COUNSELING THEORY AND PRACTICE

Master of Social Work

SEMESTER-III, PAPER-III

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FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A' grade from the NAAC in the year 2016, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 443 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson- writers of the Centre who have helped in these endeavours.

Prof. P. Raja Sekhar
Vice-Chancellor
Acharya Nagarjuna University

303SW21: COUNSELLING THEORY AND PRACTICE
Syllabus

Course Objectives: This paper will enlighten the students on conceptual theoretical understanding on counselling, approaches and types and skills of counselling. Counselling for special groups and social stigma and social pathology.

Course Outcomes: Prepare the students on the concept and purpose of counselling, types and skills of counselling. Train up on counselling for families and different groups.

UNIT–1
Introduction to Counselling: Meaning, Definition, Purpose and Goals of Counselling – Perspectives of Counselling: Psychodynamic, Cognitive, Humanistic, Behavioral and Sociological – Counselling and Guidance.

UNIT–2
Approaches to Counselling: The Directive Approach, Humanistic Approach, Roger's Self Theory to Development of Self-concept, Behavioristic Approach and Electic Approach – Factors contribute to emergence of Counselling.

UNIT– 3
Counseling Process and Skills: Nature and Characteristics of the Counselling Process – Steps in Counselling Process – Techniques of Counselling – Counsellor's Skills – Counselling as a helping Relationship – Empathy as the key to Counselling Process.

UNIT– 4
Counselling for Special Groups: Children with Learning and Behavioral Problems – Mentally Retarded – Counselling for Correction and Better Adjustment – Pre & Post Marital and Family Counselling.

UNIT– 5
Social Stigma and Social Pathology: Counselling and Psychotherapy – Counselling for Stress, Burnout and Depression – Counselling for Sexual Health and HIV/AIDS Counselling for Alcoholic and Drug Addicted.

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COUNSELLING THEORY AND PRACTICE

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LESSON-1
MEANING, DEFINITION, PURPOSE AND GOALS OF COUNSELING

OBJECTIVES

Is to make the students understand the concept, characteristics, principles, purpose and goals of counseling

STRUCTURE

1.1. Introduction
1.2. Concept of Counselling
1.3. Meaning of Counselling
1.4. Definitions of Counselling
1.5. History of Counselling
1.6. Characteristics of Counselling
1.7. Principles of Counselling
1.8. The purpose of Counselling
1.9. Rules for Counselling
1.10. Fields of counselling
1.11. Goals of Counselling
1.12. Categories of Counseling Goals
1.13. SMART Goals
1.14. Summary
1.15. Key words
1.16. Self Assessment Questions
1.17. Reference books

1.1 INTRODUCTION

Counselling is an activity that emerged during the twentieth century and reflects pressures and values of modern life. We live in a complex, busy, changing world. In this world, there are different types of experiences that are difficult for people to cope with. Most of the time, we get on with life, but sometimes we are stopped in our tracks by an event or situation that we do not, at that moment, have the resources to sort out. Most of the time, we find ways of dealing with such problems in living by talking to family, friends, neighbours, priests or our family doctor. But occasionally their advice is not sufficient, or we are too embarrassed or ashamed totell them what is bothering us, or we just do not have an appropriate person to turn to. Counselling is a really useful option at these moments. In most places, counselling is available fairly quickly, and costs little or nothing. A counsellor is someone who does his or her best to listen to you and work with you to find the best ways to understand and resolve your problem.

1.2 CONCEPT OF COUNSELLING

Concept:

1. Relationship

Counselling is relationship between two people where one person attempts to assist the other to organize himself better to attain a form of happiness by adjusting to the situation.

2. Behaviors

The relationship between the counselor and the client helps to openly discuss the problem faced by the client. This helps to increase the skills, courage and self confidence in the client and creates a new behaviour in the client.

3. New Methods

New methods are explored to identify solutions for the perceived problem faced by the client. Sometimes, the client may not find a solution, but the thought of being able to share the problem with another person itself can give a satisfaction to the client.

4. Goals

Counselling also helps to develop a set of goals for future behaviour of an individual (client).

1.3 MEANING OF COUNSELLING

Counselling is a type of talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment. A counselor is trained to listen with empathy (by putting themselves in your shoes).

Counselling Meaning as per **Webster's Dictionary**

– –Counselling means consultations, mutual interchange of opinions or deliberating together.‖

Counselling meaning as per **Glanz**

--Counselling is an open ended face to face problem solving situation within which a student with professional assistance can focus and begin to solve a problem or problems.‖

Counselling meaning as per **Carl Rogers**

--Counselling is a series of direct contacts with the individual, in which one person or the client is helped to adjust more effectively to him and its environment.‖

Counselling meaning as per **Tyler**

--The job of a Counsellor is to help a person find out what his personality is like and decide how he can use the assets like qualities, potentialities he has, in order to get rid of the obstacles blocking his progress.

1.4 DEFINITIONS OF COUNSELLING

A professional relationship between a trained counsellor and a client designed to help clients to understand and clarify their views of their life space and to learn to reach their self- determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature.

(Burks and Steffl re 1979: 14)

A principled relationship characterised by the application of one or more psychological theories and a recognised set of communication skills, modified by experience, intuition and other interpersonal factors, to clients ‗intimate concerns, problems or aspirations.

(Feltham and Dryden 1993: 6)

Counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.

(British Association for Counselling and Psychotherapy website 2013)

Counselling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

(American Counselling Association website 2013)

1.5. HISTORY OF COUNSELLING

Early stage/ pre-historic counselling period:

Early counsellors were priest, medicine man- shaman, physicians and philosophers.

Ancient Guru‘s and Religious Leaders:¬ Budha, Socrates, Mausis are considered as ancient Guru‘s and religious leaders. They assisted in spiritual, religious aspects of their followers.

The first founders of counselling:-¬ The important founder during this period was Hippocrates, a Greek Philosopher who discovers Homeostasis (physiological balance in the body) and Prognosis (how a disease develops). He was the person who introduced systematic counselling intervention. And he also takes case history and builds a trust in patient.

- Sigmund Freud and Joseph Breuer was the another important founders who founds that Hypnosis as the study of unconscious mind. Sigmund Freud brought a formal method of psychoanalysis (id, ego, super-ego, dream analysis etc.).
- Influence from psychologist (19th century)¬
- During the period of 19th Century far-reaching innovations in the field of

psychology were made. This period saw the founding of the first psychological laboratory at Leipzig by Wilhelm Wundt in 1879.

- Stanley Hall started the first psychological laboratory in the USA in1883.
- In 1895, George Merrill established the first systematic vocational programme in San Francisco.
- Lightner Witmer heralded the beginning of the counselling movement by founding the first psychological clinic in 1896.
- J. B Miner established and directed the free clinic in mental development at the University of Minnesota in 1909.
- However, it was Jesse.B.Davis who first used the term ―Counselling‖.
- Significant Events in 20th Century (1900-1930)¬
- During the first few years of the twentieth century several significant events took place. They were:
- The first convention of the International Congress of Psychoanalysis was held at Salzberg.
- Stanley Hall invited Carl Gustav Jung to lecture at the Clark University.
- Clifford beers launched the ‗Mental Hygiene Movement' with his epoch-making book, ‗The mind that found itself'.
- The use of psychological principles was advocated in pastoral counselling by Rev.Elwood Worcester.
- The vocational Guidance movement was started on a modest scale by Samuel
- Frank parsons and Eli Weaver in Boston and Brooklyn respectively.
- Guidance was introduced by Wheatly and Boyden and Jessie Davis.
- Binnet-Simon tests of intelligence were adapted to American conditions about this time.
- The progressive Education Movement was initiated by John Dewey with his epoch-making book, ‗How we Think'.
- The school of social work started by Mrs. Adolf Meyer
- E.L Thorndike and Robert Yerkes helped develop the Army Alpha and Army Beta tests for screening the defence personnel.
- James Burt Miner developed the first ever known questionnaire in 1908.
- R.S. Woodworth and F.L Wells association tests and psychometric inventoryin 1911, which was developed as a screening device for the army recruits.

Development of tools and techniques (1930-1940)

From the end of World War I to the outbreak of World War II, saw the publication of books and important psychological tests, such as Harry Kitson's ‗psychology of Vocational Adjustment' (1925), Clark. L. Hull's Aptitude Testing (1927) and E.K Strong Jr's Strong Vocational Interest Blank (SVIB-1943).

- National vocational Guidance Association (NVGA), founded in 1913 in America, formed the American Council of Guidance and Personnel Association in 1934.
- Robert Hoppock, a former secretary of NVGA published his book Job satisfaction in 1935.
- L.L. Thurstone's Tests of Primary Mental Abilities in 1938
- Donald Paterson and E.G. Williamson during 1930-1940 at Minnesota, concerned with the objective assessment of the individual's abilities.

Counselling Era (second World War and after)
Counselling which finally established as a science in its own right was achieved through Carl Roger‘s book, Counselling and Psychotherapy (1942).

In 1944, the Army separation and Classification and counselling Program was initiated and the United States Employment Services (USES) published the General Aptitude Test Battery (GATB) in 1945.

First journal of Counselling Psychology was published in 1954.

Era of therapeutic counselling:

The domain of mental health was given importance. Individual freedom, liberty, values of life all taken in to consideration. Counselling settings were diversified. Community mental health care was started and counselling involves four main aspects:

- Self understanding
- Self direction
- Self realization
- Self actualization

Licensing, regulation and research were given importance

- 1973 in US and in 1992 in India standardized counselling practice and diploma in counselling was started. But India does not have Licensing authority. Research was done on psycho social care, stress, trauma etc. And they say that counselling is necessary in those areas.
- In 2004 NIMHANS started Disaster management programme with the Govt. of India.

Foundations of Counselling:

Foundation of counselling includes many disciplines such as Philosophy, Sociology, and Psychology etc. Psychiatry, family studies and social work are the other disciplines that pave the foundations to counselling. There are main 3 foundations based on which Counselling is done:

Philosophical Foundation
Sociological Foundation
Psychological Foundation

1. Philosophical foundation

The philosophy deals with human values and the counselling gives importance to human value. The philosophy tells about the sense of purpose in life, while counselling helps to attain or make him understand about the purpose of life. Philosophy tells about values, sensible, being considerable, being right and wrong etc. On the other hand, all these are practiced in counselling. Counselling beliefs in man‘s faith, his abilities and this is what philosophy teaches us Smith‘s Philosophical **Foundation of Counselling:**

- Faith in humanity
- Concern for other person
- Belief in potentiality and inner strength of man

- Self responsibility
- Freedom to choose sovergnity
- Cherishing values of life.

2. Sociological foundation

- It studies about how a man functions in social settings. In counselling, we deal with individual and their problem. Unless, we know about the society, we cannot solve the problem. Thus, the counsellor should know the culture and values of the society in which he is practicing counselling. Values, beliefs, systems acquired from the society can be useful in providing counselling.

- Counselling respects values, beliefs, systems of the client. Sociology teaches about the uniqueness about all these aspects. It also teaches about the various aspects of life.
- Each culture and system is different from the other; hence what is right in one culture may be wrong in another culture. Hence counselling must be based on the values of the client and not of the counsellor. Eg: Children sleeping with parents are accepted in India. But in the west it is not accepted.

3. Psychological foundation

- Counselling deals with human behaviour and psychology is the scientific study of human behaviour. Counselling has roots in psychoanalysis (ego stages, free association, dream analysis). Functionalism in 1990‘s is an important aspect in counselling.

- Psychology also talks about the primary interest of the client. It deals with Motivation, Personality, Development stages, Memory, Nature and Nurture, defence Mechanism etc. It also talks about code of ethics which is applied in counselling. Concept of self and goal directed behaviour is very important in counselling.

1.6 CHARACTERISTICS OF COUNSELLING

- Counselling involves one-to-one relationship.
- Counselling involves 2 individuals – one seeking help and another professionally trained person known as counsellor.
- There should be a mutual relationship of respect between the 2 individuals.
- The objective of counselling is to help the counsellee to discover and solve his personal problems independently.
- The main emphasis is on the client‘s self-direction and self-acceptance.
- Counselling concerns itself with attitudes as well as action.
- In counseling, emotional feelings are most important.
- Counselling is more than advice-giving.
- Counselling is more than the solution to an immediate problem. Its function is to produce changes in the individual that will enable him to overcome his immediate difficulties.
- Counselling is democratic. It allows the counsellee to do freely whatever he likes

1.7. PRINCIPLES OF COUNSELLING

- Principle of Acceptance
- Principle of Respect for the individual
- Principle of Permissiveness
- Principle of thinking with the Individual
- Principle of Consistency with Ideals of Democracy
- Principle of learning
- Principle of self-direction and self-realization of the client.
- Principle of understanding the relationship of self and environment.
- Principle of structured learning situation.

1.8. THE PURPOSE OF COUNSELLING

Through counseling, individuals are encouraged to think about their problems and thus come to a greater understanding of the causes. As a result of this understanding people will, it is hoped, commit themselves to taking action that will solve the problems. The kind of action taken will be a person's own decision, althoughit may be guided, if necessary by the counsellor.

Counselling means choice, not force, not advice. A health worker may think that his or her advice seems reasonable, but it may not be appropriate to the particular circumstances of the person receiving the advice. With counselling, it is the person concerned who takes the decisions so that the solutions adopted are more likely to be appropriate. An appropriate solution will be one that the person can follow with successful results.

1.9. RULES FOR COUNSELLING

Simple rules of Counselling:

Relationships

Counsellors show concern and a caring attitude. They pay attention to buildinga good relationship from the beginning with the person they are trying to help. People are more likely to talk about their problems with someone they trust more likely to talk about their problems with someone they trust.

Identifying needs

Counsellors seek to understand a problem as the person with the problem sees it. People must identify their own problems. Counsellors do not name the problems for them. The use of questions that lead to open comments will help here. A counsellor's task is to listen carefully.

Feelings

Counsellors develop empathy (understanding and acceptance) for a person's feelings, not sympathy (sorrow or pity). A counsellor would never say 'You should not worry so much about that.' It is natural for people to have worries and fears about their problems. A good counsellor helps people to become aware of their feelings and to cope with them.

Participation

Counsellors never try to persuade people to accept their advice. If the advice turns out to be wrong, the person will be angry and no longer trust the counsellor. If the advice is right, the person may become dependent on the counsellor for solving all problems. Counsellors help people to think about all the factors involved in their problems, and encourage people to choose the solutions that are best in their particular situation.

Secrecy

Counsellors will be told about many personal and possibly embarrassing problems. The information must be kept secret from all other people, even from the client's relatives. If a person you are counselling discovers that you have told other people about the counselling session, that person will no longer trust you and will avoid you. A client may even get into trouble because of what a counsellor has told others. Counsellors always respect the privacy of the people they are helping. They never reveal information without specific permission.

Information and resources

Although counsellors do not give advice, they should share information and ideas on resources which the client needs in order to make a sound decision. For example, many people do not realize the connection between their behavior and their health. Counsellors do not lecture, but should provide simple facts during discussion to help people have a clearer view of their problems.

1.10. FIELDS OF COUNSELLING

There is a number of counselling which take place these days. They are mainly divided as per the various fields. This allows people to choose the counsellor as per their specific problem. Moreover, this assures the counsellor doing the work is a specialist in their respective field. The following are the most common forms of counselling;

- Marriage and Family Counselling
- Educational Counselling
- Career Counselling
- Rehabilitation Counselling
- Mental Health Counselling
- Substance Abuse Counselling

Marriage and Family Counselling

Couples therapists and marriage counselors treat some of the same issues as other psychologists, such as depression and anxiety, substance abuse, and PTSD. But their work focuses on issues that are specific to their target group, the family. Some common issues that family counselors encounter are marital conflicts, adolescent behavior problems, domestic violence and issues related to infertility.

People often face a lot of problems in their marriage and family life. Sometimes, these troubled people find it hard to cope up with their life. This results in constant fights with their partners or family members. Marriage and family counselling comes in here. In other words, it helps people with these problems. They take them into

confidence and prescribe solutions that will help them overcome their problems.

Marriage and family therapists observe how people behave within the family, and identify relationship problems. They then come up with treatment plans so that each individual has his or her needs met and the family unit can work for the benefit and happiness of all.

Educational Counselling

A student who is fresh out of school or college is often clueless as to which career to choose. This is completely normal for kids of that age to feel like that. Furthermore, sometimes even working individuals feel like that in the midst of their careers. This is nothing to worry about. Educational counselling helps these people in choosing their career path. They conduct seminars and orientations or private sessions where they discuss the interest of their client and offer solutions accordingly.

School psychologist‘s work with students at all levels, from elementary school to college. They are advocates for students‘ well-being, and are a valuable resource for their educational and personal development. They help students work through issues such as bullying, disabilities, low self-esteem, poor academic performance, social anxiety, problems with authority, or problems at home. School psychologists may do one-on-one therapy with students, or work in groups with family members or peers to understand and overcome psychological problems.

Career Counselling

A little different from the traditional counselling processes, career counselling means providing aspirants with career guidance and showing them the right path towards a bright career according to their areas of interest and skills. The career counselling curriculum is designed to guide people in selecting, changing, or leaving a career and can be availed at any stage of life. A career counselling expert assesses your aptitude, personality, and interests to suggest you the best career option.

Rehabilitation Counselling

The rehabilitation counselling process helps people with disabilities fulfill their goals and lead an independent life with complete participation in the community. This is a systematic method to help people with emotional, physical, cognitive, and mental disabilities accomplish their life goals and live cherish able life. The rehabilitation counselors support the concerned people to overcome psychological disabilities.

People with disabilities face challenges that require creative solutions. Whether a person has a physical, mental or emotional disability, rehabilitative counseling helps them achieve personal and professional goals, and lead their lives more freely. As Alfred Souma, MA, a professional education rehabilitation counselor in Seattle, confirms, ―Rehabilitation counseling deals with assisting people with disabilities to reach specific life goals and improve their quality of life. Most rehabilitation counselors specialize in a specific disability, such as spinal cord injury, blindness, deafness, head injury or psychiatric disability.‖Rehabilitation counselors work in a variety of state departments and community programs. They are also employed in the private sector in for-profit and nonprofit organizations, such as schools, colleges, residential care facilities and drug rehabilitation facilities.

The rehabilitation counselor will work with:

- Disabled people, either individually or in groups
- Employers, educating them about Disabilities Act
- Placement agencies who refer disabled people to employers

The vocational rehabilitation counselor will work with:

- Disabled people, assisting them in finding gainful employment
- On an individual level, counsel people through specific job training and be available for post-employment counseling
- Employment agencies and employers to ensure proper working conditions

Mental Health Counselling

A mental health counselor is responsible for providing the people with support who are going through any emotional distress like fear of something, anxiety, depression, or frustration. There are different causes when people need mental health counselling that may include, extensive grief, supreme anger issues, addiction to something, family issues, eating disorders, and so on. After talking to the clients about the problems, mental health counselors try and provide the ways to overcome this situation and nurture their well-being.

Mental illnesses have become very common these days. Awareness has helped people identify the symptoms of it and visit mental health counsellors. Mental health counselling helps people deal with issues that impact their mental health and well-being. Some of the mental illnesses are depression, PTSD, ADHD, Bipolar disorder, and more. This counselling focuses on these issues and helps in resolving them for a healthier life.

Mental health counselors offer guidance to individuals, couples, families and groups that are dealing with issues that affect their mental health and well-being. Counselors treat many of the same problems as other psychologists: depression and anxiety, PTSD, ADHD, bipolar disorder, eating disorders, personality disorders and any psychological issue. Their approach depends on their education and professional experience, but like psychologists, they may primarily practice psychodynamic therapy, cognitive- behavioral therapy, humanistic therapy, or have a holistic, integrative approach.

