it.

13.25 Grief, Loss, and Bereavement

Most people will experience loss at some point in their lives. Grief is a reaction to any form of loss. Bereavement is a type of grief involving the death of a loved one.

Bereavement and grief encompass a range of feelings from deep sadness to anger. The process of adapting to a significant loss can vary dramatically from one person to another. It often depends on a person's background, beliefs, and relationship to what was lost.

Grief is not limited to feelings of sadness. It can also involve guilt, yearning, anger, and regret. Emotions are often surprising in their strength or mildness. They can also be confusing. One person may find themselves grieving a painful relationship. Another may mourn a loved one who died from cancer and yet feel relief that the person is no longer suffering.

People in grief can bounce between different thoughts as they make sense of their loss. Thoughts can range from soothing ("She had a good life.") to troubling ("It wasn't her time."). People may assign themselves varying levels of responsibility, from "There was nothing I could have done," to "It's all my fault."

Grieving behaviours also have a wide range. Some people find comfort in sharing their feelings among company. Other people may prefer to be alone with their feelings, engaging in silent activities like exercising or writing.

The different feelings, thoughts, and behaviours people express during grief can be categorized into two main styles: instrumental and intuitive. Most people display a blend of these two styles of grieving:

Instrumental grieving has a focus primarily on problem-solving tasks. This style involves controlling or minimizing emotional expression.

Intuitive grieving is based on a heightened emotional experience. This style involves sharing feelings, exploring the lost relationship, and considering mortality.

No one way of grieving is better than any other. Some people are more emotional and dive into their feelings. Others are stoic and may seek distraction from dwelling on an unchangeable fact of living. Every individual has unique needs when coping with loss.

13.26 Models of Grief

Grief can vary between individuals. However, there are still global trends in how people cope with loss. Psychologists and researchers have outlined various models of grief. Some of the most familiar models include the five stages of grief, the four tasks of mourning, and the dual process model.

13.26.1 Five stages of grief

In 1969, Elisabeth Kubler-Ross identified five linear stages of grief:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

Kubler-Ross originally developed this model to illustrate the process of bereavement. Yet she eventually adapted the model to account for any type of grief. Kubler-Ross noted that everyone experiences at least two of the five stages of grief. She acknowledged that some people may revisit certain stages over many years or throughout life.

13.27 Four tasks of mourning

Psychologist J. W. Worden also created a stage-based model for coping with the death of a loved one. He divided the bereavement process into four tasks:

- To accept the reality of the loss
- To work through the pain of grief
- To adjust to life without the deceased
- To maintain a connection to the deceased while moving on with life

13.28 Dual process model

As an alternative to the linear stage-based model, Margaret Stroebe and Hank Schut developed a dual process model of bereavement. They identified two processes associated with bereavement:

Loss-oriented activities and stressors are those directly related to the death. These include:

- Crying
- Yearning

- Experiencing sadness, denial, or anger
- Dwelling on the circumstances of the death
- Avoiding restoration activities

Restoration-oriented activities and stressors are associated with secondary losses. They may involve lifestyle, routine, and relationships. Restoration-oriented processes include:

- Adapting to a new role
- Managing changes in routine
- Developing new ways of connecting with family and friends
- Cultivating a new way of life.

Stroebe and Schut suggest most people will move back and forth between loss-oriented and restoration-oriented activities.

13.29 The Process of Recovering from Grief

- Everyone grieves in their own way and in their own time. Some people recover from grief and resume normal activities within six months, though they continue to feel moments of sadness. Others may feel better after about a year.
- Sometimes people grieve for years without seeming to find even temporary relief. Grief can be complicated by other conditions, most notably depression. The person's level of dependency on the departed can also cause complications.
- The grieving process often involves many difficult and complicated emotions. Yet joy, contentment, and humor do not have to be absent during this difficult time. Self-care, recreation, and social support can be vital to the recovery. Feeling occasional happiness does not mean a person is done mourning.
- Grieving the loss of a loved one be a difficult process, whether the loss is due to death, a breakup, or other circumstance. One of the hardest challenges is adjusting to the new reality of living in the absence of the loved one. Adjusting may require a person to develop a new daily routine or to rethink their plans for the future. While creating a new life, a person may adopt a new sense of identity.

13.30 Complicated Grief

The experience of grief is not something a person ever recovers from completely. However, time typically tempers its intensity. Yet an estimated 15% of people who have lost a loved

one will experience “complicated grief.” This term refers to a persistent form of bereavement, lasting for one year or more.

Again, the length of time it takes for a person to grieve is highly variable and dependent on context. But when symptoms persist without improvement for an extended period, they may qualify as complicated grief. In addition, the symptoms of complicated grief to be more severe. Complicated grief often dominates a person’s life, interfering with their daily functioning.