Substance Abuse Counselling

Substance abuse counselling is a form of counselling which helps people in treating them and supporting them from breaking free from their drug and alcohol addiction. It helps people discuss the cause of this addiction and reach to the root of it. The counsellor thereby suggests coping strategies which make a positive impact on their lives. Moreover, they also provide them with practicing skills and behaviours which helps in their recovery.

Substance abuse counselors diagnose and assess addiction problems, and treat clients in a variety of ways. Because every patient is an individual and is struggling with addiction in different ways, substance abuse counselors customize treatment plans for each client. They may meet regularly with clients as they recover, or work intensely with individuals in crisis.

They teach clients how to alter their attitudes and false beliefs, and develop

strategies to overcome denial and rationalization in the hope of achieving full recovery. Because clients are susceptible to relapse, many substance abuse counselorswork with clients on an on-going basis.

In conclusion, all types of counselling carry equal importance. They allow people to work through their problems and lead a happier and healthier life. There is no shame in taking counselling sessions as it only helps in the growth of an individual.

1.11. GOALS OF COUNSELLING

After understanding the meaning and concept of counselling an attempt is made to discuss what is achieved through counselling. The counselling has different goals with different clients. For example, the counsellor may provide counselling for assisting client to heal past emotional deprivations, manage current problems, handle transitions, make decisions, manage crises and develop specific life skills, etc. Sometimes goals of counselling are divided between remedial goals and growth or developmental goals. Both the remedial and developmental goals serve preventive functions. Though much of counselling is remedial, its main focus is on the developmental tasks of a vast majority of ordinary people rather than on the needs of more severely disturbed minority (Richard Nelson – Jones: 2000). For the social work professionals counselling goals may be listed as follows:

1. Counselling As Emotional Release

Suppression of thoughts, feelings and emotions often lead to physical or mental problem. The counsellors in such cases help the client to deal with their unexpressed feelings and emotions. The client usually benefit from learning to let them go in a way that is not damaging to themselves or to others. A person who has just lost a loved one but is unable to grieve or a person who is furious with his/her boss but holds it in, for these and such other cases counselling is given as emotional release. Venting of emotions can be a great relief to these persons and freedom for such expressions is important aspects of social workers.

2. Facilitating Behavior Change

The goal of counseling is to bring about change in behavior that will enable to the client to be more productive. Goals can be measurable so that client can measure that program. According to Rogers (1951) behavior change is a necessary result of the counseling process although specific behaviors receive little or no emphasis during process.

Counselling aims at developing a healthy value system in the clients‘ personality.

The socialization process and internalization of values shape the personality of the individual. The value system directs ones thinking, feeling and accordingly the action. Sometimes people are involved in activities which are anti social and/orharmful to themselves or to others. In such a situation, counselling helps as a remedialmeasure. The counselor helps the clients to clarify their values and if needed bringabout appropriate changes in the value system of the clients.

3. Improving Relationship

Many clients tend to have major problems relating to others due to poor self- image. Likewise inadequate social skills cause individuals to act defensively in relationships.

The counselor would then strive to help the client improve the quality of their lives by developing more effective interpersonal relationships.

4. Facilitate Client's Potential

While working with people as social worker there are many occasions where individuals seek crisis intervention and short-term support from the social worker. A young man frustrated after completing higher education and not getting suitable employment, a woman severely depressed after the sudden death of her husband, a youth confused and finding it difficult to make choice about career are some of the examples of this. Anyone under acute stress or depression might benefit from this kind of temporary assistance. Social worker helps individuals to cope with newsituation and challenges. Many inevitably run into difficulties in the process of growing up. Most of them do not completely achieve all over the development tasks within a life time. All of the unique expectations and requirements imposed on them by others will eventually lead to problem learning coping patterns, however may not always work.

5. Promoting Decision Making

The goal of the counseling is to enable the individual to make critical decisions regarding alternative courses of actions without outside influence. Counseling will help individuals obtain individuals obtain information and to clarify emotional concern that may interfere with or be related to the decision involved. These individuals will acquire an understanding of their capabilities and interests. They will also come to identifying emotions and attitudes that could influence their choice and decisions.

6. Enhance Potential and Enrich Self Development

Counseling seeks to maximize an individual freedom by giving him or her control over their environment while analyzing responsiveness and reach to the environment. Counselors will work to help people learn how to overcome. Counselors will also assist to overcoming sexual dysfunction, drug addition, gambling and obesity as well as anxiety shyness and depression. They help individuals to cope with new situations and challenges.

Counselling goal can be for the nourishment of a natural tendency toward psychological maturation which presumably exists in every individual. According to psychologists like Carl Rogers and Abraham Maslow, everyone has a natural tendency towards –self-actualization‖.

The counsellors, through their skills and by providing a conductive emotional atmosphere, help the clients to promote this innate positive orientation.

1.12. CATEGORIES OF COUNSELING GOALS

Counseling Goals may be simply classified in terms of counselor goals and client goals or the immediate, intermediate, or long range goals of therapy. Broadly speaking, counseling goals may also be separated into the following categories:

1. Developmental Goals

Developmental Goals are those wherein the client is assisted in meeting or advancing her or his anticipated human growth and development (that is socially , personally, emotionally, cognitively, physical wellness and so on)

2. Preventive Goals

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

3. Enhancement Goals

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

4. Remedial Goals

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

5. Exploratory Goals

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

6. Reinforcement Goals

Reinforcement is used in those instances where clients need help in recognizing that what they are doing, thinking, and/or feeling is okay.

7. Cognitive Goals

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

8. Physiological Goals

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

9. Psychological Goals

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

1.13. SMART GOALS

SMART is an acronym that stands for:

- Specific
- Measurable
- Achievable
- Realistic
- Time Limited

SMART goals are:

1. Specific

Understand the client‘s struggle in context- How will you know when the problem is managed or resolved?

1. Emotionally - I will feel hopeful.
2. Cognitively - I will take time to be mindful of my thoughts

3. Socially - I will make time for meaningful relationships.
4. Situationally - I will be more motivated and purposeful at work/school.
5. Physically - I will have more energy and be in better physical shape

2. Measurable

1. Frequency (number of times)
2. Duration (how long)
3. 3.Intensity (mild, moderate, intense, excruciating)

3. Achievable

- How will you know when the client has achieved their goal(s)? What will success look like?
- What is the role of the counselor and what is the role of the client in working towards achieving a goal?
- What are the counselor and client each responsible for doing? When, where, and how will they carry out their responsibilities?
- How will the client and counselor's behaviors help the client meet their goal

4. Realistic

- Has to be a changeable growth area
- Set goals that enable change to happen in small steps across time

5. Time Limited

- Identify a specific time frame for the behaviors/actions to take place

This helps clients to see incremental improvements across time, which is reinforcing

GOALS SERVE THREE IMPORTANT FUNCTIONS IN THE COUNSELLING PROCESS

1. Goals can have a motivational function in counseling
2. Goals can also have an educational function in counseling in that they can help clients acquire new responses.
3. Goals can also meet an evaluative function in counseling where by the client‘s goals help the counselor to select and evaluate various counseling strategies appropriate to the client‘s goals

1.14. SUMMARY

Counselling is a talking therapy that allows people to discuss their problems with trained professionals in a peaceful and safe ambiance. The exact meaning of counselling might vary among individuals. It is a process wherean individual, couple or family meet with a trained professional counsellor to talk about issues and problems that they are facing in their lives. Counselling can provide people with the opportunity to share their views, be heard and gain new perspectives on their situation and experiences. Counselling can help people to gain clarity in surrounding issues. Together with their counsellor people identify and work towards achieving the desired outcomes and goals for counselling.

Counselling is used to deal with a broad range of issues and problems .It can help you to deal with stress, provide treatment for anxiety and treatment fordepression. Counselling can provide you with the opportunity to reassess or set new goals in life and help to gain clarity and direction. Counselling can be used to address issues and problems within relationship or provide mediation between client andhis/her partner.

A professional counselor is trained and registered, and will provide you with a genuine, caring and empathic response to your problems. A trained counsellor will have tools and techniques that are evidence based. They can use these tools to support you or help you to move through the difficult, problem, feelings, behaviour, thoughts or situation that are you experiencing.

Professional counselling is confidential and non-judgmental. A counselor is a professionally trained expert who helps people overcome their issues after a systematic chain of sessions. The types of counselling vary, depending on the needs of the clients. The role of a counselor doesn‘t limit to suggesting to do this or that. Rather they support the client to speak about problems in detail to identify the primarycause behind them. Furthermore, they develop an action plan to help to cope up with the issue or win over it. There are different formats through which the counselling sessions can take place, the client is free to choose a format that suits and fits his needs the best.

Counselling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully. Counselling relationships will vary according to need but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict or improving relationships with others.

The five most common goals of counseling include: Facilitating behavioral change, helping improve the client‘s ability to both establish and maintainrelationships, helping enhance the client‘s effectiveness and their ability to cope, Helping promote the decision-making process while facilitating client potential and development.

Goals are important for everyone, whether they are in therapy or not. Goals help you navigate through life whether they are personal goals, professional goals, a goal to replace a bad habit or simply a goal for achieving success. Research shows that therapy is much more useful when it involves having a set plan for what you hopeto achieve or accomplish. Setting goals can also give the therapist a better grasp of client growth as they proceed with therapy.

1.15. KEY WORDS

Counselling, Marriage and Family, Mental Health, Substance Abuse, Goals

1.16. SELF ASSESSMENT QUESTIONS

1. Explain the concept, definition and meaning of counselling
2. Discuss the various fields of counselling
3. What is a Goal and explain different categories of goals.

1.17. REFERENCE BOOKS

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LESSON-2
PERSPECTIVES IN COUNSELLING

OBJECTIVES

The student will be able to understand the various perspectives like biological, psychodynamic, behavioural, humanistic, cognitive, constructionist and systemic theories of counseling.

STRUCTURE

2.1. Introduction

2.2. Perspectives of Counselling

2.3. Biological Perspective

2.4. Psychodynamic Perspective

2.5. Behavioural Perspective

2.6. Humanistic Perspective

2.7. Cognitive Perspective

2.8. Constructionist Perspective

2.9. Systemic Perspective

2.10. Summary

2.11. Key Words

2.12. Self Assessment Questions

2.13. Reference Books

2.1 INTRODUCTION

Counselling can be defined as a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. (American Counselling Association, 2010) In order to practice counselling, it is vital that the counsellors have a thorough understanding and learning of psychology and its theories. Psychology is an intriguing scientific study ofthe human mind and behaviour which has a diversity of perspectives, each presenting a unique way of interpreting human beings. we have to analyze some of the widely used psychological perspectives in counselling, which will emphasize the necessity for counsellors to have a thorough understanding and learning of theories.

Determining whether one counseling approach works better than another is difficult, because there are so many variables to consider in the counseling process. For example,

if we try to compare the effectiveness of two counselors applying the same theoretical model, there can be major differences in the counseling outcome due to differences in the clients' histories and situations, differences in the counselors' communication styles, and even differences in client and counselor mood on the dayof the comparison. Such differences are hard to control for experimentally, thusmaking it almost impossible to prove that one approach to counseling is the absolute best way. Without such proof, it becomes the responsibility of counselors to do all they can to see that the treatment model(s) they apply are the best ones to addresseach client's needs.

A counseling ***theory*** is an intellectual model that purports certain ideas about underlying factors that affect behavior, thoughts, emotions, interpersonal interactions, or interpersonal interpretations. A theory also must provide a focus of study (e.g., thoughts, behaviors, emotions, relationships, systems of relationships, social agreements) for clinicians using the model. The model outlines the limits of activities used by the clinician to examine and evaluate the client. Once evaluated, it provides specific techniques of intervention that can be used by the clinician to affect the client. Therefore, a counseling theory is a model of understanding and intervention; it provides the clinician with ways to view and to change a client‘s behaviors, feelings, thoughts, or interactions. Over the history of mental health treatment, wide variations in the models of treatment have evolved. There are those that are more medically oriented, assuming biological bases for unusual behavior. Some theories purport a psychological nonphysical *individual* (e.g., the self) that is the focus of study and target of intervention. Other theories hold that relationships (healthy and unhealthy) are crucial to understanding behavior and should be viewed as treatable. Some clinicians hold that mental problems are housed in language, and treatment should act as a re-narration of a person‘s life. There is one common thread in all psychotherapy i.e., the counselor is a change agent.

2.2. PERSPECTIVES OR THEORIES OF COUNSELLING

The perspectives are as follows;

- Biological perspective
- Psychodynamic perspective
- Behavioural perspective
- Humanistic perspective
- Cognitive perspective
- Constructionist perspective
- Systemic perspective

2.3. BIOLOGICAL PERSPECTIVE

Biological psychology is the study of the physiological, evolutionary and developmental mechanisms of behaviour and experience devoted to studying brain functioning. (Kalat, 2007) It pays key attention to the areas of the nervous system, brain, vision, movement, sleep, reproductive behaviour, emotions, cognitive functions and disorders. The biological psychologist tries to study the animal roots of behaviour and experiences to genetics and physiology. The importance of studying this

perspective for counsellors may appear as a latent function as the biological perspective depicts an image which bends more towards natural sciences and away from the conventional image of psychology and counselling. Yet the awareness of this field can be most advantageous to a counsellor. For an example let us envisage an instance where the counsellor meets a new client who implies that he is suffering from depression. In order to identify whether the client is actually suffering from depression or whether it a level of stress or else is it a reaction which comes out due to another physiological condition, the understanding that the counsellor has of sleep patterns, emotions, and disorders may prove beneficial. Or else if a client suffering from anorexia, schizophrenia or even a bipolar disorder, where the client may need medical attention, even to direct and understand the symptoms this understanding is important. This provides a basic understanding of the necessity of the biological perspective.

2.4. PSYCHOANALYTIC/ PSYCHODYNAMIC PERSPECTIVE

The psychodynamic perspective has its roots in the theories of Sigmund Freud. His studies focused on the belief that our emotions, thoughts and behaviour stem from the unacceptable thoughts from childhood that allow to influence the current thinking. During his career as a medical doctor, Freud came across many patients who suffered from medical conditions which appeared to have no _physical cause‘. This led him to believe that the origin of such illnesses lay in the unconscious mind of the patient.

These repressed thoughts and feelings eventually manifest as depression, fears and conflicts. The therapy is relationship-centred and is powered by our interactions with close friends and family. (Martin, 2013) The Psychodynamic perspective helps to understand the root cause of client problems and issues. But this can only be done if the counsellor has a thorough understanding of the theoretical features, for an example in this perspective it is vital that the counsellor is familiar with the stages of personality development, defense mechanisms, iceberg theory, and the techniques such as free association, transference and interpretation of resistance. If a client comes who is fixated in the oral stage, his behaviour brings out this condition. However the counsellor would be able to recognize this only if he is aware of these theories. Even when assisting clients the therapeutic method would depend on the nature of the client‘s condition and also the psychological orientation of the counsellor. But if the counsellor has a broad idea and capacity he has the potential to assist clients in a more effective manner. Even when it comes to problems like depression, anxiety, anger and social isolation, these can all be successfully treated and improved using some form of psychodynamic approach.

Psychoanalytic counseling theories hold that psychological problems result from the present-day influence of unconscious psychological drives or motivations stemming from past relationships and experiences. Dysfunctional thought and behavior patterns from the past have become unconscious "working models" that guide clients toward continued dysfunctional thought and behavior in their present lives. Psychoanalytic counselors strive to help their clients become aware of these unconscious working models so that their negative influence can be understood and addressed. Some currently preferred therapies grounded in psychoanalytic theory include psychoanalysis, attachment therapy, object relations therapy and Adlerian therapy.

Psycho-dynamic counselling evolved from the work of Sigmund Freud (1856-

1939). During his career as a medical doctor, Freud came across many patients who suffered from medical conditions which appeared to have no ‗physical cause'.This led him to believe that the origin of such illnesses lay in the unconscious mind of the patient.

Freud therefore started to investigate the unconscious mind, so that he could understand his patients and help them recover. Over time, many of Freud's original ideas have been adapted, developed, disregarded or even discredited. They have therefore been used in a number of different schools of thought and practice. Psycho-dynamic counselling is based on Freud's idea that true knowledge of people and their problems is possible through an understanding of three particular areas of the human mind.

These areas are:

The Conscious – things that we are aware of, including feelings or emotions, such as anger, sadness, grief, delight, surprise, and happiness.

The Subconscious – these are things that are below our conscious awareness but fairly easily accessible. They may include, for example, events that we have forgotten, but will easily remember when asked an appropriate question.

The Unconscious – this is the area of the mind where memories have been suppressed and is usually very difficult to access. Such memories may include extremely traumatic events that have been blocked off and require a highly skilled practitioner to help recover.

Freud's main interest and aim was to bring things from the unconscious into the conscious. This practice is known as psychoanalysis. Psychoanalysis is used to encourage the client to examine childhood or early memory trauma to gain a deeper understanding of events. This in turn may help the client to release nativities associated with these earlier events. Psychoanalysis is based upon the assumption that we can only progress psychologically by becoming aware of earlier dilemmas that have been repressed into our unconscious because of painful associations.

Psychoanalytic counseling theories hold that psychological problems result from the present-day influence of unconscious psychological drives or motivations stemming from past relationships and experiences. Dysfunctional thought and behavior patterns from the past have become unconscious "working models" that guide clients toward continued dysfunctional thought and behavior in their present lives. Psychoanalytic counselors strive to help their clients become aware of these unconscious working models so that their negative influence can be understood and addressed. Some currently preferred therapies grounded in psychoanalytic theory include psychoanalysis, attachment therapy, object relations therapy and Adlerian therapy.

Freud maintained that the personality consists of three related elements:

- The Id is the part of our personality concerned with satisfying instinctual basic needs of food, comfort and pleasure. It is therefore present from (or possibly before) birth.

- The Ego is defined as ―the realistic awareness of self‖. It is the logical and common sense side to our personality. Freud believed that the Ego develops as the infant becomes aware that it is a separate being from its parents.The Superego develops later in a child's life, from about the age of three. The

Superego curbs and controls the basic instincts of the Id, which may besocially unacceptable. It therefore acts as our conscience.

Freud believed that everybody experiences tension and conflict between the three elements of their personalities. For example, desire for pleasure (from the Id) is restrained by the moral sense of right and wrong (from the Superego). The Ego balances the tension between the Id wanting to be satisfied and the Superego being over strict. The main goal of psycho-dynamic counselling, therefore, is to help people to balance the three elements of their personality so that neither the Id nor the Superego is dominant. It is rooted in exploring and understanding past experience to identify repressed issues that are affecting current behaviour. Psycho-dynamic counselling is therefore a long and ongoing process, and is mainly used when people are experiencing severe problems that are not resolved using other methods.

Other theorists, notably Carl Jung and Alfred Adler, diverged from Freud and developed new theories. All of these are considered to be psychodynamic theories, as they share Freud‘s belief that human functioning is shaped by dynamic (interacting) psychological forces.

Psychodynamic therapies involve several techniques such as the following:

Free association involves the client describing any thought, feeling or image that comes to mind, even if it seems unimportant or irrelevant. This helps uncover unconscious events and underlying dynamics.

Therapist interpretation involves the therapist looking for clues and sharing interpretations when clients are ready to hear them. Three types of interpretations are particularly important: resistance, which involves the unconscious refusal to fully participate in therapy; transference, where clients act and feel toward the therapist the way they do or did to someone important in their life; and the interpretation of dreams.

Catharsis is the reliving of past repressed feelings, which therapists believe clients must experience to settle internal conflicts and overcome their problems. Working through is the process of a therapist and client examining the same issues over and over with greater clarity. This occurs over many sessions and can take years.

Psychodynamic therapy helps in counselling clients understand the root cause of their problems and issues. It also helps equip them with knowledge and suggestionsto enable them to cope with further difficulties. With a strong emphasis on the trust between a client and counsellor or psychotherapist, psychodynamic therapy provides the tools required to make progress. The therapy is relationship centered and is powered by one‘s interactions with close friends and family. Psychodynamic therapy helps by understanding and acknowledging that most emotional problems originate in a client‘s childhood, and that all experiences will have some kind of subsequent subconscious effect on the individual. Identification of subconscious thoughts and understanding how these thoughts affect behaviour are accomplished by reflecting and looking inward at the feelings, thoughts and reactions a client expresses. Psychodynamic approaches take many forms and the key principles include: i) Early experiences of a client in childhood is important ii) All internal experiences relate to relationships with other people iii) Free association and other techniques provide more information in exploring the problem iv) Insight is essential in order to achieve positive progress and success in counseling.

2.5. BEHAVIOURAL PERSPECTIVE

Behaviourism on the other hand doesn‘t stress the unconscious and does not place emphasis on gaining insight into early childhood experience. Instead this approach assumes that we have learnt our current behaviours and can learn new behaviours by applying the principles of behaviourism. Hence behavioural refers to a wide range of ideas, practices, and theories. On one end are radical behaviourists, focusing predominantly on learning principles and avoiding any mentalist concepts, such as thoughts. On the other end are cognitive behaviour theorists, likeMeichenbaum, who emphasized mental processes in behaviour. (Mitchell & Gibson, 2005) Behavioural approaches are designed to change unwanted or maladaptive behaviour through the application of basic learning principals. Behavioural approaches maintain that both abnormal and normal behaviours are learned. Good behaviour is maintained by reinforcement and unwanted behaviour can be eliminated by punishment.

Behavioral counseling theories hold that people engage in problematic thinking and behavior when their environment supports it. When an environment reinforces or encourages these problems, they will continue to occur. Behavioral counselors work to help clients identify the reinforcements that are supporting problematic patterns of thinking and acting and replace them with alternative reinforcements for more desirable patterns. Currently preferred therapies based in behavior theory include behavior therapy, dialectical behavior therapy, multimodal therapy and conjoint sex therapy.The behavioural approach to counselling focuses on the assumption that the environment determines an individual‘s behaviour.

Behaviour therapy focuses on individual behaviour and aims to help people to modify unwanted behaviours. Unwanted behaviour is defined as an undesired response to something or someone in the environment. Using this approach, a counsellor would identify the unwanted behaviour with a client and together they would work to change or adapt the behaviour. Problems which respond well to this type of therapy include phobias, anxiety attacks and eating disorders.

A primary concept in behaviorism is conditioning, which refers to simple forms of learning that involve stimuli and rewards. Several forms of conditioning mayproduce normal or abnormal behavior.

- In operant conditioning, humans and animals learn to behave in certain ways as a result of receiving rewards whenever they do so.
- In classical conditioning, learning occurs by temporal association. This means that when two events repeatedly occur close together, they become fused in a person‘s mind, and a person responds in the same way to both events. Ivan Pavlov discovered this form of conditioning in his famous experiments with dogs. The dogs associated the sound of a dinner bell with food and began drooling at the sound.
- In modeling, individuals learn responses simply by observing other individuals and repeating their behaviors.

Behavioral therapy seeks to identify behaviors that are causing a person‘s problems and then tries to replace behaviors with principles of operant conditioning, classical conditioning and modeling. For instance, one classical conditioning treatment is systematic desensitization, which changes abnormal reactions to particular stimuli. A therapist will apply this treatment method to specific phobia to help clients learn how

to react calmly to feared objects or situations. The client will imagine or confront feared objects or situations, starting with the least feared and ending with the most feared. Hence, this therapy focuses on an individual‘s learnt, or conditioned, behaviour and how this can be changed. The approach assumes that if behaviour can be learnt, then it can be unlearnt (or reconditioned). So it is useful for dealing with issues such as phobias or addictions. Examples of this therapy are behaviour therapy and cognitive behaviour therapy. The behavioral approach to counselling makes the basic assumption that most problems are problems in learning and as such the behavioral counsellor tries to help the individual to learn new and more adaptable behaviour and to unlearn the old non adaptable behaviour. The behavioral counsellor focuses attention on the individual‘s ongoing behaviour and their consequences in his own environment of school and home. He tries to restructure the environment so that more adaptable patterns of behaviour can be learned and non- adaptable patterns of behaviour can be unlearned.

2.6. HUMANISTIC PERSPECTIVE

Over fifty years a humanistic approach has been used in the field of therapeutic counselling. Although behavioural and psychoanalytic forms of counselling are also available, the humanistic approach is an extremely successful option. Counselling clients with a humanistic approach provides them with an opportunity to explore creativity, personal growth and self-development, as well as acknowledging a variety of choices. The foundations of the humanistic approach provide the client with a deeper understanding of who they are, what they feel and the opportunity to explore the possibility of creating personal choices. It encourages self- awareness and self-realization. Humanistic believe in free will, that individuals whether consciously or unconsciously create their existence and if afforded the right circumstances can recreate their existence through change. Most of the humanistic psychologists such as Carl Rogers, Abraham Maslow believe that there is an inborn tendency in individuals to self actualizes in order to fulfil their potential if they are afforded an environment conducive to growth. (Neukrug, 2003) The humanistic approach provides a distinct method of counselling and focuses predominately on an individual‘s unique, personal potential to explore creativity, growth, love and psychological understanding. The understanding of theoretical knowledge in humanistic psychology is extremely beneficial to clients as well as counsellors because they are able to offer a non-judgmental, supportive and understanding service, in a safe and confidential environment. There are many different types of humanistic theories, of which the person centred theory which emphasize the necessity of congruence, empathy and unconditional positive regard from the side of the counsellor can be considered one of the most significant of all theories. This empowers the counsellor to allow the client to grow in a positive manner, through genuine understanding and encouragement.

Let us assume if a client who has committed a number of rapes comes for counselling, the reaction of the counsellor and his behaviour would certainly frame the relationship between the two. If the counsellor has a sound theoretical knowledge he has the potential to use the technique of here and now, where the counsellor can genuinely assist the client to reach his fullest potential by being non judgmental and supportive. Another theory that falls under humanistic perspective is the transactional analysis, which again would help counsellors. Based around a client‘s self-development and personal growth, transactional analysis provides a connection

between a client‘s past and how this influence‘s present decisions and choices. Transactional Analysis also acknowledges the three ego states that run through every relationship a person has with others. These are the Parent, Adult and Child ego states. (Martin, 2013) The client is encouraged to look back over past decisions they have made, and to analyze and understand the consequences and subsequent direction. This form of humanistic approach to counselling also helps clients become more in tuned with their thinking and acting skills.

Humanistic counseling theories hold that people have within themselves all the resources they need to live healthy and functional lives, and that problems occur as a result of restricted or unavailable problem-solving resources. Humanistic counselors see their role not as one of directing clients in how to address theirproblems but, rather, as one of helping clients to discover and access within themselves the restricted resources they need to solve problems on their own. Some currently preferred humanistic counseling therapies include person-centered, existential, emotion-focused, Gestalt and positive psychology.Humanistic counselling recognizes the uniqueness of every individual. It assumes that everyone has an innate capacity to grow emotionally and psychologically towards the goals of self- actualization and personal fulfilment.

Humanistic counsellors work with the belief that problems are not caused by life events themselves, but how we experience them. Our experience, in turn, will affect and be affected by how we feel about ourselves, influencing self-esteem and confidence. The humanistic approach to counselling therefore encourages the client to learn to understand how negative responses to life events can lead to psychological discomfort. The approach aims for self-acceptance of both negative and positiveaspects of our characters and personalities. Humanistic counsellors therefore aim to help clients to explore their own thoughts and feelings and to work out their own solutions to their problems.

The American psychologist, Carl Rogers (1902-1987) developed one of the most commonly used humanistic therapies, client-centred counselling. This encourages the client to concentrate on how they feel at the present moment; this is also the essence of mindfulness.

There are three major types of therapies and theories under the humanistic approach.

- Carl Rogers developed a humanistic approach called client-centered therapy, which creates a supportive climate for clients to openly and honestly look at themselves. Therapists need to display important qualities such as unconditional positive regard (full acceptance), accurate empathy (skillful listening and reinstatements) and genuineness (sincere communication).
- Gestalt therapy is another humanistic approach. Developed by Frederick Perls, gestalt therapy focuses on the client‘s experience in the present moment. A common technique in gestalt therapy is role playing, in which the therapist instructs clients to act out various roles to ―own‖ or accept feelings that previously made them uncomfortable.

- Existential therapy encourages clients to accept responsibility for their lives and their problems. This is done by helping clients understand their freedom so that they can choose a different course and live with greater meaning. Existential therapy is rooted in the existential philosophy (existentialism) of figures like Soren Kierkegaard and Friedrich Nietzsche.

A humanistic approach provides a distinct method of counselling and focuses

predominately on an individual‘s unique, personal potential to explore creativity, growth, love and psychological understanding. Counsellor‘s specializing in providing clients with humanistic counselling are skilled in offering a non-judgmental, supportive and understanding service, in a safe and confidential environment.

2.7. COGNITIVE PERSPECTIVE

Cognitive theories of counselling focus on these mental processes and their influence on mental health. A common premise of all cognitive theories is that how people think largely determines how they feel and behave. As Burns (1980) points out, –every hard feeling you have is the result of your distorted negative thinking. Let us take Mahoney‘s constructive approach for an example. According to this approach it challenges the assertion of objectivists that there is a single authenticated external reality. This allows the client to understand his/her unique ways of thinking and making sense of the world and helps clients to create new constructions that might work for them.

Cognitive counseling theories hold that people experience psychological and emotional difficulties when their thinking is out of sync with reality. When this distorted or "faulty" thinking is applied to problem-solving, the result understandably leads to faulty solutions. Cognitive counselors work to challenge their clients' faulty thinking patterns so clients are able to derive solutions that accurately address the problems they are experiencing. Currently preferred cognitive-theory-based therapies include cognitive behavior therapy, reality therapy, motivational interviewing, and acceptance and commitment therapy.

The central place of cognition in this theory helps explain and resolve abnormal behavior. Clinicians need to understand what assumptions and attitudes clients have, which can influence their perceptions and thoughts and ultimately impact the conclusions they have. Several types of cognitive problems — like assumptions, attitudes that are disturbing and inaccurate, and types of illogical thinking such as overgeneralizations — can lead to abnormal functioning.

Cognitive therapy helps people overcome problems by developing new, more functional ways of thinking. By changing their thoughts, people can change how they feel and act. Therapists help clients recognize negative thoughts, errors in logic and biased interpretations that dominate their thinking and can, for instance, lead them to feeling depressed. This type of therapy challenges dysfunctional thoughts and encourages people to apply new types of thinking to their lives.

2.8. CONSTRUCTIONIST THEORY

Constructionist counseling theories hold that knowledge is merely an invented or "constructed" understanding of actual events in the world. While actual events in the world can trigger people's meaning-making processes, it is those meaning-making processes, rather than the events themselves, that determine how people think, feel and behave. Constructionist counselors work collaboratively with clients to examine and revise problematic client constructions of self, relationships and the world. Some currently preferred constructionist-theory-based therapy models include solution focused brief therapy, narrative therapy, feminist therapy, Eriksonian therapy and identity renegotiation counseling.

Constructionist Therapy is concerned with the meanings humans construct regarding the world around them. Within this framework, qualities believed to be related to gender, race, and social class are shaped by cultural influences and human

interpretation (Sutherland & Strong, 2010). Constructionist Therapy is concerned with power imbalances and the importance of language (Munro, Knox, & Lowe, 2008).
More specifically, language is considered the avenue through which individuals create meaning about themselves and others. Language is viewed as constructive, involving various aspects of communication (e.g., questions, reflections, and interpretations), along with the invitation for ―*clients to develop specific constructions of their identities, problems, and relationships*‖ (Sutherland & Strong, 2010, p. 257).It is a client-driven process in which the client actively participates in discussions as to their problematic perceptions and constructions.

2.9. SYSTEMIC THEORY

Systemic counseling theories hold that thinking, feeling and behavior arelargely shaped by pressures exerted on people by the social systems within which they live. Accordingly, individual thinking, feeling and behavior are best understood when examined in relationship to the role they play within a person's family or other important social networks. Systemically focused counselors work to revise social network dynamics that influence a client's undesirable thoughts, feelings and behaviors. Some currently preferred therapies drawing from systemic theory include structural family therapy, strategic family therapy, human validation process family therapy and Gottman method couples therapy.

During their initial training, counselors are typically introduced to a variety of currently preferred counseling models falling under each of the six main theoretical categories. From there, the counselors' task is to determine through continued training and experience which models best fit (a) their personal view of human function and change, (b) their preferred style of communication and (c) the needs of the client population they are currently working with and/or the client population they plan to work with in the future.The central theme of client-centred counselling is the belief that we all have inherent resources that enable us to deal with whatever life brings.

Client-centred therapy focuses on the belief that the client and not the counsellor is the expert on their own thoughts, feelings, experiences and problems. The client is therefore the person most capable of finding appropriate solutions. The counsellor does not suggest any course of action, make recommendations, ask probing questions or try to interpret anything the client says. The responsibility for working out problems rests wholly with the client. When the counsellor does respond, theiraim is to reflect and clarify what the client has been saying.

A trained client-centred counsellor aims to show empathy, warmth and genuineness, which they believe will enable the client's self-understanding and psychological growth. Empathy involves being able to understand the client‗s issues from their own frame of reference. The counsellor should be able to accurately reflect this understanding back to the client. Warmth is to show the client that they are valued, regardless of anything that happens during the counselling session. The counsellor must be non-judgmental, accepting whatever the client says or does, without imposing evaluations. Genuineness (sometimes termed congruence) refers to the counsellor's ability to be open and honest and not to act in a superior manner or hide behind a 'professional' facade. Hence Systemic Therapy underscores the influence of how patterns across systems (e.g., family, school, and employment)influence behaviors and psychological issues. A Systemic approach aims to treat the underlying system rather than focusing on the problem itself (Carlson & Lambie, 2012).

2.10. SUMMARY

Mental health counseling theories provide a framework for understandingclients and helping them with their problems. Psychologists, counselors and therapists use these theories in psychotherapy to help guide clients once a diagnosis is made. Behavioral theorists hold that actions are determined largely by life experiences. In other words, behavior is learned. As a result, explanations and treatments rely on principles of learning, or processes by which behaviors change in response to the environment. Like behavioral theorists, psychodynamic theorists believe that actions are determined largely by life experiences. In fact, psychodynamic theories rest on the assumption that all behavior is determined by past experiences; no symptom or behavior is ―accidental,‖ The cognitive model asserts that cognitive processes are at the center of behaviors, thoughts and emotions. Proposed by Albert Ellis and Aaron Beck, cognitive theory emphasizes what people think instead of what they do. Humanistic therapists emphasize helping clients achieve their highest potential. They are often grouped together with existential theorists because of their common focus on broader dimensions of human existence. The central place of cognition in this theory helps explain and resolve abnormal behavior. In conclusion the importance of havinga thorough understanding of psychology and its perspectives for the purpose of counselling is paramount. Without this scientific knowledge it would be wrong to consider counselling as a profession because the specialty in a counsellor comes along with his expertise which is embedded by his understanding of psychology. It is true that not all perspectives have the same approach to issues but it is these differences that allow the counsellor to have a broad mind and assist the clients to overcome their difficulties while improving the effectiveness of true counselling.

2.11. KEY WORDS

Biological, Psychodynamic, Behavioural, Humanistic, Cognitive, Constructionist Systemic perspective

2.12. SELF ASSESSMENT QUESTIONS

1. Explain the Psychodynamic perspective of counselling
2. Discuss the behavioral theory of counselling
3. Write an essay on cognitive perspective of counselling

2.13. REFERENCE BOOKS

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LESSON-3
GUIDANCE AND COUNSELLING

OBJECTIVES

Students will know about history meaning, definition of guidance and counselling and relationships and differences between guidance and counseling.

STRUCTURE

3.1 Introduction
3.2 History of Counseling
3.3 History of Counseling & Guidance in India
3.4 Foundations of Counselling
3.5 Meaning of Guidance
3.6 Definition of Guidance
3.7 Meaning of Counselling
3.8 Definition of Counselling
3.9 Levels of Counselling
3.10 Purpose of Guidance and Counselling
3.11 Principles of Guidance and Counselling
3.12 Relationship between Guidance and Counselling
3.13 Difference between Guidance & Counselling
3.14 Summary
3.15 Key words
3.16 Self Assessment Questions
3.17 Reference books

3.1. INTRODUCTION

The concept of guidance has emerged many years ago and it is as old as human civilization. In earlier times, guidance was offered to the young people by elders in the family and the family priest gave guidance to those in distress. This practice continues even today, in India, where people acquire guidance from the family priest, significant elders in the family, palmist, astrologer or numerologist in personal, educational, vocational or political matters. Guidance, as an organized professional activity, dates back to 1905 and this is because of the work of Frank Parsons, Boston, USA. Author of the classic ‗Choosing a Vocation' and his efforts to help find the Vocation Bureau, made him a pioneer in the guidance movement in America. Various social reformers followed Pearson and contributed to the guidance movement. In India, guidance as an organized professional activity is more than four decades old.

Counselling is an interactive learning process in which the counsellor

(sometimes termed therapist), helps the counsellees (those seeking help) to understand the cause(s) of difficulties and guides them to sort out issues and reach decisions. The approach in counselling is holistic, addressing social, cultural, economic and emotional issues. Counselling can be sought at any time in life, although many people reach out only in times of change or crisis. The qualified professional counsellor speaks with the counsellees in a way to help that person solve a problem or helps to create conditions that will cause the person to understand and improve life circumstances.

3.2. HISTORY OF COUNSELLING

***Early stage/ pre-historic counselling period*: -**

- Early counsellors were priest, medicine man- shaman, physicians and philosophers.

***Ancient Guru's and Religious Leaders*:**

- Budha, Socrates, Mausis are considered as ancient Guru's and religious leaders. They assisted in spiritual, religious aspects of their followers.

***The first founders of counselling*:-**

- The important founder during this period was Hippocrates, a Greek Philosopher who discovers Homeostasis (physiological balance in the body) and Prognosis (how a disease develops). He was the person who introduced systematic counselling intervention. And he also takes case history and builds a trust in patient.
- Sigmund Freud and Joseph Breuer was the another important founders who founds that Hypnosis as the study of unconscious mind. Sigmund Freud brought a formal method of psychoanalysis (id, ego, super-ego, dream analysisetc.).

Influence from psychologist (19th century)

During the period of 19th Century far-reaching innovations in the field of psychology were made.

- This period saw the founding of the first psychological laboratory at Leipzigby Wilhelm Wundt in 1879.
- Stanley Hall started the first psychological laboratory in the USA in1883.
- In 1895, George Merrill established the first systematic vocational programme in San Francisco.
- Lightner Witmer heralded the beginning of the counselling movement by founding the first psychological clinic in 1896.
- J. B Miner established and directed the free clinic in mental development at the University of Minnesota in 1909. However, it was Jesse.B.Davis who first used the term –Counselling‖.