Prolonged symptoms may include:

- Intense sadness and emotional pain
- Feelings of emptiness and hopelessness
- Yearning to be reunited with the deceased
- Preoccupation with the deceased or with the circumstances of the death
- Difficulty engaging in happy memories of the lost person
- Avoidance of reminders of the deceased
- A reduced sense of identity
- Detachment and isolation from surviving friends and family
- Lack of desire to pursue personal interests or plans
- The Diagnostic and Statistical Manual (DSM-5) does not classify complicated grief as a clinical condition. Yet it does include diagnostic criteria for “persistent complex bereavement disorder” in the section of conditions requiring further study.
- Broken Heart Syndrome

Generally speaking, grief cannot kill a person. That said, there are cases in which severe stress could harm an otherwise healthy person’s heart.

When a person experiences a shocking event, their body fills with stress hormones. These hormones can cause part of a person’s heart to briefly swell and stop pumping. The rest of the heart continues beating, causing blood to flow unevenly. A person may feel intense chest pain, similar to a heart attack (but unlike a heart attack, the arteries are not blocked). This temporary malfunction is called “broken heart syndrome.”

As the name suggests, the broken heart syndrome often follows news of loss, such as a divorce or death of a loved one. Yet symptoms can also appear after a good shock, such as winning the lottery. Women are more likely than men to develop the condition.

Most people who experience broken heart syndrome recover within weeks. Deaths from the condition are rare. Since the syndrome is prompted by a shocking event, people have a low risk of experiencing it twice.

13.31 Depression and Grief

The DSM-5 does not define bereavement as a disorder. Yet typical signs of grief, such as social withdrawal, can mimic those of depression.

So how can one tell the difference between grief and depression?

Grief is typically preceded by loss. Depression can develop at any time.

The sadness present in grief is typically related to the loss or death. Depression is characterized by a general sense of worthlessness, despair, and lack of joy.

Symptoms of grief may improve on their own with time. Someone with depression often needs treatment to recover.

Despite their differences, depression and grief are not mutually exclusive. If someone is vulnerable to depression, grief has the potential to trigger a depressive episode. If someone already has depression, their condition may prolong or worsen the grieving process. A therapist can help a person in mourning recognize and manage any depressive symptoms.

13.32 Bereavement and Culture

Certain aspects of grief are virtually universal. Most cultures have rituals of mourning after a death. Crying is common, regardless of a person's origins. However, the bereavement process can vary dramatically depending on one's culture. Cultural values may affect a person's:

Attitude toward death: Many Western cultures display death-denying traits. Death is often depicted as something to fight or resist. Eastern cultures, meanwhile, tend to characterize death to be a part of life. Death is often considered more of a transition than an end. Research suggests people in death-denying cultures tend to have more anxiety around death than people in death-accepting cultures.

Remembrance of the deceased: Some cultures, such as the Hopi or Achuar peoples, grieve by attempting to forget as much of the deceased as possible. It may be taboo for loved ones to say the person's name or to touch their belongings. Rituals are done to sever connections with the dead. Other cultures mourn by sharing memories of the deceased. People in the Akan

region of Ghana often hold elaborate funerals which may cost a full year's income. The deceased are typically placed in "fantasy coffins" personalized with symbols of their life.

Emotional Displays: Social norms can differ regarding how much emotion is "appropriate" to show. A 1990 study compared bereavement norms in two Muslim societies. Mourners in Egypt may be encouraged to grieve for an extended period of time. A person might display their love for the deceased through displays of unrestrained emotion. Meanwhile, Balinese culture tends to pathologize overt sorrow. People are encouraged to put on a happy face in front of others and to cut ties with the deceased.

When analyzing grieving behaviours, context matters as much as the symptoms themselves. Bereavement trends which are typical in one culture may be stigmatized in another. When working with individuals in grief, therapists may need to keep cultural influences in mind.

13.33 Disenfranchised Grief

Disenfranchised grief occurs when a person's mourning is restricted in some way. Society may stigmatize a person's mourning process or refuse to acknowledge their loss. Grief may be disenfranchised for several reasons:

Society devalues the loss. The loss of a pet often garners less sympathy than the loss of a human relative. Others may say "it was just an animal" and accuse the person of being too emotional. Yet research shows the mourning period for a pet is about the same length as for a human family member.

The loss is ambiguous. An adopted child may grieve the loss of their birth parents, even if said adults are alive. If a loved one has late-stage dementia, family members may feel as if the person they knew is gone.