Significant Events in 20th Century (1900-1930)

During the first few years of the twentieth century several significant events took place. They were:

- The first convention of the International Congress of Psychoanalysis was held at Salzberg.
- Stanley Hall invited Carl Gustav Jung to lecture at the Clark University.
- Clifford beers launched the ‗Mental Hygiene Movement' with his epoch-making book, *‗The mind that found itself'*.
- The use of psychological principles was advocated in pastoral counselling by Rev.Elwood Worcester.
- The vocational Guidance movement was started on a modest scale by Samuel Frank parsons and Eli Weaver in Boston and Brooklyn respectively.
- Guidance was introduced by Wheatly and Boyden and Jessie Davis.
- Binnet-Simon tests of intelligence were adapted to American conditions about this time.
- The progressive Education Movement was initiated by John Dewey with his epoch-making book, *‗How we Think'*.
- The school of social work started by Mrs. Adolf Meyer
- E.L Thorndike and Robert Yerkes helped develop the *Army Alpha* and *Army Beta* tests for screening the defence personnel.
- James Burt Miner developed the first ever known questionnaire in 1908.
- R.S. Woodworth and F.L Wells association tests and psychometric inventory in 1911, which was developed as a screening device for the army recruits.

Development of tools and techniques (1930-1940)

- From the end of World War I to the outbreak of World War II, saw the publication of books and important psychological tests, such as Harry Kitson's *‗psychology of Vocational Adjustment'* (1925), Clark. L. Hull's *Aptitude Testing* (1927) and E.K Strong Jr's *Strong Vocational Interest Blank* (SVIB-1943).
- National vocational Guidance Association (NVGA), founded in 1913, formed the American Council of Guidance and Personnel Association in 1934.
- Robert Hoppock, a former secretary of NVGA published his book *Job satisfaction* in 1935.
- L.L. Thurstone's *Tests of Primary Mental Abilities* in 1938.
- Donald Paterson and E.G. Williamson during 1930-1940 at Minnesota, concerned with the objective assessment of the individual's abilities.

Counselling Era (Second World War and after)

- Counselling which finally established as a science in its own right was achieved through Carl Roger's book, *Counselling and Psychotherapy* (1942).
- In 1944, the *Army separation and Classification and counselling Program* was initiated and the *United States Employment Service*s (USES) published the *General Aptitude Test Battery* (GATB) in 1945.
- First journal of Counselling Psychology was published in 1954.

Era of therapeutic counselling:-

The domain of mental health was given importance. Individual freedom, liberty, values of life all taken in to consideration. Counselling settings were diversified. Community mental health care was started and counselling involves four main aspects:

- Self understanding
- Self direction
- Self realization
- Self actualization

Licensing, regulation and research were given importance

- 1973 in US and in 1992 in India standardized counselling practice and diploma in counselling was started. But India does not have Licensing authority.
- Research was done on psycho social care, stress, trauma etc. And they say that counselling is necessary in those areas.
- In 2004 NIMHANS started Disaster management programme with the Govt. Of India.

3.3. HISTORY OF COUNSELING & GUIDANCE IN INDIA

Guidance as an organized activity is nascent in India, through it was in vogue in developed western countries since very long. Historically, the first professional counselor is Lord Krishna. He used Gita Updesh as purposive counseling for Arjuna, removing his doubts and conflicts, teaching all mankind through Arjuna, the meaning of life and death, self-realization, meaning of justice and protecting the weaker section of society from injustice. Counseling is not a novel institution in the Indian context. The first Counselor is Lord Krishna himself and Bhagavad Gita embodies the finest principles of counseling for people of all lands, all ages and all times. In the ancient Gurukula system of education, there were harmonious relations between the teacher (Guru) and the taught (Shisya).

The origin of the Counseling movement in the India should be traced to the beginning of psychology in India. 1915, Calcutta University: It had the privilege of starting the first psychological laboratory in India in 1915. It was introduced guidance as a section of its department of applied psychology as an academic discipline in 1938 under the direction of Dr. G.S. Bose, then Head of the Department, to conduct researches in the field of educational and vocational guidance. 1941, Bombay University: In Bombay, in 1941, Baltiboi Vocational Guidance Bureau wasestablished with the efforts of a retired accountant and Dr. Mukerjee, a psychologist from Calcutta University. 1945, Patna University: In 1945, a Department for Psychological Services and Researches was established in Patna University to offer personal and vocational guidance to students. 1947, Parsi Panchayat: Dr. H.P. Mehta, the Director of the Parsi Panchayat Vocational Guidance Bureau established by trustees of the Parsi Panchayat Funds and Properties, published the first journalVocational and Educational Guidance. 1947, Utter Pradesh Government: The Bureau of Psychology at Allahabad was established by U.P. Government in 1947 on the recommendation of Acharya Narendra Deo Committee. 1950, Bombay Government: In 1950, the Bombay Government set up Vocational Guidance which was renamed in 1957 as Institute of Vocational Guidance.

1950s Delhi: There was workshop and seminars held in Delhi during the 1950s. In March 1953, Dr. W.L. Barnette, an American Fulbright Professor, held a workshop for guidance workers at the Central Institute of Education, Delhi. Another seminar was held in November 1954, at the same venue. It was decided to form an All India Educational and Vocational Guidance Association and to affiliate it to International Association of Vocational Guidance.

In 1954 the Ministry of Education, Central Government of India, set up the Central Bureau of Educational and Vocational Guidance in 1954 with the following specifications: Production and distribution of tools and aids serviceable of guidance bureau in schools, Technical assistance for setting up education and vocational guidance bureaus in the states, Training guidance personnel, particularly psychologists and counselor, Preparation of manuals for dealing with educational and vocational guidance careers and occupation. This bureau has been rendering valuable service ever since it‘s established in the field of guidance. The bureau is now part of the Department of Psychological Foundations of the National Institute of Education under the National Council of Educational Research and Training.

State Bureau of Educational and vocational Guidance was established to perform the functions like Organization of sample group guidance activates for a few schools, Collection of occupational information and production of information material, Development and adaption of translation of tests, questionnaires, etc, Training of guidance workers, Planning, coordination and supervision of guidance service within the state, Consultative and field service and Research work.

Government of India’s Initiatives:-

1. Vocational Guidance and Employment Counseling programme of Director General of Employment and Training the website aims to provide career Guidance and Employment counseling services to students and job seekers through employment exchange.

2. The Advanced Training Institute for Electronics and Process Instrumentation in Dehradun has been set up for training and skill enhancement of people from industries, Govt. / Semi Govt. organization in the field of Electronics and process Instrumentation.

3. The Department of Educational Psychology and Foundations of Education (DEPFE), NCERT, New Delhi is a nodal center for guidance activities at the national level has been offering its academic resources to guidance departments/units/agencies at the state level for training of guidance personnel and for setting up guidance services.

4. National Employment Services functions within the frame work of employment Exchange users can register with a district employment exchange online through this portal.

5. National Policy on Skill Development by Ministry of Labor and Employment. 6. Indian Occupational Safety and Health Information Network.

3.4. FOUNDATIONS OF COUNSELLING

There are main 3 foundations based onwhich Counselling is done:

- Philosophical Foundation
- Sociological Foundation
- Psychological Foundation.

Foundation of counselling includes many disciplines such as Philosophy, Sociology, and Psychology etc. Psychiatry, family studies and social work are the other disciplines that pave the foundations to counselling.

Philosophical foundation:

The philosophy deals with human values and the counselling gives importance to human value. The philosophy tells about the sense of purpose in life, while counselling helps to attain or make him understand about the purpose of life. Philosophy tells about values, sensible, being considerable, being right and wrong etc.

On the other hand, all these are practiced in counselling. Counselling beliefs in man's faith, his abilities and this is what philosophy teach us

Smith's Philosophical Foundation of Counselling:

- Faith in humanity
- Concern for other person
- Belief in potentiality and inner strength of man
- Self-responsibility
- Freedom to choose sovergnity
- Cherishing values of life

Sociological foundation

It studies about how a man functions in social settings. In counselling, we deal with individual and their problem. Unless, we know about the society, we cannot solve the problem. Thus, the counsellor should know the culture and values of the society in which he is practicing counselling. Values, beliefs, systems acquired from the society can be useful in providing counselling.

Counselling respects values, beliefs, systems of the client. Sociology teaches about the uniqueness about all these aspects. It also teaches about the various aspects of life. Each culture and system is different from the other; hence what is right in one culture may be wrong in another culture. Hence counselling must be based on the values of the client and not of the counsellor. Eg: Children sleeping with parents is accepted in India. But in the west it is not accepted.

Psychological foundation

Counselling deals with human behaviour and psychology is the scientific study of human behaviour. Counselling has roots in psychoanalysis (ego stages, free association, and dream analysis). Functionalism in 1990's is an important aspect in counselling.

Psychology also talks about the primary interest of the client. It deals with Motivation, Personality, Development stages, Memory, Nature and Nurture, defence Mechanism etc.

3.5. MEANING OF GUIDANCE

Guidance means to guide or direct or to lead. Guidance is the assistance given to an individual to help him, to adjust to himself, to others and to his own environment. In this way guidance is a process of all-round development.

In the post-independent period, Indian Government set up Indian Education Commission (1964-66) who has defined ―Guidance is a help to the students in making possible adjustment to the situations in the educational institutions and in the home and at the same time facilitates the development of all aspects of the personality‖. Guidance aims to prepare an individual for his future life.

Guidance is required at various stages of our development, right from birth till the end, so that we can deal with life events. Guidance is needed most when the individual enters the period of adolescence. The adolescent has to face various challenges in the area of education, vocation, health, and personal life. If proper guidance is given at this stage, his further development will be facilitated

Guidance can be explained as assistance made available by competent counsellors to an individual of any group to help him/her direct the life course, develop a point of view, make decisions and be better adjusted. Guidance does not mean giving directions, nor is it an imposition of one‘s point of view on another person. The person, who is guiding another does not take the onus (responsibility) of making decisions on behalf of the client. We can see that guidance is more about assisting people to find their way rather than giving instructions or readymade solutions.

Guidance is based upon a philosophy of human uniqueness, goodness, worth and dignity all of which can be nurtured. The guidance processes are based on the belief that given certain conditions, an individual‘s potential to make a choice and make a decision can be utilized for maximum benefit to the individual and society.

The goal of education is to bring out and develop the inherent potentialities of an individual. Guidance has an important contribution in achieving these goals.To guide means to indicate, to point out, and to show the way. It means more than to assist. A man falls on the street; we assist him to get up but we do not guide himunless we help him to go in a certain direction.

The synonyms of *'to guide'* are – to lead, to conduct, to regulate, to direct, to steer, to show, to channel, to point.

Guidance involves personal help given by someone; it is designed to assist a person to decide where he wants to go, what he wants to do, or how he can best accomplish his purpose; it assists him to solve problems that arise in his life. It does not solve problems for the individual but helps him to solve them. The focus of guidance is the individual, not the problem; its purpose is to promote the growth ofthe individual in self-direction. This guidance may be given to groups or to individuals, but it is always designed to help individual even though they may be in group.

Guidance in India, is comparatively a new field within the larger and more inclusive field of education and is used as a technical term as a specific meaning. It covers the whole spectrum of education, which starts from the birth of the child and continues till his death. This is a wide meaning of the term, which includes all types of education such as formal, non-formal, informal and vocational etc., which aims to

adjust the individual in his environment in an effective way. There are usually three connotations attached to the word guidance:

1. Guidance as a Specialized Service whose primary concern is with the individual and to help them to solve their problems and take appropriate decisions in their choice-points;
2. Guidance as a General Service and is considered to be synonymous with education and educational processes; and
3. Guidance as a Sub-Process of education in which developmental needs of the learners are considered the basic points.

3.6. DEFINITION OF GUIDANCE

Ruth Strang. ―Guidance is a process of helping every individual, through his own efforts, to discover and develop his potentialities for his personal happiness and social usefulness.‖

A.J. Jones. ―Guidance involves personal help given by a competent person; it is designed to assist a person in deciding where he wants to go, what he wants to do, or how he can best accomplish his purposes; it assists him in solving problems that arise in his life. It does not solve problems for the individual, but helps him to solve them. The focus of guidance is the individual and not the problem; its purpose is to promote the growth of the individual in self-direction.‖

Knapps ―Learning about the individual student, helping him to understand himself, effecting changes in him and in his environment which will help him to grow and develop as much as possible – these are the elements of guidance.‖

Secondary Education Commission, 1952, ―Guidance involves the difficult art of helping boys and girls to plan their own future wisely in the full light of all the factors that can be mastered about themselves and about the world in which they are to live and work.‖

Crow and Crow, ―Guidance is assistance made available by personally and adequately trained men or women to an individual of any age to help him manage his own life activities, develop his own points of view, make his own decisions and carry his own burdens.‖

John Brewer. ―Guidance is a process through which an individual is able to solve his problems and pursue a path suited to his abilities and aspirations.‖

Woodworth. ―Guidance helps an individual to develop his personality and enables him to serve the society to the best of his capabilities and talents.‖

Kitson. ―Guidance is ‗individualized education‘. Each student is to be helped to develop himself to the maximum possible degree in all respects.‖

V.M. Proctor. ―Guidance is a process through which an individual or groups of individuals are helped to make necessary adjustment to the environment – inside or outside the school.‖

3.7. MEANING OF COUNSELLING

Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be ‗sent' for counselling. By listening attentively and patiently the counsellor can begin to perceive the difficulties from the client's point of view and can help them to see things more clearly, possibly from a different perspective.

Counselling is a way of enabling choice or change or of reducing confusion. It does not involve giving advice or directing a client to take a particular course of action. Counsellors do not judge or exploit their clients in any way. In the counselling sessions the client can explore various aspects of their life and feelings, talking about them freely and openly in a way that is rarely possible with friends or family. Bottled up feelings such as anger, anxiety, grief and embarrassment can become very intense and counselling offers an opportunity to explore them, with the possibility of making them easier to understand. The counsellor will encourage the expression of feelings and as a result of their training will be able to accept and reflect the client's problems without becoming burdened by them.

Acceptance and respect for the client are essentials for a counsellor and, as the relationship develops, so too does trust between the counsellor and client, enabling the client to look at many aspects of their life, their relationships and themselves which they may not have considered or been able to face before. The counsellor may help the client to examine in detail the behaviour or situations which are proving troublesome and to find an area where it would be possible to initiate some change asa start. The counsellor may help the client to look at the options open to them and help them to decide the best for them.

3.8. DEFINITION OF COUNSELLING

Counselling has been understood and defined in a number of ways.
According to Cormier and Hackney (1987) counselling is defined as the ―helping relationship that includes –

a) Someone seeking help,
b) Someone willing to give help, who is capable or trained to help,
c) A setting that permits help to be given and received.

Arbunckle has mentioned three points about counselling. They are:

a) Counselling is a process between two persons.
b) The basic aim of counselling is to help the person in solving his problems independently.
c) Counselling is a professional job involving professionally trained persons.

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

According to British Association for Counseling and Psychotherapy (2002),

counselling takes place when a counselor sees a client in a private and confidential setting to explore a difficulty a client is having, distress that the client may be experiencing or perhaps the client‘s dissatisfaction with life or loss of a sense or direction and purpose.

The American Counseling Association conference (2010), a consensus definition of counseling: ―Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.‖American Counseling Association (ACA), defined counselling on numerous occasions. These definitions contain -:

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

3.9. LEVELS OF COUNSELLING

In day-to-day life you may have noticed that the term counselling is being used informally to refer to any kind of information seeking interaction including appraisal of a person for careers. It may be useful to understand that there are different levels of counselling as shown below.

Informal Counselling: It is generally rendered by a person who may be approachable and understanding, but may not be professionally qualified. This empathetic person could be an aunt, uncle, friend or colleague.

Non Specialist Counselling: It is the help provided by specialists of other areas like teachers, doctors, lawyers, religious preachers who, along with their respective specialisation, also wish to handle psychological problems. They try to provide alternative ways of dealing with the problems of people they come across in their daily interactions at work.

Professional Counselling: Professional counsellors are the ones who have received special training in counselling and have the required qualifications. These counsellors deal with the person‘s social, emotional and personal problems. In the counselling process, the professional counsellor may use different techniques. Let us brieflydiscuss three techniques. These are:

Directive, counsellor-centred counselling: Here the counsellor plays major role and does all that is possible to get the counsellees to make decisions in keeping with diagnosis of the problem.

Non-Directive or permissive or client-centred counselling: Here the Counsellor‘s role is comparatively passive. The counsellees takes an active part in the process of therapy. The person seeking help is encouraged to gain insight into the problem with the help of the counsellor. The counsellees takes the final decisions. Thus, this

counselling process turns out to be a growth experience for the person.

Eclectic counselling: Counsellors who advocate using this type of counselling are of the view that directed or non-directed counselling are at two ends of continuum. And counsellors should incorporate suitable techniques from both the types of counseling mentioned above as and when required, depending on the situation, the problem and the temperament of the client

3.10. PURPOSE OF GUIDANCE AND COUNSELLING

The purpose of Guidance and Counselling can be related to

1) Individual
2) Society

1) Individual Related Purpose

(i) To help students recognize and develop their potentialities to achieve their educational aims and objectives and improve academically and to develop positive attitude.

(ii) To help students aware about vocational and career opportunities available regionally, nationally and internationally so as to help them make informed decisions from among various choices.

(iii) To help students for all round personal and social development on the basis of their interests, abilities and resources.

(iv) To help students recognize their capacities, develop self-confidence and adjust to academic, school, family and personal problems.

2) Society Related Purpose

(i) To develop good citizenship in students
(ii) To develop positive attitude towards family life and the society
(iii) To help in proper and best utilization of resources.

3.11. PRINCIPLES OF GUIDANCE AND COUNSELLING

When you plan to guide an individual it is important to keep the following Principles in mind.

- Maintain dignity of the individual which is supreme. For example, providing Privacy while talking or calling the person by name.
- As each individual is unique and is different from every other individual. It is best not to compare one person with another.
- Each person‘s problems are different. The problems and causes are interrelated, soa deep knowledge of the causes is essential.
- While giving guidance or counselling, the social setting of the individual is essential. The community, language, place must be taken into consideration.
- It should be based on the attitudes and personal perceptions of the individual

- It helps the individual to enhance him or herself.
- The individual has the ability to learn and can be helped to make choices that will lead to self-direction and appropriate decision making.
- Each individual may, at times need information and personalized assistance which is best given by competent professional personnel.
- It is a continuous and slow process.

Thus we see that guidance and counselling is a continuous process, flexible and dynamic process concerned with the _whole individual'.

3.12. RELATIONSHIP BETWEEN GUIDANCE AND COUNSELLING

The Terms guidance and counselling, in some way or the other are related to each other. They are similar in some ways and dissimilar in some other ways. Their relationship is drawn as under.

1. Guidance is an organized service to identify and develop the potentialities of pupils. Comprehensive information about every (all the) pupil is collected with thehelp of different tests/tools, resources, which are recorded and interpreted. The findings are communicated to the individual to help them to understand themselves. Pupils are also given information about educational and vocational opportunities available to them and are helped in their career planning and development.

2. In counselling more often than not the information's are collected and shared related to problem situations faced by the pupils. The individual is encouraged to talk about her/his problem(s). The counsellor may also ask questions, seek his/her views, and make observations. Information sought through guidance makes the basis for counselling sessions. Based on the findings the individual is encouraged to make suitable decisions and take actions to solve the problem(s). Thus, information's are gathered and shared in both the process but two are no same.
3. Guidance is helping individual to develop his/her potentialities for all round development whereas counselling helps individual to deal with complex problem situations and make adjustment/adaptations if necessary to lead useful life.

4. Guidance is promote and preventive whereas counselling is therapeutic.

5. Guidance can be given in any normal setting whereas counselling requires guidance may be done by any teacher or guiding person whereas counselling can be done by skilful counsellor who has had professional training in counselling.

6. Guidance may be done by any teacher or guiding person whereas counselling can be done by skilful counsellor who has had professional training in counselling.

7. Guidance is an integral part of education and assists in fulfilling in educational organized as specialized services to deal with problem situations faced by students and may be of teachers.

8. Guidance includes some degree of counselling to help students deal with their day to day problems which is done by teachers, parents, significant others.

3.13. DIFFERENCE BETWEEN GUIDANCE & COUNSELLING

Guidance is a term which is broader than counselling.It includes counselling as one of its services.Butter makes a logical separation of the counselling process i.e.

(i) Adjustive phase- The emphasis is on social, personal and emotional problems of the individual- C**ounselling**

(ii) Distributive phase – the focus is upon educational, vocational and occupational problems. – G**uidance**

Guidance–one way exchange.

It includes educating, influencing, instructing and showing the way. It is encouraging in nature. Counselling-Two way exchanges, It is enabling clients to explore problems, understand problems and resolve, come to terms with problems. It is facilitative in nature.

Key Differences between Guidance and Counseling

The significant differences between guidance and counseling are given in the following points:

- Advice or a relevant piece of information given by a superior, to resolve a problem or overcome from difficulty, is known as guidance. Counseling refers to a professional advice given by a counselor to an individual to help him in overcoming from personal or psychological problems.
- Guidance is preventive in nature, whereas counseling tends to be healing, curative or remedial.
- Guidance assists the person in choosing the best alternative. But counselling tends to change the perspective, to help him get the solution by himself or herself.
- Guidance is a comprehensive process; that has an external approach. On the other hand, counseling focuses on the in-depth and inward analysis of the problem, until client understands and overcome it completely.
- Guidance is taken on education and career related issues whereas counseling is taken when the problem is related to personal and socio-psychological issues.
- Guidance is given by a guide who can be any person superior or an expert in a particular field. As opposed to counseling, this is provided by counselors, who possess a high level of skill and undergone through professional training.
- Guidance can be open and so the level of privacy is less, unlike counseling, wherein complete secrecy is maintained.
- Guidance can be given to an individual or group of individuals at a time. On the contrary, counseling is always one to one.
- In the guidance, the guide takes the decision for the client in contrast to counseling, where the counselor empowers the client to take decisions on his own.

3.14. SUMMARY

Guidance is a process by which individuals are assisted in the making of their life and carrier to better adapt to the environment and enjoy temporary world life. It is a process by which Individual solves his problems by his own efforts. The guide or counsellor only shows him the way how to solve the problems. Guidance is continuous process it is the process by which individual is helped to choose the best alternatives available in accordance with his potentialities and interests. It is theprocess by which individual can solve educational, vocational and personal problems. It provides relevant information to the individual to choose a better carrier.

Counseling is a process that brings about sequential changes over a period of time leading to a set goal and relationship between counselor and counselee is not causal and business like rather characterized by trust, warmth and understanding. Counselling is processes of helping a client explore themes, issues, and emotions new to his or her awareness. Counseling is an interactive process conjoining the counselee who needs assistance and the counselor who is trained and educated to give the assistance (Perez, 1965). According to Arbuckle guidance focuses on educational, vocational and occupational problems and in Counseling the emphasis is the social, personal and emotional problems of the individual. Counseling may occur in any setting but some circumstances are more likely than others to promise itsdevelopment. Counselors need to be aware of the physical setting in which thecounseling takes place. Clients may adjust to any room, but certain qualities about an environment such as the seating arrangements, proximity between client and counselor make counseling more conducive.

3.15. KEY WORDS

Assistance, Advice, Professional Relation, Client centred

3.16. SELF ASSESSMENT QUESTIONS

1. Define and explain the concept of Guidance
2. Discuss the meaning of counselling
3. Explain the relationship and differences between Guidance and Counselling

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Prof. D. Sai Sujatha

LESSON-4
DIFFERENT APPROACHES FOR COUNSELLING

OBJECTIVES

The main objectives of this lesson are to study the different approaches for counselling and Roger‟s concept Theory to development of Self-Concept.

STRUCTURE

4.1. What is a Theory?
4.2. The different Approaches
4.3. Humanistic Approach
4.4. Roger's Self Theory to development of Self-Concept
4.5. Behaviouristic Approach to Counselling
4.6. The Eclectic Approach
4.7. Summary
4.8. Technical Terms
4.9. Self Assessment Questions
4.10. Reference Books

4.1. WHAT IS A THEORY?

A theory is considered acceptable if it meets the criteria, the most important being precision, clarity, and comprehensiveness, with its scope as many facts or phenomena as possible, provide for empirical and verifiability and stimulate research. Different approaches to counselling are based on the varying conceptions of human personality structure and dynamics.

The term „approach‟ is used in preference to theory" as no single theory has yet been able to encompass all the aspects of counselling. Counselling therapies are broadly divided into two major categories, 1. Supportive and 2. Insight therapies. Supportive therapies believe in restoring the individuals adaptive capacities by teaching him new ways to maintain an control by strengthening the existing defences and capabilities against persuasion, pressure and coercion, reassurance, environmental manipulation, prestige Suggestion, suggestive hypnosis, muscular relaxation, use of drugs and electric shock. While Behaviour modification and learning theory are supportive therapy. Insight therapies like Rogers client centred are reconstructive therapy.

Insight theories are broadly of two kinds, I)re-educative and 2)re-constructive. These therapies differ from the supportive they try to release what has been called the self-actualizing tendency in the Insight therapies, instead of removing the anxiety-

producing sources of factors in the life of the individual, bolster behaviour thatpermits and enables individual to cope with anxiety. Re-educative approaches to therapy are directed toward producing more harmonious self-structure. Rogers client- centred approach is an outstanding example of insight therapy with re-educative goals. The reconstructive therapy gains insight into the individual‟s unconscious conflict, thereby bringing extensive alteration in the individual‟s character structure and the release of energies for the development of new adaptive capacities. Freudian and psychoanalytic approach adumbrates this point view.

4.2. THE DIFFERENT APPROACHES

Psychoanalysis comes from the two words," Psyche means "soul" and analysis implies "taking part" It development is closely associated with the work of Sigmund Freud. Psychoanalysis is a complete theory of personality generated concurrently with its therapeutic techniques. It is based on acquiring an understanding of oneself and one's unconscious conflicts and reworking or reconstruction their effects on the individual. Freud's friend Breurer stumbled on the 'talking cure 'took the simplistic concept of "catharsis' and developed it into a therapy that is intricately integrated with the theory of personality.

Fine divides Freud's work into four periods, 1. The exploration of neurosis, from inception of practice, 2. Self-analysis, 3. Id psychology., Finally, ego psychology involving a considerable extension of ideas.. Psychoanalysis which was conceptualised by Sigmund Freud. Psychotherapy is based on the development of self-understanding which leads to the resolution of the unconscious conflicts. Freud's theory of the individual is a deterministic one. Freud believed that this psychic determinism suggests that in the mind nothing happens by chance or at random. Freud defined three constructs of the mind, the conscious, the unconscious, and the preconscious. Freud further divided the mind into three parts, the id, ego and the superego. The id functions by 'primary process'. The superego is the base of our moral and social values. It emerges as a result of the introjection of the moralistic warnings and values of our parents and other adults. The superego functions unconsciously and would instil altruistic behaviour in the individual locking the person into rigid morality. The ego like the superego is not present at birth, both structures evolve out of the id as the infant develops. The id calls for gratification of all its without regard for moral or social appropriateness. The ego becomes the "middleman" between the id and superego, thus the ego's purpose is to permanently disengage the unacceptable instinctual drives by employing the appropriate defence mechanisms which makes secure its own boundaries.

Criticism of psychoanalysis suggests that the theory is far too deterministic and greatly reduces the individual‟s responsibility for his behaviour. This therapy is also time consuming and expensive. The deterministic view of the individual appears both pessimistic and animalistic in its outlook toward the human impulse. Critics often charge that insight alone does not cause people to change. Insight needs to be accompanied by attempts at behaviour change .Finally; criticism is levelled at psychoanalysis for a lack of empirical validation. The only research used is case-study which yields limited results.

4.3. HUMANISTIC APPROACH

In contrast to psychoanalysis, Carl Roger's "client-centred" approach is more directly related to the field of psychological counselling. Client centred therapy that is the practical application of humanistic psychology made a great impact on the academic scene. Counselling aims at bringing about psychological growth or maturityto the client. The helping relationship is also generally one-to one relationship. It could also be in some cases individual-group relationship. The course of treatment proposed was relatively brief compared to that of psychoanalysis. Its dim was not to cure sick people but to help people live more satisfying and creative lives. Rogers was influenced by phenomenological psychology Popular during that period. He is also counted as one of the important protagonists of the humanistic approach popularly known as the third force" of psychology.

Client-centred therapy, that is the practical application of humanisticpsychology made a great impact on the academic scene. Rogers held that counselling is essentially of the same nature as psychotherapy and there is no justification for discrimination between counselling and psychotherapy.

Counselling aims at bringing about psychological growth or maturity to the client. Thus helping relationship is one to one relationship.

Rogers attaches enormous importance to helping relationship
These are:

1. It is meaningful to the person‟s involved-mutual self-commitment.
2. It has a marked tone of feeling; the individuals who are involved experience certain emotional states.
3. It implies integrity-persons involved to be honest emotionally and intellectually to each other.
4. It can exist only be mutual consent and when one is need of some kind of help which another can reasonably provide.
5. It comes into existence or becomes necessary when one is in need of help
6. It involves communication and interaction This may involve nonverbal behaviour, such as facial expressions, gestures and the like and also direct verbal communication.
7. It is not vague or amorphous, it is often structured. The helping individual knows what sort of help he is could provide and the individual receiving help knows what kind of help he is in need of.
8. It is sustained through mutual cooperation and collaboration, If a certain kind of help is help is provided which is not useful the receiver will indicate the same, and the helping person will naturally, modify his approach.
9. The helping person must have a sense of security. An insecure person obviously cannot be of much help to the individual who is in need of help.
10. The goal or object of the helping relationship is to change the client positively.

A helping relationship is essentially an attitude which exudes a feeling of acceptance and a democratic value of life. It implies that the helping relationship does not in any way make a person feel superior to the one he helps. It also implies that the helping individual does not impose the values upon the person being helped. Such an

approach is essentially called the client-centred. However all therapies the orthodox psychoanalytic and the more recent approaches-are basically "client-centred”. The goal of all therapy is to help the client. So the object of very system of therapy is to help the client, for the betterment and well-being of the client. Roger's theory of personality, more popularly known as the self-theory of personality, has evolved from his counselling practice. Rogers theory basically views man as a socialised,, forward moving, rational and realistic" individual.

Self-concept therefore is the central construct of Rogers‟s theory. It may be conceived as an organised gestalt comprising.

1. The individual‟s perceptions of himself and the values he attached to them.
2. The individuals perceptions of himself in relation to other persons and the values attached to them
3. The individual‟s perceptions of the various aspects of the environment and the values he attached to them. Self-concept is not self-awareness or unconscious Years of clinical observation of human behaviour were recognised by psychologists. That one‟s attitude towards oneself is an important determiner of one‟s behaviour. Therefore the changes of an individual‟s attitudes towards others seem to follow changes in his attitudes towards himself. Needs are basically determiners of behaviour When the urge to satisfy a strong need conflicts with his self-concept, then the individual may adopt devious measures to find gratification.

The core concepts of Rogers‟s self-theory are

1. The organism, which is the total individual.
2. The totality of experience which is the phenomenal field 3. The self, which is differentiated part of the phenomenal field which comprises of the "I" and "me" along with the values attached to them.

4.4. BEHAVIOURISTIC APPROACH TO COUNSELLING

Behavioural counselling involves the application of experimentally derivedand established principles of learning to weaken or eliminate maladaptive behaviour and to build or strengthen replacement behaviours that are adaptive. The foundation of behavioural counselling is learning theory developed by various philosophers, clinical psychologist, experimental psychologists, and researchers.

Counselling and psychotherapy are concerned with behaviour change and therefore according to some theorist, must involve the applications of principles of learning and learning theory. Learning here is changes in behaviour which are relatively long lasting and not due to maturation or physiological factors like fatigue and effect of drugs. However, counselling by and large has developed outside the learning theory. It is only in recent times that the principles of learning theory have been sought to be applied in the counselling technique. All behaviour of organisms, including human beings ranging from simple to complex behaviour, is learnt.

The learning approach in the behaviouristic model would be classical conditioning or operant conditioning model. From the behaviouristic point of view all behaviour adjustive or maladjustive is primarily learnt in the same manner as the four basic principles (DCCR). The first is drive or motivation that compels the organism to act. Drives could be primary needs or secondary needs (learnt). Without drive there

would be no action, no learning can occur. The second is the cue stimulus, theorganism is hungry the stimulation by food would be more effective. Reinforcement is the fourth principle of learning, it is usually reward. The behaviouristic approach to counselling employs four principles, namely, drive, cue, response and reinforcement.

The behaviourist approach counselling differs from the psychoanalytic and medical approaches with regard to its attitude towards maladaptive or maladjusted behaviour. In psychoanalysis the concern is with the past, that is, as to how a particular symptom or syndrome is caused. In sharp contrast to this view, the behaviour therapist is least concerned with the past. He is concerned with thesymptom here and now. Therapy essentially consists of several simple steps.

4.5. THE ECLECTIC APPROACH

There is no gain saying the fact that counsellors, like medical men adopt variations of their theoretical positions in actual practice. This kind of variation becomes necessary to suit different individuals and specific situations. It is argued that it is unscientific to stray away from any theory but with equal vehemence that puritanical rigidity may be counterproductive that if one wishes to succeed, one must appreciate the realistic aspects of different expectations and goals.

Diagnosis is considered inimical to client-centred counselling. Diagnosis is arrived at by a logical process of inference. Diagnosis involves identifying the problem.

Determining the causes that is searching for relationship past, present and future which help in the understanding the cause of the symptoms.

Diagnosis is always the nature of a hypothesis and is open to modifications. Diagnosis and prognosis are both relevant to the goals the counselee strives to achieve. There are no restrictions on the client no limitations imposed, he is free to tryas much solution as he likes till he is able to reach an optimal solution. The last step isthe follow up and includes the assistance the counsellor gives to deal with new problems of recurring nature. The counsellor adopts different viewpoints and combines them into a working theory. This trend in practitioners‟ approach towards theory is described as "emerging eclecticisın". English and English, (1958) define eclecticism in theory building and orderly combination of compatible features from diverse sources and incompatible theories and systems into a harmonious whole. Brammer 1969) explains that eclecticism in counselling refers to selecting choosing, from various theories and systems. Garfileld (1969) summarizes Thorne's system as one which is comprehensive and organised and which has brought together a variety of methods though it still remains a loosely gathered system.

Eclecticism is to be distinguished from unsystematic and uncritical combination of things. The eclectic seeks consistency as far as possible. The formalist sees the eclectic position as too loose and uncritical. The eclectic finds the schools too formal, dogmatic and rigid. The newer concept of eclecticism is not a theoretical. Individuals suggest a need for an integrated, comprehensive and pragmatic approach. This suggests that the position of every eclectic counsellor will naturally differ from every other electrician, making the position impossible to define or describe. They claim that the openness of this approach to be an advantage. Thorne, eclecticism is the most practicable and apt approach to counselling. Similarly the problems of individuals vary

both in content and intensity and an approach suitable to one individual need not necessarily suit another individual. Thorne this „integrative psychology‟ and claims that it provides systematic theoretical foundations for eclectic clinical practice. Thus from an eclectic point of view the self is able to regulate the whole organism and even cause it to do things that are against its own interest. The self-concept is crucial sinceit operates as the functional core of being. Personality development is affected by constitutional, biological and cultural factors as well as by the drive for self-actualisation the powerful drive of self -actualisation motivated human being towards improvement or perfection. Garfield summarises Thorne's system as one which is comprehensive and organised and which has brought a variety of methods though it still remains essentially a loosely gathered system.

4.6. SUMMARY

Some of the approaches to counselling have been outlined. These approaches differ with regard to the importance they attach to rationality in human behaviour. At one extreme, the behavioural approach to counselling tends to view human behaviour as simply reactive to the environment. The psychoanalytic view takes a dim view of human rationality and explains human behaviour as mostly unconsciously caused by irrational forces. They believe that the environment exerts little if any effect on the unconscious. The client-centred approach places a great premium on man‟s goodness and makes it the focal theme. The existential view point views man as purposeful, seeking the meaning of life and striving to determine his own destiny. The trait-and-factor approach Believes in the individual's capacity to act rationally and purposefully provided he is given the necessary assistance to use his innate resources. The eclectic approach tries to combine into a consistent system the positive aspects of all the systems.

All the approaches aim at reducing man's suffering and increasing his efficiency, productivity and happiness. Some theories, they hold consider man as a pilot steering his course and others consider him as a mere robot automaticallycontrolled by suitable manipulations of the environment by the counsellor. The behaviouristic approaches take a mechanistic view and explain human behaviour to result from suitable operations of environmental stimulations. Client-centred, trait factor, existential and psychoanalytical approaches look upon providing insight as a major technique of therapy. Behaviourally oriented approaches are concerned with symptoms, behaviour and actions which they seek to eliminate, modify, and changeby suitably manipulating the environmental stimulations and reinforcements.

Counsellor education and training stress the need for developing a plausible and consistent approach which is meaningful in terms of ones values and expectations. However inexperienced a counsellor may be, he implicitly operates on the basis of some theory. This he is perfectly free to modify change or even abandon on the basis of his experience for another point of view which he considers more beneficial. Reality therapy, developed by William Glasser sees people as acting to satisfy their needs, they develop identities to achieve that end. Feelings of being loved and worthwhile are essential in living. The basic concept of reality therapy is individual responsibility in initiating inappropriate behaviours to satisfy these needs. Counselling is seen as a process of involvement, communication and instruction.

4.7. TECHNICAL TERMS

1. Counselling is an interactive process conjoining the counselee who needs assistance and the counsellor who is trained and educated to give the guidance.
2. Psychotherapy: a body of knowledge that gathers its data from a number of related professions which are basically concerned with the helping function.
3. Diagnosis; which identifies the problem and causes.
4. Follow-up which attempts to find the outcome of counselling as well as help the client deal with future problems.

4.8. SELF ASSESSMENT QUESTIONS

1. Describe the different approaches to counselling?
2. What are the differences between cognitive and behavioural approach to counselling?
3. What counselling process is followed by the trait-factor counsellor?
4. Compare classical conditioning to operant conditioning.

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Prof. K. Dhanalakshmi

LESSON-5

DIRECTIVE AND HUMANISTIC APPROACH

OBJECTIVES

To learn about the Directive and Humanistic approach to counselling.

STRUCTURE

5.1. The Directive and Humanistic Approach
5.2. Importance of Human Relationships
5.3. Goals of Client Centered Therapy
5.4. Nineteen propositions to the theory of Personality
5.5. Summary
5.6. Technical Terms
5.7. Self Assessment Questions
5.8. Reference Books

5.1. THE DIRECTIVE AND HUMANISTIC APPROACH

The authoritarian point of view is largely associated with the work of Sigmund Freud. The Directive or Authoritarian approach the client is ignorant and unaware of the reason for his difficulties or suffering which are deeply embedded in the unconscious. The client is therefore helpless and it is the therapist who has to play the role of interpreting the material for him or her. This principle is known as psychological determinism. The personality structure is explained to comprise of the id, the ego and the superego. The id is the source of all energy Understanding oneself or others in a humanistic way requires delving into this phenomenological world rather than presuming it from what some would calls „facts Humanistic theory is a model that continues to give people a way of accepting these inherent and increasing pressures and a means of dealing with them in a humanistic manner through relationships and other humans.

Social and interpersonal interventions can be both preventive and therapeutic. A variety of group activities are included in the child's educational programs such as birthday parties, attendance at recreational activities (such as games, movies, participation in youth sport activities and visits to community sites. The goal of these activities is to teach appropriate social skills relevant to group participation andbuilding self-esteem. Parents also benefit as they get respite from providing care to address their

own needs. Parents can be much more effective when their own needs have been met. Therapeutic intervention with the children and families may include family therapy, individual child behaviour therapy, parent training and group therapy for mild mental retarded children that focus on developing appropriate social skills.