Society stigmatizes the circumstances of the loss. Pregnancy-related loss is often considered taboo. Women who undergo a miscarriage may feel guilt and shame. They may avoid telling others about the loss to avoid being blamed.

Society doesn't recognize the person's relationship to the deceased. A co-worker or friend may mourn a person, but they will likely receive less support than a family member. The same is true for ex-spouses, even though they used to be family. In societies with systemic homophobia, same-sex partners may also have disenfranchised grief.

Others do not consider the person capable of grief. When young children experience loss, adults may misinterpret signs of bereavement. They may believe the child is not capable of understanding the loss or have prolonged feelings about it. People who have cognitive impairments or intellectual disabilities may also have disenfranchised grief.

Disenfranchised grief can interfere with the bereavement process. If society does not recognize a loss, the person may have trouble accepting it themselves. They may try to repress or deny their emotions. Shame and secrecy can make the symptoms of grief more severe.

Social support is often vital to recovery. A community can provide emotional and financial aid when people are vulnerable. Mourning rituals can offer closure. If a person is forced to grieve alone, they may have a delayed recovery.

If you have lost someone or something precious, you may wish to find a therapist. Therapy can help with any sort of loss, whether society validates the grief or not. Therapy is an opportunity to explore your feelings and memories without judgment. No loss is too big or too small to warrant support. You do not have to endure your grief alone.

13.34 Counseling Techniques for Child Abuse

Child abuse includes physical abuse, sexual abuse, abandonment, emotional abuse and exploitation. An abused child often experiences fear, anxiety and severe emotional distress. Child abuse is usually discovered when the child's teacher notices a change in his/her behavior, the child comes to school with bruises, bumps or cuts, when the child continuously daydreams and/or when the child has trouble making friends or interacting with others.

The effects of child abuse can follow the child into adulthood. Thankfully, therapists have developed successful techniques that can help children effectively cope with the trauma they have endured. Therapists can help children understand that the abuse is not their fault and that they can lead a healthy, happy, abuse-free life. Therapists can also provide a loving and nurturing environment for these children and give them the tools they need to handle future crises. There are a variety of psychological techniques that are beneficial for children who have been abused.

These techniques include:

- Play Therapy:
- Medical Approach:
- Art Therapy:
- Talk Therapy:
- Family Therapy:
- Developmental Play Groups:

Play Therapy:

Play therapy is ideal for young children because they tend to imitate what they have witnessed or experienced. It is a psychodynamic counseling technique that is generally used with a child who is under the age of 11. During play therapy, the child reenacts his/her abusive situation through play with dolls and dollhouses, action figurines, memory games and/or guessing games. Play therapy provides the therapist with an idea of what the child has experienced.

The therapist uses play therapy to help the child understand what is "right" and what is "wrong" behaviors, teach the child healthy coping skills and guide the child through the healing process. The therapist provides support and a nurturing environment for the child.

The most important element of play therapy is a warm, caring and secure atmosphere. The child needs to feel cared about and safe when he/she is in the presence of the therapist. It is the responsibility of the therapist to provide a non-threatening environment for the child when he/she is in the office.

Please note that counseling an abused child requires more than just listening and talking. As a therapist, you may have to use structured or unstructured play situations such as music, reading stories, role playing, art and/or clay to allow the child to release tension and express him/herself. In addition, play therapy has proven successful in providing children with a non-threatening environment to act out family issues. can treat many of the symptoms associated with child abuse such as stress, depression, anxiety and/or feelings of hopelessness with medications. Some children require a combination of medication and counseling to heal from the effects of child abuse. This approach helps abused children achieve and maintain healthy and productive lives. The medical approach helps abused children cope with the trauma they experienced so that they can heal from the abuse.

Art Therapy:

Art therapy is a psychological technique that is often used to treat children who have been abused. This type of treatment is often used in hospitals and university settings. Art therapy provides children with an opportunity to discuss sensitive topics and express how they feel about what has happened to them in a non-verbal way. This type of therapy is especially helpful when a child experiences grief, loss and/or abuse.

Talk Therapy:

Talk therapy, is a psychological technique, used to treat children and adolescents who have been abused. Talk therapy is goal-oriented. Its main goal is to reduce anxiety and rectify behavioral issues stemming from the trauma. This type of therapy helps abused children understand and cope with their emotions. Talk therapy is only appropriate for children who can fully understand the concept of abuse. It can be used in conjunction with other treatments such as medication, support groups and/or art therapy.