In contrast to psychoanalysis, Carl Rogers client centred approach to counselling is more directly related to the field of psychological counselling. The emphasis in client centred therapy is on providing facilitative conditions that allow the client the freedom and safety necessary for growth. Client centred therapy and Carl Rogers are almost synonymous .The Rogerian system emerged as a set of procedures in counselling from his intimate clinical observation. The major concepts of 'client centred 'therapy thus does not arise from psychopathology. Its aim was not to cure sick people but to help people live more satisfying and creative lives. Since 1942, when his book 'counselling and psychotherapy" was first published, client centred therapy has been continuously developed as approach for human growth and change.

Rogers‟s therapy can be divided into three concepts even though each concept cannot be accurately assessed independent of the other two. The organism is composed of all that individuals are their physical being, their thoughts and behaviour. The organism is at all times a total organised system in which alteration of any part may produce changes in any other part. Individuals then react to the total perceptual field which is their reality. What is important is the perception of the event making reality individuality and subjective.

As a person interacts with the environment in his or her perceptual field, the self-concept starts developing, perception of experiences influence by a need for positive regard. Any experience that is not consistent with the self-concept is seen as a threat, as it would disturb the self-concept .The client centred approach conceptualizes the individual as motivated in positive direction.

5.2. IMPORTANCE OF HUMAN RELATIONSHIPS

1. It is meaningful to the persons involved, implies mutual self-commitment.
2. It has a marked tone of feeling; individuals who are involved experience certain emotional states.
3. It implies integrity-the persons involved are intellectually and emotionally honest with each other.
4. It can exit by mutual consent only, no compulsion.
5. It comes into existence or becomes necessary when one is some kind of help.
6. It involves communication and interaction.
7. It is often structured, that is, it is not vague and amorphous.
8. It is sustained through mutual cooperation and collaboration.
9. The helping person must have a sense of security.
10. The goal or object of the helping individual is to change the client positively.

A helping relationship is essentially an attitude which exudes a feeling of acceptance and a democratic value of life. It implies that the helping relationship does

not in any way make a person feel superior to the one he helps. It also implies that the helping individual does not impose his values on to the client. Such an approach is called the client-centred approach.

5.3. GOALS OF CLIENT CENTRED THERAPY

All therapies-the orthodox psychoanalytic and the more recent ones are all client centred. The therapist is the centre of the stage, and it is he who directs the course of the therapy interprets the client's communications and terminates the session. Rogers"s theory of personality, more popularly known as self-theory has evolved from his practice. Rogers views man as a socialized, forward moving, rational and realistic individual". The basic goal for the client is to become more fully functioning. Some that can be expected with client centred counselling are those clients become more.

1. More realistic in their self-perception.
2. More confident and self-directing.
3. More positively valued by them.
4. Less likely to repress aspects of their experiences.
5. More mature, socialized and adaptive in their behaviour.
6. Less upset by stress, and quicker to recover from it.
7. More like the healthy, integrated well-functioning person in their personality structures.

The counsellor goal is to recognize and confront the incongruence between the client"s experiences and self-concept. Client centred therapy is an if-then proposition. If certain conditions are present, then the client will become more self-actualized. Rogers avoided evaluation, interpretation, probing questions, reassurance, criticism, praise, or description, while generally encouraging, reflecting, and restating.

5.4. NINETEEN PROPOSITIONS TO THE THEORY OF PERSONALITY

Rogers postulated a theory of personality in series of 19 propositions

1. The individual exists in constantly changing world of his own experience of which he is the centre.
2. In individual's private world of experience can be known in any genuine and complete sense to the individual self. The reality is his own perceptual field.
3. The individual reacts as a whole to the phenomenal field.
4. The individual has a basic tendency to actualize, maintain and enhance himself.
5. Behaviour is fundamentally goal-directed and it is the expression of the individual who satisfies the needs as they are perceived.
6. Feelings and emotions accompany goal-directed behaviour and facilitate the expression of it.
7. The best way of understanding the significance of any behaviour is from the internal frame of the individual himself.
8. The self is differentiated from the total phenomenal field.
9. The differentiation of the self is the result of interaction between the

individual and the environment.

10. The values attached to experience and self-structure taken from others may be perceived in a distorted fashion.
11. New experiences are encountered by the individual in his day to day life. Occasionally these experiences are ignored.
12. The modes of behaviour adopted by the individual are those, which are consistent with the concept of the self.
13. Behaviour is also caused oy organic experiences and needs. The individual does not accept the responsibility for his action.
14. Psychological maladjustment is essentially the result of the individualsrefusal to become aware of significant experiences.
15. Psychological adjustment obtains in a state in which the individual accepts all the experiences and integrated them into his self-structure.
16. Any experience inconsistent with the structure of the self may be perceived as a threat.
17. Under certain conditions, which are inconsistent with the individual self-structure and hence threats to it may be perceived and assimilated into the self-structure.
18. When the individual is able to perceive and accept experiences distorted and integrated into self-structure, dismissing the cause of conflict.
19. When the individual is able to accept experiences with any distortion, he is able to lead a healthy and integrated life.

The self-theory is basically phenomenological in nature and depends heavily on explanatory concept. The theory looks upon congruence between the phenomenal field of experience and the conceptual structure of the self is essential to healthy adjustment. Absence of this congruence results in internal strain, anxiety and tension. The major thrust for the client centred is to create the proper relationship, climate and conditions for enhancing the process of therapeutic growth. Client centred is an if- then proposition and if certain conditions are present, then the client becomes self-actualized. Empathetic understanding is the crux for client centred therapy If the three therapeutic conditions are met, the client will first explore feeling and attitudes at deeper levels, new meaning and understandings previously not developed will be achieved. Clients develop more self-acceptance. Rogers avoided evaluation, interpretation, probing questions, reassurance, criticism, praise or description, while generally encouraging, reflecting, and restating.

5.5. SUMMARY

The client centred approach reflects a sincere commitment to the self-actualization process. Much emphasis is placed on the I-thou relationship of counsellor and client-a relationship if founded on certain conditions , may well be sufficient to encourage client change, Some of the representative approaches to counselling have been outlined, several lacunae are evident in these approaches. The client centred therapy approach reflects a sincere commitment to the self actualizationprocess. Much emphasis is placed on the relationship of counsellor and client. The major contributions of client -centred therapy have been the identification of the necessary therapeutic characteristic of the counsellor during the counselling process and development of a philosophy that conceptualises the individual in a positive growth-oriented context.

A variety of factors have been linked with its occurrence such as biophysical factors, social and cultural factors and educational factors such as crowded classrooms that give rise to learning problems. Children with LD have academic problem in the area of reading, writing, spelling and mathematics. Interventions include psychological and behavioural models that stresses on the skills of academic tasks and on-building positive thinking.Behavioural problems exhibited by children are subsumed under the headings of externalizing and internalizing syndromes. Multimodal and behavioural counselling that include procedures such as positive reinforcement, extinction, shaping and modelling Role playing and desensitization help to promote desirable behaviours in children with both externalizing and internalizing syndromes.

A major difficulty with the client centred approach is with individuals whose perceptions are significantly different from the perception of others and who because of distortion, continuously engage in self-defeating behaviour that may be destructive of themselves and others. According to some critics of client centred therapy, the establishment of the therapeutic relationship will be insufficient to change inaccurate perceptions outside the therapy situation. This implies that counsellor must recognize and confront the incongruency in the client between the experience and the self-concept. The psychoanalytic view takes a dim view of human rationality and explains human behaviour as mostly unconsciously caused by irrational forces. The client centred view of man presents a pessimistic and unedifying view of human nature. All the approaches aim at reducing man's suffering and increasing his efficiency, productivity, and happiness. It is through the talking out' process that the individual gains insight into himself and understands the significance of the symptoms underlying his difficulties. No one therapy is best for all clients, but an understanding of the various theoretical approaches to counselling, enables the counsellor to maximize personal therapeutic strengths.

5.6. TECHNICAL TERMS

Organism: is composed of all that individuals are, their physical being, their behaviour, and their thoughts.

Perceptual field: the reality.

Self-concept: is a learned sense of self and is based on individuals perception of the regard they have received from outside the self.

5.7. SELF ASSESSMENT QUESTIONS

1. Describe the various concepts of Rogers client centred therapy?
2. What are the basic goals of Rogers‟s therapy?
3. Elucidate the nineteen propositions that Rogers postulated in his theory of Personality?
4. What are counselling techniques involved for children with learning and behavioural problems?
5. How can counsellors promote better adjustment in adolescents?

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LESSON-6
BEHAVIOURISTIC APPROACH

OBJECTIVES

To study and understand the Behaviouristic Approach to Counselling.

STRUCTURE

6.1 Introduction
6.2 Factors in Learning Behaviour
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6.1. INTRODUCTION

Behavioural counselling involves the application of experimentally derivedand established principles of learning to weaken or eliminate maladaptive behaviour and to build or strengthen replacement behaviours that are adaptive. The foundation for behavioural counselling is learning theory developed by numerous philosophers, clinical psychologist, experimental psychologists, and researchers. There is no one thinker who discovered and developed this theoretical approach.

Gray 1032 is credited as the first to use the term behaviour modification, when he promoted its use in the educational setting. Behaviour therapy was introduced by Skinner and Lindsley, 1954 in their report. "Studies in Behaviour Therapy" The field of behavioural counselling began with animal research from which evolved learning theory. The early 1950's saw the testing of theory on people. During the middle and late 1950‟s techniques of behaviour change were emphasized. More recently the field stretched into cognitive behaviour modification. Attention has mainly focused on how people learn and can change unhelpful and troublesome learning.

Counselling and psychotherapy are concerned with behaviour change and therefore some theorists must involve the application of the principles of learning theory. From the behaviouristic point of view all behaviour adjustive or maladjustive is primarily learnt in the same manner.

Attention has focused mainly on how people learn and change unhelpful and troublesome learning. Most behaviourists adhere to the tabula rasa, or blank slate, theory of John Locke. People are born into this world neither intrinsically good nor bad they are neutral. As they interact with their environment, their experiences and resultant behaviour are recorded on the slate.

Behaviourist believes that behaviours are learned through three paradigms classical conditioning, operant conditioning and imitative learning. The learning approach employed in the behaviouristic model could be either in the classical or in the operant conditioning model. All behaviour of organisms, including human beings ranging from simple to complex behaviour is learnt four basic principles (DCRR) are involved in learning. The first is drive or motivation which impels the organism to act. The drives could be primary, tissue needs or secondary, (learn). Without drive, there can be no action, consequently no learning can occur. The second is the stimulus. Thus drive and cue together determine the response of the organism.

1. Classical Conditioning: A number of things in our environment elicit a human response spontaneously. Therefore the response is not learned. Since the reaction is natural, like loud noise, salivation, the stimulus is called unconditioned stimulus. When the response follows spontaneously it is called the unconditioned response. A neutral response is one that does not elicit a specific response repetitively. A previously neutral stimulus that has been paired with an unconditioned stimulus in eliciting the unconditioned response is called a conditioned stimulus the response is learned and is called a conditioned response. Pavlov and his dogs are an example of learning through classical conditioning. The presence of food (unconditioned stimulus) caused the dog to salivate (unconditioned response) This type of behaviouris an innate characteristic, which enables an organism to maintain itself. When the ringing of the bell is added to the appearance of food, the dog learns to salivate. Phobias and sexual perversions are examples of classical conditioning.

2. Operant Conditioning: B.F. Skinner is credited with defining the laws of operant conditioning. This approach suggests that behaviour (stimulus) occurs spontaneously or at random and some event follows the behaviour that is experienced as giving pleasure (reinforcement). This reinforcement increases the chance that the stimulus will reoccur in the future. Thus a dog comes when she is rewarded with a piece of food. The likelihood of coming the next time she is called has been increased. If no reinforcement is given, including petting or any kind of attention, the probability of her coming the next time will not change .Dollard and Millers reinforcement theory is a thought provoking approach. They define neurosis as a learned behaviour. Thus unwanted and maladjusted behaviour is acquired or learnt. This includes phobias, compulsions, hysterical symptoms, regression, alcoholism, etc most behavioural reactions are maladaptive. The therapeutic situation is characterised by permissiveness which leads to the removal of repression. The process is slow and difficult one because fear and anxiety accompany the repressed ideas . The reinforcement theory of Dollard and Miller is an integration of psychoanalytic concepts with behaviouristic techniques. But the approach has been useful in stimulating other thinkers and therapists to explore the use of the learning approach incounselling.

3. Imitative Learning: Imitative learning is also known as modelling, Social learning and observational learning. Bandura's work has refined this theory which “teaches” him what to "copy. If the model is rewarded for the behaviour, the lesson is strengthened. If the behaviour is performed by the observer and is reinforced, the learning is strengthened. Commercials and styles of clothing worn as well as behaviours adopted from admired athletes are vivid examples of the potency of imitative learning. This explains why the saying "Do as I say and not as I do" has no effect.

6.2. FACTORS IN LEARNING BEHAVIOUR

Reinforcements are those events that when they follow, increase its probability of recurring. There are two types of reinforcement. Positive and negative, Positive reinforcement: is the presentations of a pleasurable event following some behavior any form of recognition may be reinforcing, examples are presentations of a gift, money or food. Positive reinforcements are determined by the recipient. Additionally what constitutes as punishment for Jane might be reinforcement for Bill. Careful attention must be given to the individual‟s values and valence given to the possible reinforcements. It increases the likelihood that the behaviour will be repeated, Negative reinforcement is the operation of removing an aversive stimulus contingent upon a response .Punishment is the application of an aversive response after the display of a disapproved behaviour punishment is by definition the application of an aversive event that will decrease the likelihood of the targets behaviours recurrence.

Schedules of reinforcement: The frequency and timing of the application of providing reinforcement is called a schedule of reinforcement. The best schedule of reinforcement to initially condition a response is called continuous reinforcement while this schedule is best to condition a new behaviour; it shows the least resistance to being extinguished. Intermittent schedules are very resistant to extinction. They do not provide the reinforcement every time but instead, intermittently. Gambling is example of intermittent reinforcement, and gambling addiction speaks of the strength of both imitative learning and intermittent reinforcement. Extinction Behaviour has been conditioned will occur for as long as it elicits intermittent reinforcements. will result in the behaviour disappearing. An interval schedule has to do with the lapse of time since the last correct reinforced response. The cessation of all reinforcement result in the behaviour disappearing.

Generalisation is the principle that permits us to transfer learning from one situation to another when there is some similarity in the situations. Discrimination is a person‟s ability to discriminate between two or more similar stimuli that give different responses to the conditioned stimulus. Discrimination is a person‟s ability to discriminate between two or more similar stimuli that give different responses to the conditioned stimulus.

Shaping is the learning of complex behaviours starts with learning behaviours and then using the laws of discrimination extinction, generalisation and of course, reinforcement to learn successively more complex behaviours until the target behaviour is learned.

6.3. STEPS IN THE THERAPEUTIC PROCESS

The behaviourist takes much time with the client
1. Problem definition: It is necessary to determine all the circumstances surrounding the inappropriate behaviour. The clients, strengths, weaknesses, and limitations are noted Essentially the counsellor needs to ascertain when the problem occurs, what precedes and what follows it and what about the behaviour is reinforcing to the client.

2. Ascertainment of Development and Social History: The clients history is valuable insofar as it may delineate many problem areas The counsellor specifically seeks information about the clients development, the changes that occurred and how he

adapted to these changes. The client's sense of control over his life and his problems needs to be assessed. The client�because ability to relate to others and to his environment is also assessed. Finally, the counsellor seeks to understand the client's culture, value structure and behavioural norms from both a historical and current perspective.

3. Specification of counselling Goals: The goals for an individual client will depend on the specific problem. The client and counsellor come to an agreement on what actually is the problem. It is the counsellor‟s responsibility to decide if the goal is within the realm of expertise. Goal setting depends on the data collected Goals need to be specified in terms that are behavioural and observable to ensure.

4. Selection of Methods to be utilized: While techniques used in the counselling process will vary, they must be compatible with the client‟s goals. Counselling consists of whatever ethical activities a counsellor undertakes in an effort to help the client engage in those types of behaviour which lead to a resolution of the clients problems.

5. Evaluation and Termination. The client's progress toward the specified goals will be evaluated at regular intervals. If the evaluation yields negative results the goals or techniques need further assessment and possible alteration. If the evaluation is positive and the goals have been attained then the client is ready to either determine new goals to work toward or to terminate counselling.

The principles of reward, aversion, omission and punishment (RAOP) are employed either individually or in combination as required in specific cases Criticisms of behavioural counselling generally stress the meaninglessness of the mechanistic view of human behaviour..

According to Wolpe, all behaviour conforms to causal laws. Changes in the behaviour of any organism are caused by 1.growth, 2.lesions. 3. Learning, According to Wolpe, learning is assumed to have occurred if a response has been evoked in temporal contiguity with a given sensory stimulus and it is found that the stimulus can evoke the response although it could not have done so before. The strengthening of the relation between the stimulus and the response is called reinforcement. Reinforcement is strengthened by several factors such as optimal interval between the conditioned and the unconditioned stimulus. Wolpe is a protagonist, according to him; reciprocal inhibition eliminates or weakens an old response by the substitution of new ones. In therapy this process follows the basic assumption that neurotic behaviour is a learned behaviour. Anxiety is unpleasant and may often interfere with performance. In this technique of counter conditioning, anxiety is eliminated by a competing response by means of a reciprocal inhibition. This principle is also the basis for aversive therapy. Positive reconditioning in the technique of establishing new behaviour pattern. And experimental extinction is the procedure that consists of continued non reinforcement of a habit such that it is progressively weakened and disappears.

6.4. TECHNIQUES OF BEHAVIOURAL COUNSELLING

Relaxation Training: Training in relaxation is appropriate for anyone in tension or anxious it was introduced as deep muscle relaxation by Jacobson and Popularised by Wolpe as systematic desensitisation. Essentially the client is taught to flex muscle groups to a straining point and focus on the feeling produced, recognizing it as tension. The client is then told to relax those muscles by letting go' of the tension, gradually and notice the resultant feelings of relaxation, calmness and warmness Systematic

Desensitisation. This technique is used when anxiety is the product of either thought about or exposure to a specific, identifiable event Therefore the client 'unlearns' to associate the event with anxiety and learns to associate relaxation with it.

Wolpe suggest three steps to the procedure:

1. Training in deep muscle relaxation.
2. The construction of anxiety hierarchies.
3. Counter posing relaxation and anxiety-evoking stimuli from the hierarchies.

Assertiveness Training: Assertiveness is the appropriate expression of a person's feelings other than anxiety. Assertive people usually feel good about themselves and frequently achieve their wishes people who are assertive are able to express their opinions, desires, wishes, disappointments regrets, and feelings of hurt, sad, happy or angry. Assertive people usually feel good about themselves and frequently achieve their wishes. Assertiveness is learning to express one's hones feelings in an appropriate manner, it should make the client feel good about herself or himself not manipulate others.

The Behaviouristic approach to counselling employs the four principles of learning, namely, the drive, cue, response, and reinforcement therapy essentiallyconsist of several steps, like identifying the undesirable, unwanted, maladjusted and maladaptive behaviour. Careful analysis of the maladaptive behaviour into smallunits. Each unit is eliminated by an appropriate technique.

6.5. SUMMARY

Behavioural modification is a technique or rather a group of techniques which employ the learning theory. The behaviouristic approach takes a mechanistic view and explains human behaviour to result from suitable operations of environmental stimulations. Behaviourist believes that personality is the composite of what theperson has learned in the process of interacting with the environment. The counsellor who conducts behavioural counselling will be a warm, empathetic person and will establish strong relationship with the client and take a detailed behavioural history. Behavioural counselling has fostered the application of behavioural goals to counselling. Finally, behavioural counselling makes no attempt to treat that which is not overt and quantifiable; it ignores the realms of feelings and conflicts that defy definition. Behaviourists believe that personality is the composite of what the person has learned in the process of interacting with the environment.

The three modes of learning are classical conditioning, operant conditioning, and imitative learning. There are few innate influences on our feelings and behavior and they are not amenable to change. Therefore the counsellor who conducts behavioural counselling will be warm, empathic person and will establish a strong working relationship with the client and take a detailed behavioural history. Behavioural counselling has fostered the application of behavioural goals to counselling. These goals permit the counsellor and the client to identify specific limits to their counselling, specify the criteria for termination, permit the use of contracts and incorporate a built in method for measuring results. Finally behavioural counselling makes no attempt to treat that which is not over, and quantifiable, it ignores the realm of feelings, and conflicts that defy definition.

Some of the representative approaches to counselling are outlined. The behavioural approach to counselling tends to view human behaviour as simply reactive and entirely determined by the environment. The psychoanalytic view takes adim view of human rationality and explains human behaviour as mostly unconsciously caused by irrational forces. The client centred places great premium on man‟s goodness and makes it the focal theme. However the counsellor is perfectlyfree to modify, change or even abandon on the basis of his experience for another point of view which he considers more beneficial.

6.6. TECHNICAL TERMS

Systematic desensitisation: a technique used when anxiety is the product of either thought about or exposure to a specific identifiable event.

Assertiveness is the appropriate expression of a person‟s feeling other than anxiety.

Punishment: is the application of an aversive response after the display of disapproved behaviour

6.7. SELF ASSESSMENT QUESTIONS

1. Trace the theoretical Beginnings of Behavioural counselling.
2. Describe, classical conditioning, operant conditioning and Imitative behaviour?
3. What are factors in, learning behaviour?
4. State the steps in the Therapeutic process?
5. Elucidate the techniques of Behavioural counselling.

6.8. REFERENCE BOOKS

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LESSON-7
NATURE AND CHARECTERISTICS OF COUNSELLING PROCESS, STEPS IN COUNSELLING PROCESS

OBJECTIVES

The main Objectives of this lesson are to study the Nature and characteristics of counselling process and to study the steps in counselling process

STRUCTURE

7.1. Introduction
7.2. Defining Counselling Process
7.2.1. Nature and Characteristics of Counselling Process
7.3. Stages of Counselling Process
7.4 Steps in the Counseling Process
7.4.1. Key steps for the client
7.4.2. Key steps for the Counsellor
7.5. Factors Influencing Counselling Process
7.6. Summary
7.7. Keywords
7.8. Self Assessment Questions
7.9. Reference Books

7.1. INTRODUCTION

The counseling process is planned, structured dialogue between a counselor and client. It is a cooperative 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 the person has new skills and increased understanding of themselves and others. The process begins with exploring the challenges a client faces before assisting them in resolving developmental and situational difficulties (Sajjad, 2017).The counselor supports clients with physical, emotional, and mental health issues, helping them resolve crises, reduce feelings of distress, and improve their sense of wellbeing (American Psychological Association, 2008).

Counseling is more or less a scientist art, as such there are no hard and fast rule regarding it"s process. Much depends on the needs, problems and personality of the client and the training and background. Carl Rogers was among the earliest to emphasize the importance of building and relationship between the counselor and the client. He identified three important conditions for the establishment of an effective counselor- client relationship: Empathy, Genuineness and unconditional Caring.

7.2. DEFINING THE COUNSELING PROCESS

All of us will, occasionally, take on the role of counselor. We informally offer family, friends, and colleague‟s advice regarding their relationships, finances, career, and education. On the other hand, "a professional counselor is a highly trained individual who is able to use a different range of counseling approaches with their clients" (Krishnan, n.d., p. 5).According to the American Psychological Association (2008), counseling psychologists "help people with physical, emotional and mental health issues improve their sense of wellbeing, alleviate feelings of distress and resolve crises."

Counseling works with clients from childhood through to old age, focusing on "developmental (lifespan), environmental and cultural perspectives," including (American Psychological Association, 2008):

- Issues and concerns in education and career
- Decisions regarding school, work, and retirement transitions
- Marital and family relationship difficulties
- Managing stressful life events
- Coping with ill health and physical disability
- Mental disorders
- Ongoing difficulties with getting along with people in general

While we often see counseling and psychotherapy as interchangeable, there are subtle distinctions. Counseling is typically short term, dealing with present issues and involving a helping approach that "highlights the emotional and intellectual experience of a client," including how they feel and think about a problem or concern (Krishnan, n.d., p. 6).Psychotherapy is often a longer term intensive treatment, helping the client overcome profound difficulties resulting from their psychological history and requiring them to return to earlier experiences (Krishnan, n.d.; Australia Counselling, n.d.).

7.2.1. Nature and Characteristics of Counselling Process

The counseling process has been described as both an art and a science, helping to bring about changes in thought, emotion, and behavior in the client (Sajjad, 2017).

Counselling is a process guided by theory. Process can refer to what the counselor does with the client as well as how change occurs within the client. The process of counseling develops in definable stages with recognizable transitions. There is anatural progression that takes place within the context of the helping relationship. This process enables the counselor and the client to build a relationship, assess the situation, set goals and come up with a plan to bring about the desired results. This progression is known as the counseling process.

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

Counseling as a profession involves (Krishnan, n.d.):

- Dedicated time set aside to explore difficulties, stressful situations, or emotional upset faced by a client

- Helping that client see their situation and feelings from a different viewpoint, potentially to facilitate change
- Building a relationship based on trust and confidentiality
- The counseling process should not include:
- Providing advice
- Being judgmental
- Pushing the counselor‟s values
- Encouraging the client to behave as the counselor would in their own life
- Emotional attachment between the counselor and client

The term counselling process means a systematic professional help given to an individual. The analysis of various view-points and definitions of counselling points out that:

i. It is a process of helping the individuals to help themselves. It involves helping the individuals to recognize and use their own inner potentials, to set goals, to make plans and to take action accordingly.

ii. It is a continuous process as it is needed at the different stages of life viz. childhood, adolescence, adulthood and even in old age.

iii. The process involves a sequence of stages and steps which are followed by the trained professionals in order to help the client.

The importance of understanding the counselling process is that it guides theworker in forecasting probable future scenarios, setting objectives, organising perceptions assessing clients problems, developing realistic and optimistic expectations that are stage specific and initiating different programmes according to the specificity of the stages. The whole process of counselling is meant to help the persons to get from where they are to where they want to be.

The process of counselling has been discussed by many authors. However, some of the authors‟ views in this regard will be discussed here. With regards to counselling process Judy Harrow (2001) writes, „One way to understand the process of change is as an ongoing spiral. Like all models, this is simplified, but the simplification helps one to understand a very complex process. … Every human being has many facets. One can grow at a different rate (or even regress) in each facet, in different periods of one‟s life‟.

Characteristics

Counsellors as specialists in helping enterprise are considered to possess features that distinguish them from other professionals. Basically, counsellors are trained individuals whose characteristics are such that increase their effectiveness while discharging their professional duties.

Akinade, Sokan and Osarenren (2005) identified such characteristics as:

1. Warmth: This is the ability to like people, become receptive to people, friendly and to be able to communicate such feelings to them so that they can equally reciprocate the same gesture.
2. Patience: A counsellor is expected to be tolerant and capable of accepting his clients without limits or discriminations.

3. Confidentiality: This is the ability to keep secrets. A good counselor owes his clients the responsibility of keeping whatever transpired during their counselling encounter intact. Information should not be divulged for any reason except with the consent of the client involved and for his benefit.
4. Empathy: A good counsellor should be able to feel or put himself in the position of others during counselling in order to understand their view points, feelings, thoughts and actions.
5. Above average intelligence: Counselling is not meant for people below average intelligence since it is a problem-solving venture. The counsellor should be intelligent enough to engage in mental ability or activities that can enable him unravel his clients' problems and proffer acceptable solutions to them.
6. Relative emotional freedom: A good counsellor is one who alienates himself/herself from severe emotional problems to enable him/her handle his/her clients‟‟ problems. He/She should not be the type that will shed tears when his/her client is doing so in the course of presenting his/her problem.

Other characteristics of a counsellor include: humility, honesty, love, truthfulness, and ability to handle psychological testing. A counsellor should be highly trained in the art of counselling as none of the above skills are inherently inborn but acquired through training. He/She needs not to be religious as his/her faith might be different from that of his/her client which invariably will be a setback in an attempt to solve counselling problems as presented.

7.3. THE STAGES OF THE COUNSELING PROCESS

Counselors and clients must both be aware that the counseling process requires patience. There is rarely a quick fix, and things may need to get worse before they get better. In addition, the counseling process is collaborative. The counselor does not fix the client; the work requires interaction and commitment from both parties (Krishnan, n.d.).

The counseling process is a planned and structured dialogue between client and counselor. The counselor is a trained and qualified professional who helps the client identify the source of their concerns or difficulties; then, together, they find counseling approaches to help deal with the problems faced (Krishnan, n.d.).

Hackney and Cormier (2005) propose a five-stage model for defining the counseling process through which both counselor and client move (Krishnan, n.d.).

There are four stages in Counseling Process,

1. Identify the need for counseling.
2. Prepare for counseling.
3. Conduct counseling.
4. Follow up.

Counselling is a process. It focuses on enhancing the psychological wellbeing of the client, so that the client will able to reach his/her full potential. This can be achieved by the counsellor facilitating the client in his/ her personal growth, development, and self-understanding, which in turn empowers the client to adopt more constructive life practices.

Marjorie Neslon's (2001) nine steps in the counseling process.

1. Establish a safe, trusting environment.
2. Clarify: Help the person put their concern into words.
3. Active listening: find out the client"s agenda
4. Paraphrase, summarizes, reflect, interpret.
5. Focus on feelings, not events.
6. Transform problem statements into goal statements.
7. Explore possible approaches to the goal.
8. Help person choose one way towards goal Develop a plan (may involve several steps).
9. Make a contract to fulfill the plan (or to take the next step).
10. Summarize what has occurred, clarify, and get verification. Evaluate progress.
11. Get feedback and confirmation.

While counseling varies in both form and purpose, most counseling theories embody some form of the following three stages (Krishnan, n.d.): relationship building, problem assessment, and goal setting.

Stage one: (Initial disclosure) Relationship building

The counseling process begins with relationship building. This stage focuses on the counselor engaging with the client to explore the issues that directly affect them. The vital first interview can set the scene for what is to come, with the client reading the counselor"s verbal and nonverbal signals to draw inferences about the counselor and the process. The counselor focuses on using good listening skills and building a positive relationship.

The first stage in the process of counselling is a continuous process. It begins by having the counsellor win the battle for structure and client win the battle for initiative. In such situations both parties are winners. The client wins by becoming more informed about the nature of counselling and learning what to expect. The counsellor wins by creating an atmosphere where the client is comfortable about sharing thoughts and feelings. In order to develop positive helping relationships with the client, the counsellor has to connect with them. This can only happen when they are made to feel like the counsellor genuinely cares about the clients wellbeing and that the counsellor understands why the clients are coming and the causes thereof. It is about behaving and demonstrating the core conditions of genuineness, respect and empathy. To develop solid relationships, the counsellor needs to create a safe environment where they will feel comfortable enough to open up and talk to the counselor about anything that is on their minds. The counsellor also needs to help them see that despite their circumstances they have strengths. Early stages of the counselling relationship afford the chance to build counsellor understanding of client and issues faced. The counsellor is advised to use listening skills and attend to nonverbal communication. The counsellor should not be judgmental in his decisions and jump to conclusions immediately.

For this stage to be successful, the Counselor should be able to empathize with the client so that the client is engaged to explore the issues affecting him. The Counselor should win over the client with his strategic convincing communication skills. Communication skills play a vital role in this initial disclosure stage.

Skills for relationship building with the client can be summarized as follows:

- Start with an introduction.
- Make the client comfortable by making him sit down.
- Address the client with his name.
- If the Counseling is for addressing health issues engage the client in
- Some social conversations to make him/her anxiety free.
- If it is for addressing professional problems let the client talk about his problems affecting him.
- The Client should get a vibe that the Counselor is interested in his talk. Be genuine.

Fuster (2005) has listed some of the questions that the counselee raises at this stage. The counselee has many questions in his/her mind, such as –

1. Is the counselor interested in me?
2. Is he/she willing to give me time and listen carefully?
3. Can I share my intimate thoughts and feelings with him?
4. Does the counselor has anything I can use?
5. Would he be successful in my world?
6. Can he help me?

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

i. Empathetic understanding: Empathy promotes rapport and relationship.
ii. Unconditional positive regard: Considering Client as person of worth, and is separate from actions.
iii. Congruence: Showing Genuine self in client interaction Carkuff (1969) adds to these…

i. Respect: It strengthens the focus.
ii. Confrontation: It promotes realistic and accurate view.
iii. Immediacy: Consideration of problem with Here and Now attitude.
iv. Concreteness: Paying attention on what is practical in the process.
v. Self-disclosure: Promoting positive perception and appropriate focus in counseling relationship

Stage two: (In-depth exploration) Problem assessment

While the counselor and client continue to build a beneficial, collaborative relationship, another process is underway: *problem assessment*.

The counselor carefully listens and draws out information regarding the client‟s situation (life, work, home, education, etc.) and the reason they have engaged in counseling. Information crucial to subsequent stages of counseling includes identifying triggers, timing, environmental factors, stress levels, and other contributing factors.

This stage is the stage of assessment of the problem the client is facing either professional or personal interfering with their daily life or professional targets causing despair. According to Seligman (19990), assessment should attempt to recognize the importance and uniqueness of the client. The key is to extract all possible information and knowledge about the client‟s grievances or problems and ensure nothing is left out. Any missing link can disastrously affect the whole counseling process.

The exploration or problem assessment begins with noting down the client‟s personal data, like name, age, address, marital status, occupation. This should be

followed by the problems affecting the client"s professional or personal life. Also making a note of the duration of the problem, his family history, personal history is a must. This helps in joining the dots. That is to form a connection between theproblems of the client and other information collected and grasped. This gives a rough idea of how much counseling might be required and to which particular counselor the client needs to be assigned.

Counselors who do not assess the problems presented by their clients are more likely to formulate wrong conclusions and non-workable counseling strategies and conclusions, resulting in hit and miss counseling. The Client may leave with the same set of problems brought to the first session sans any solution.

The exploratory stage is meant for entering into the counselee"s frame of reference in order to accurately understand how they experience the world. The purpose of this stage is also building the counsellees trust in the counsellor. Further the counselor tries to gather more facts and data about the counsellees and assess the client"s readiness to pass on to the next stage. At this stage the information is obtained primarily from the client, but it may also be sought from significant others in the client"s life. (With the permission of the client)

The areas of enquiry for getting information include the following:

- The problem, and its effects on the client and his environment
- Probable factors that create and maintain these problems;
- Probable factors that may relieve these problems;
- The client understands about the problem and efforts to tackle the problem.

Information is also obtained about the client"s personality and life which include:

- The client"s adjustment at home, at work, with friends, with persons of theopposite sex, and with society in general.
- The client"s strengths and weaknesses, good and bad habits, likes and dislikes;
- How the client spends his time or runs his life

After gathering data the counselor must integrate the data into something meaningful in order to appropriately respond to the clients" feelings and content. Thus, at this stage the counselors use the skill to label correctly the counselee"s feeling and the reason for the feeling. As the counselor keeps accurate responding, the client builds up trust in the counsellor. This trust in the counselor together with the counselor"s attitudes of empathy, genuineness and respect will prepare the counselee to go deeper into self-exploration.

Stage three: (Commitment to action) Goal setting

Effective counseling relies on setting appropriate and realistic goals, building on the previous stages. The goals must be identified and developed collaboratively; with the client committing to a set of steps leading to a particular outcome. This stage is the goal-setting stage, wherein the client with the help of the counselor identifies specific ways of problem-solving getting in the way to achieve the target. Goals are the results and outcomes the client wants to achieve at the end of the counseling sessions. Without the achievement of goals, the whole process of counseling goes down the drain. This is a crucial stage of counseling as the goals when stated clearly help both the client and the counselor to recognize progress during the process of counseling sessions

Some of the guidelines for goal selection are summarized as follows:

- Goals should relate to the desired end sought by the client.
- Goals should be well defined in explicit and measurable terms.
- Most importantly they should be in the range of the Counselors‟ knowledge and skills.
- They should be feasible.
- They should also be consistent with the client‟s mission and policies(if the clientis an organization).

Thus the three-stage counseling process is a planned, progressive movement towards the achievement of a desired, ultimate conclusion.

This stage is also called as personalizing the problem and the goal. Once the client accepts and acknowledges the counselor‟s response in the form of summary, s/he shows readiness to formulate appropriate goals and plans for the intervention. The counselor must ensure the clients readiness; otherwise the process will not be helpful to the client. The counselor guides the client in setting the specific goals. The specific goals are useful in monitoring the progress of achieving these goals.

Involvement of the client in setting the goals is very important. At this stage, the counselor uses the skill of personalizing the problem and the goal together. This makes the client take responsibility and accept their contribution to the problemsituation. The counselee‟s contribution to the problem or personal limitation must be expressed in concrete behavioral terms. This contribution is something negative and is generally something that the counsellee is doing or not doing. In this case while planning the goal it is just the opposite of the problem and, thus it channels the counselee‟s energy into something positive and constructive. For example, if the client‟s problem is that he cannot control his temper, the goal is to control his temper.

It is the stage during which the counselor analyses the clients‟ feelings and behavior, provides constant feedback, support and guidance to plan behavioral change.

Stage four: Counseling intervention

This stage varies depending on the counselor and the theories they are familiar with, as well as the situation the client faces.

For example, a behavioral approach may suggest engaging in activities designed to help the client alter their behavior. In comparison, a person-centered approach seeks to engage the client‟s self-actualizing tendency. The focus of this stage is to motivate the client to act in order to solve his/her problem. This is done by identifying what can be done to reach the goal and by taking up specific steps in such a way that the counselee realizes that the goal is attainable.

The client is helped to achieve the goal through various available counselling models and techniques. Some of the models used at this stage are –

- Rational Emotive Therapy (RET)
- Transactional Analysis (TA)
- Gestalt Psychotherapy (GT)
- Learning theories (LT)

Some of the techniques used are supportive and behavioral, cognitive and psychoanalytical, problem solving and other. The therapeutic gains during the action

stage include

- Resolution of emotional crisis
- Resolution of problem behaviors
- Uplifted self-confidence and self-esteem
- Better self-control and frustration tolerance
- Improving reality orientation and appraisal of threats
- Modified communication and problem-solving skills
- Improved overall adjustment, judgment, and emotional stability

Stage five: Evaluation, termination, or referral

Termination may not seem like a stage, but the art of ending the counseling is critical. Drawing counseling to a close must be planned well in advance to ensure a positive conclusion is reached while avoiding anger, sadness, or anxiety (Fragkiadaki & Strauss, 2012).Part of the process is to reach an early agreement on how the therapywill end and what success looks like. This may lead to a referral if required. While there are clear stages to the typical counseling process, other than termination, each may be ongoing. For example, while setting goals, new information or understanding may surface that requires additional assessment of the problem.

Evaluation is an important part of the counselling process. It is essential that the counselor undertakes evaluation before the termination of the process. Evaluating means to review how the counselee has taken the action in order to achieve the goal and in view of the plans how far the client is progressing. However, at this stage the purpose is of terminating the process.