Family Therapy:

Family therapy is a psychological technique that can help abused children and their families work through the effects of abuse. These issues may include: dysfunctional communication patterns, anger and rage issues, domestic violence, generational abuse and/or substance abuse. At the beginning of family therapy, abused children attend individual therapy sessions and later the family is asked to join the sessions. The family is looked at one whole unit instead of individual people and family therapy focuses on resolving issues within the family. Once the family issues are resolved then the family can help the child heal from the abuse.

Developmental Play Groups:

Abused children also benefit from developmental play groups. These types of play groups have proven especially effectively in younger children, but they help older children who are grappling with fluctuating emotions related to the abuse. Older children tend to do best when they are in a group of their peers who have experienced a similar trauma. In addition, developmental play groups/group counseling can be especially useful with abused children and adolescents because it helps them understand that what happened to them was not their fault and it teaches them how to defend themselves if the situation arises again.

Sexual and gender-based violence (SGBV) is a medical emergency.

We strive to make comprehensive healthcare available to survivors of sexual violence, regardless of their age or gender, in all of our projects.
Sexual violence shatters the lives of millions across the globe. It can occur in any society at any time but often increases in unstable situations, such as conflicts.

Sexual violence is complex and stigmatising, has long-lasting consequences, and can result in physical and psychological health risks.

In 2018, MSF provided medical care to 24,900 victims of sexual violence.

What is sexual and gender-based violence?

SGBV encompasses many different acts of violence against women, children and men, ranging from rape to genital mutilation.

In conflict, rape is often used as a weapon or as a reward for soldiers. Rape and other forms of sexual abuse are also used as a means of torture or, in some cases, as a strategy to spread HIV/AIDS within a community.

Medical consequences

SGBV can have a wide variety of medical consequences affecting physical and reproductive health.

Physical injuries can range from stab wounds, fractures and bleeding to vaginal fistulas.

People who are sexually abused are also more susceptible to sexually transmitted infections (STIs), such as HIV. STIs are more likely to be transmitted by forced sex as vaginal or anal tears provide an entry for the virus.

Another medical consequence can be unintended pregnancies. According to the World Health Organisation, women who have suffered sexual violence are twice as likely to have an

abortion. Abortions performed under unsafe conditions often have further consequences for reproductive health.

Psychological consequences

Survivors of sexual violence often suffer from severe and varied psychological effects. It is common for a person to feel guilty and to think the incident could have been avoided. A loss of control and trust can also affect a survivor's ability to form relationships with others. These feelings are often accompanied by clinical conditions such as depression, post-traumatic stress disorder and anxiety. The mental health of someone who has suffered sexual violence can be further deteriorated by stigmatisation. In some cultures, survivors are rejected by partners and family members, with some communities even humiliating people who have been raped.

How do we respond?

Medical care

As sexual violence can occur anywhere at any time, MSF ensures that all of its projects are equipped to handle sexual violence cases.

However, in some places such as Colombia, Kenya and Democratic Republic of Congo, for example, we have projects that are set up specifically to provide treatment to victims of violence, including sexual violence. In these situations, we:

- Prevent against infection (HIV, STIs, Hepatitis B, Tetanus)

- Provide pregnancy tests and emergency contraceptives
- Help to manage unwanted pregnancies

Provide psychological support

Treat physical injuries

Our medics urge people to seek treatment within three days of an attack, to not only treat physical injuries but also to prevent disease. Survivors of rape are given post-exposure prophylaxis to try and prevent possible infections, such as HIV. The sooner the drugs are iven

the more effective they are. Antibiotics, vaccinations and emergency contraception can also be provided.

Psychological care

As well as treating physical injuries, MSF also provides psychological support to victims of sexual and gender-based violence. We provide initial counselling to help patients deal with shock, as well as counselling and follow up care to prevent the development of post-traumatic stress.

Awareness and access to care

Medical care is central to MSF's response to sexual violence, but stigma and fear may prevent many victims from coming forward. A proactive approach is necessary to raise awareness about the medical consequences of sexual violence and the availability of care. Where MSF sees large numbers of victims – especially in areas of conflict – advocacy aims to raise awareness among local authorities, as well as the armed forces when they are involved in the assaults.

13.35 Terminologies

1. Crisis: is a state of emotional turmoil or an acute emotional reaction to a powerful stimulus.
2. Grief: is a reaction to any form of loss.

13.36 Activity

1. Discuss three characteristics of a crisis.
2. Write basics of crisis interaction.
3. Discuss different stages of relationship.
4. Analyse the following theories of career guidance.

(a) Traint and factor theory.
(b) Theory of person-environment fit.
(c) Learning theory of career counselling.

13.37 Reflection

What do you think are strengths and weaknesses of the social cognitive career theory?

13.38 Summary

In this unit you have learnt about trauma, grief, gender based violence, career, and child abuse counselling.

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