Counselling is never abruptly terminated. The termination of counselling is systematically done after following a series of steps. The counsellor during the evaluation and termination stage ensures the followings –

1) Evaluating readiness for termination of counselling process;
2) Letting the client know in advance about the termination of counselling;
3) Discuss with client the readiness for termination;
4) Review the course of action plan;
5) Emphasis the client"s role in effecting change;
6) Warning against the danger of „flight into health";
7) Giving instructions for the maintenance of adaptive functioning;
8) Discussion of follow up sessions; and
9) Assuring the availability of counsellor in case of relapse into dysfunction

Lastly, at this stage some discussion of follow up sessions and continued uncritical accessibility of the counselor to the clients is necessary. There is need for the client to continue to maintain contact with the counselor for continued assistance for the maintenance of the functional equilibrium.

7.4. STEPS IN THE COUNSELING PROCESS

Many crucial steps go together to form the stages of the counseling process. How well they are performed can affect the success of each stage and overall outcome of counseling.

7.4.1Key steps for the client

The client must take the following four steps for counseling to be successful:

1. *Willingness*

   Being willing to seek and attend counseling is a crucial step for any individual. It involves the recognition that they need to make changes and require help to do so. Taking the next action often involves overcoming the anxiety of moving out of the comfort zone and engaging in new thinking patterns and behaviors.

2. *Motivation*

   Being willing to make changes and engage in them involves maintaining and sustaining motivation. Without it, the counseling process will falter when the real work begins.

3. *Commitment*

   The client may be willing and motivated, but change will not happen without continued patience and commitment. Commitment may be a series of repeating decisions to persist and move forward.

4. *Faith*

   Counseling is unlikely to succeed unless the client has faith in themselves, the counselor, and the process. Taking the step to begin and continue with counseling requires the belief that it can be successful.

7.4.2. Key steps for the counselor

Each step in the counseling process is vital to forming and maintaining an effective counselor–client relationship. Together they support what Carl Rogers (1957) describes as the core conditions for successful therapy:

1. *Unconditional positive regard*

Through acceptance and nonjudgmental behavior, the therapist makes space for the needs of the client and treats them with dignity. For more on developing this, we have these Unconditional Positive Regard worksheets, which may prove helpful.

2. *Empathy*

   The counselor shows genuine understanding, even if they disagree with the client.

3. *Congruence*

   The words, feelings, and actions of the counselor embody consistency.

Counselors often help clients make important and emotional decisions in their lives. To form empathy, they must intimately take part in the client"s inner realm or *inscape*.

Several well-performed steps can help the counselor engage with the client and ensure they listen openly, without judgment or expectation. The counselor must work on the following measures to build and maintain the relationship with the client

(Krishnan, n.d.):

1. Introduce them clearly and with warmth.
2. Invite the client to take a seat.
3. Address the client by the name they are most comfortable with.
4. Engage in relaxed social conversation to reduce anxiety.
5. Pay attention to nonverbal communication to identify the client"s emotional state.
6. Invite the client using open questions to explain their reason for coming to counseling.
7. Allow the client time to answer fully, without pressure.
8. Show that they are interested in the client as a person.

Each of the above steps is important. Taken together, they can facilitate the formation of a valuable counseling relationship.

Ultimately, counseling is collaborative and requires a series of ongoing steps – some taken by the client, others by the counselor, and several jointly. For a successful outcome, appropriate resources, time, and focus must be given to each one, and every win must be recognized and used to support the next.

7.5. FACTORS INFLUENCING COUNSELLING PROCESS

The counselling process is influenced by several factors. The counselor needs to know these so that he can help it to make the counseling time a productive one bothfor the client and counsellor.

The major factors which influence the counselling process are as follows.

Structure

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

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

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

Initiative

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

state of the involuntary, reluctant and resistant client. A reluctant client is one who has been referred by the third party and is frequently unmotivated to seek help. They do not wish to be in counselling. Many reluctant clients terminate counselling pre maturely and report dissatisfaction with the process. A resistant client is one who is unwilling or opposed to change. Such an individual may actively seek counselling but does not wish to go through the pain that change demands. There are several ways in which counsellors can help clients to win the battle for initiative and achieve success in counselling. One way is to anticipate the anger, frustration and defensiveness that some clients display. A second way is to show acceptance, patience, and understanding as well as nonjudgmental attitude. A third way is to use persuasion and the fourth way is through confrontation.

Setting

Counselling can happen anywhere, but some physical settings promote the process better than others. Among the most important factors that help or hurt the process is the place where the counselling occurs. The room should be comfortable and attractive with soft lighting, quiet colors, an absence of clutter, and harmonious and comfortable furniture. The professional generally works in a place that provides Privacy, Confidentiality, Quiet and Comfort. When working with a client, youthe counselor must want to send a message that he is listening. This can be done by being attentive both verbally and nonverbally. A distance of 30 to 39 inches is the average range of comfort between counsellor and clients of both genders. In addition to the above arrangements the counsellors should not be interrupted during sessions.

The counsellor should keep in mind the **SOLER** technique.

SOLER is an acronym which serves to remind the counselors how to listen:
S: Face the client squarely; that is, adopt a posture that indicates involvement.
O: Adopt an open posture. Sit with both feet on the ground to begin with and with your hands folded, one over the other.
L: As you face your client, lean toward him or her. Be aware of their space needs.
E: Maintain eye contact. Looking away or down suggests that you are bored or ashamed of what the client is saying. Looking at the person suggests that you are interested and concerned.
R: As the counselor incorporates these skills into the attending listening skills, relax.

7.6. SUMMARY

Counselling is a process that focuses on enhancing the psychological wellbeing of the client, such that the client is then able to reach their full potential. This is achieved by the counsellor facilitating the client‟s personal growth, development, Process of Counseling and self-understanding, which in turn empowers the client to adopt more constructive life practices. Counselling may be helpful in a number of ways. It can enable the client to develop a clearer understanding of his or her concerns and help the client acquire new skills to better manage personal and educational issues. The counsellor can offer a different perspective and help the client to think of creative solutions to problems. For the client, sharing his thoughts and feelings with someone not personally involved in his life can be most helpful. The counsellor treats all the information that the clients share as confidential material. The counsellors are involved in case consultations and supervision for the purposes of bestpractice. These meetings involve discussion of clients concerns with the aim of formulating the best possible

assessment and intervention plan. The counseling process becomes a continuous flow from one stepping-stone to the next in order to achieve the client"s goals and improve well-being. The first stages build a foundation by establishing rapport and assessing the problem; the middle stages work toward finding solutions and then focus on meeting the objective; and the final stage brings the process to a close, terminating the relationship after the client reaches his or hergoals.

7.7. KEY WORDS

Counselling, Client, Exploratory, Evaluation, Termination

7.8. SELF ASSESSMENT QUESTIONS

1. Explain the meaning of counselling process
2. Discuss the stages in counselling process
3. Describe the factors influencing counselling process

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LESSON-8
TECHNIQUES OF COUNSELLING PROCESS AND COUNSELLOR'S SKILLS

STRUCTURE

8.1. Introduction
8.2. Techniques of Counselling
  8.2.1 Directive Counselling
  8.2.2 Non-Directive Counselling
  8.2.3 Eclectic Counselling
8.3. Counselling Skills
8.4. Types of Counselling Skills
8.5. Summary
8.6. Keywords
8.7. Self Assessment Questions
8.8. Reference Books

8.1. INTRODUCTION

Another key concept in counselling is the concept of technique. Several people confuse technique with method of counselling. The term technique is described as a specific activity and action required to carry out assignment. It is simply a process of activity through which a counsellor gets his counsellees to solve their problems during counselling sessions. Counselling techniques are specific actions or activities and processes a counsellor can apply to achieve the goal of a particular counselling method. For instance, an action that facilitates a change of state or behaviour is a counselling technique. Hence, the use of induction to achieve relaxation of the conscious mind and thoughts of clients which allows a deeper focus on other areas that give greater access to the unconscious mind is a specific action to alleviate stress. Induction is thus a counselling method of solving problem arising from stress.

In a typical counselling encounter, a counsellor can use questioning, periodic summarization, feedback, confrontation and positive assertions as his counselling techniques to progressively solve his clients „problems. The cognitive therapists for instance make use of direct instruction, teaching, encouragement and forcing conformity techniques of counselling to influence behavior through the power of the mind. The behavioral therapists on the other hand use reconditioning, reinforcement, social modeling, explanation and encouragement techniques of counseling to analyses clients‟ past in order to determine their present behavior and proffer solutions to problems presented by clients. The eclectic therapists on their own employ deliberate action, re-education, training, and selective treatment techniques of counselling while working on various approaches to solve clients‟ problems.

8.2. TECHNIQUES OF COUNSELLING

The three major techniques used in counselling process in schools. The techniques are:

(1) Directive Counselling,
(2) Non-Directive Counselling, and
(3) Eclectic Counselling.

8.2.1 Directive Counselling

In this counselling the counsellor plays an active role as it is regarded as a means of helping people how to learn to solve their own problems. This type of counselling is otherwise known as counsellor-centered counselling. Because in this counselling the counsellor does everything by himself i.e. analysis, synthesis, diagnosis, prognosis, prescription and follow-up.

Features of Directive Counselling:

It has the following features:

1. During the interview attention is focused upon a particular problem and possibilities for its solution.
2. During the interview the counsellor plays a more active role than the client or pupil.
3. The pupil or client makes the decision, but the counsellor does all that he can to get the counselee or client makes a decision in keeping with his diagnosis.
4. The counsellor tries to direct the thinking of the counsellee or client by informing, explaining, interpreting and advising him.

Steps in Directive Counselling:

The following steps are followed in this type of counselling:

(i) Analysis:

In this step data is collected from a variety of sources for an adequate understanding of the pupil.

(ii) Synthesis:

This step implies organizing and summarizing the data to find out the assets, liabilities, adjustments and mal-adjustments of the pupil.

(iii) Diagnosis:

Formulating conclusions regarding the nature and causes of the problems expressed by the pupils is the major concern of this step.

(iv) Prognosis:

This step implies predicting the future development of the problem of client or pupil.

(v) Counselling:

This step indicates taking steps by the counsellor with the pupil to bring about adjustment in life.

(vi) Follow-up:

This step implies helping and determining the effectiveness of the counselling provided to the pupil or client.

Role of the counsellor in Directive Counseling:

The counsellor plays the vital role in this counselling process. He is the pivot of the process and the leader of the situation. The counsellor does most of the talking problems and individual is not the focus. The counselee in fact, works under the counsellor and not with him. The counsellor tries to direct the thinking of the counselee or client by informing, explaining, interpreting and sometimes advisingalso.

The counsellor collects all possible information about the pupils or counselees and analyses them for an adequate understanding. He summarizes and organizes the data so as to understand the abilities and limitations, adjustment and mal-adjustment of the pupils. He formulates conclusions about the nature and causes of his problems. He predicts the future development of his problems.

He prescribes what the pupil should do to solve his problems and follows the consequences or effects of his prescription. Directive counselling is also called the prescriptive counselling because the counsellor prescribes the solutions or the course of action for the pupils.

8.2.2 Non-Directive Counselling

In this type of counselling the counselee or client or pupil, not the counsellor is the pivot of the counselling process. He plays an active role and this type of counselling is a growing process. In this counselling the goal is the independence and integration of the client rather than the solution of the problem. In this counselling process the counsellee comes to the counsellor with a problem. The counselor establishes rapport with the counsellee based on mutual trust, acceptance and understanding.

The counsellee provides all information about his problems. The counsellor assists him to analyze and synthesize, diagnose his difficulties, predict the future development of his problems, take a decision about the solution of his problems; and analyses the strengths and consequences of his solutions before taking a final decision. Since the counsellee is given full freedom to talk about his problems and work out a solution, this technique is also called the "permissive" counselling.

Steps in Non-Directive Counselling:

The following steps are adopted in this counselling process:

1. The pupil or individual comes for help as the counselee.
2. The counsellor defines the situation by indicating that he doesn"t have theanswer but he is able to provide a place and an atmosphere in which the client orpupil can think of the answers or solutions to his problems.
3. The counsellor is friendly, interested and encourages free expression of feeling regarding the problem of the individual.
4. The counsellor tries to understand the feeling of the individual or client.
5. The counsellor accepts and recognizes the positive as well as the negative feelings.

6. The period of release or free expression is followed by a gradual development of insight.
7. As the client recognizes and accepts emotionally as well as intellectually his real attitudes and desires, he perceives the decisions that he must make and the possible courses of action open to him
8. Positive steps towards the solution of the problem situation begin to occur.
9. A decreased need for help is felt and the client is the one who decides to end the contract.

8.2.3 Eclectic Counselling

Eclectic counselling is a combination of directive and non-directive technique depending upon the situational factors. This approach in counselling is best characterized by its freedom to the counsellor to use whatever procedures or techniques seem to be the most appropriate to any particular time for any particular client. This counselling is one where one who is willing to utilize any procedures which hold promise even though their theoretical bases differed markedly.

Eclectic counseling is defined as the synthesis and combination of directive and non-directive counseling. It represents a middle status between the two extremes represented by the „non-directive" technique on one hand and the „directive" technique on the other. In eclectic counseling, the counselor is neither too active as in the directive counseling nor too passive as in the non-directive counseling. He just follows the middle path between these two.

In eclectic counseling, the needs of a person and his personality are studied by the counselor. After this the counselor selects those techniques, which will be useful for the person. The main techniques used are reassurance giving information, case history, testing etc. In eclectic counseling the counselor first takes into consideration the personality and need of the counselee. He selects the directive or non-directive technique that seems to serve the purpose best. The counselor may start with the directive technique. When the situation demands, he may switch over to the non-directive counseling and vice-versa. An attempt is made to adjust the technique to the requirements of the situation and the individual.

This counselling recognizes that each theory may contain some truth and that so long as a final decision between theories can"t be made practical necessity justifiably takes precedence over orthodoxy. The counsellor in this counselling may start with directive technique but switches over to non-directive counselling if the situation requires. He may also start with the non-directive technique and switches over to directive techniques if the situation demands.

So the counsellor in this counselling makes use of directive and non-directive counselling and also of any other type which may be considered useful for thepurpose of modifying the ideas and attitudes of the counsellee. Hence it is possible for the counsellor to alternate between directive and non-directive techniques depending upon the requirements of the situation.

It can be said that directive and non-directive counselling are at the opposite ends of the pole of guidance. It is eclectic counselling that bridges the gap between the two and makes adjustment between directive and non-directive techniques.

Features/Characteristics of Eclectic Counselling

This counselling has the following features or characteristics of it:

1. Methods of counselling may change from counselee to counselee or even with the same client from time to time.
2. Flexibility is the key note of this counselling.
3. Freedom of choice and expression is open to both, the counsellor and the client.
4. The client and the philosophical framework are adjusted to serve the purposes of the relationship.
5. Experience of mutual confidence and faith in the relationship are basic.
6. Feelings of comfort are essential.

Competence of the Counsellor in Eclectic Counselling

Eclectic counselling assumes high level competence and should never be used as a rationalization by the counsellor for indiscriminate use or neglect of particular procedures advocated in other philosophies. The competent eclectic counsellor is well acquainted with all other major theories of philosophies in counselling and uses this knowledge in choosing techniques and in the establishment of a positive working relationship with the client. A rejection of any philosophical framework is justified by the counsellor if he had a better way to achieve the task in hand.

The counsellor must be aware of the fact that problems differ from individual to individual. The counsellee or the pupil must be accepted as he is and attempts be made to understand him. Each problem must be treated as unique. All pre-conceived notions of dealing with all the counsellee"s personal problems in the same way should be discarded. The task of the counsellor is very difficult.

He has to shift and interpret all the matter that is available about the individual. The worker should take care in working with the pupils to be warm, co- ordinal, friendly, responsive and understanding but at the same time will be impersonal and objective. To be impersonal and objective, however he needs not to becold, indifferent or not interested

Eclectic Counseling is a combination of directive and non-directive counseling. In this counselor is neither too active nor too passive .Counselor studies the personality and needs of client based on the need of client.

Techniques used are:

Reassurance

- Giving information
- Case history
- Testing

Counselor starts with directive technique, then switches on to the non-directive technique. The counsellor bases his/her counseling on concepts taken from various available viewpoints.

According to Thorne, eclecticism is the most practicable and apt approach to counselling. Because no two people are able and as such no single theory of personality could explain the various behavioral pattern exhibited by individuals. So also each problem is unique in its content and intensity and a technique or approach suitable in one case need not even he effective in the second case. These suggest an approach which is tailor made to handle individual cases.

Steps in Eclectic counseling

The leading exponent of the Eclectic counseling Thorne, suggested the following in the process;

1. Diagnosis of the cause.
2. Analysis of the problem.
3. Preparation of a tentative plan for modifying factors.
4. Securing effective conditions for counseling.
5. Interviewing and stimulating the client to develop his own resources and to assume its responsibility for trying new modes of adjustment.
6. Proper handling of any related problems which may contribute to adjustment.

Assumptions of Eclectic Counseling

1. In general, passive methods should be used whenever possible.
2. Active methods may be used with specific indications.
3. In the early stages when the client is telling his story, passive techniques are usually the methods of choice. This permits emotional release.
4. Until simple methods have failed, complicated methods should not be attempted.
5. All counseling should be client centered.
6. Every client should be given an opportunity to resolve his problems indirectly. Inability of the client to progress through therapy as using passive methods alone is an indication for utilizing more directive methods.
7. Directive methods are usually indicated in situational mal adjustment where a solution cannot be achieved without co-operation from other persons.

Characteristic of Eclectic Counseling

1. In this, objective and coordinating methods are used.
2. In the beginning of counseling, client-active methods are used and the counselor remains passive.
3. In this, more importance is assigned to the job efficiency and treatment.
4. In this, the principle of low expenditure is emphasized.
5. In such counseling, for the use of all the methods and techniques, the professional efficiency and skill of the counselor are must.
6. Keeping in mind the need of the client, it is decided whether directive method or non-directive methods should be used.
7. Making an opportunity available to the client is insisted so that he may find himself the solution of the problem.

Disadvantages of Eclectic Counseling

1. Some people are of the view that eclectic counseling is vague, opportunistic and superficial.
2. Both directive and non-directive counseling cannot be mixed together.
3. In this, the question arises how much freedom should be given to the client? For this there is non-definite rule.
4. The problem with an eclectic orientation is that counselors often do more harm than good if they have little or no understanding about what is helping the client.

Hierarchy of Eclectic Practices McBride and Martin advocate a hierarchy of

eclectic practices and discuss the importance of having a sound theoretical base as a guide. The lowest or first level of eclecticism is really syncretism – a sloppy unsystematic process of putting unrelated clinical concepts together. It is encouraged when graduate students are urged to formulate their own theories of counselingwithout first having experienced how tested models work. The second level of eclecticism is traditional. It incorporates "an orderly combination of compatible features from diverse sources harmonious whole". Theories are examined in greater depth. On a third level, eclecticism is described as professional or theoretical or as theoretical integration. This type requires that counselor master at least two theories before trying to make any combinations. A final level of eclecticism is called technical eclecticism. In this approach, procedures from different theories are selectedand used in treatment.

F.C. Thorne, who is the exponent of this view, finds that it is possible for a counselor to alternate between directive and non-directive methods even in the same interview without disrupting the non-directive permissive relationship with the client. He selects the techniques according to the requirements of the situation and the individual. The counselor must be competent and proficient in the use of all available methods. The validity of the results is determined by the skill with which any method is used. The critical factor is not what method is used but rather the skill with which it is used.

8.3. COUNSELLING SKILLS

Meaning and History of Counselling Skills

A skill is generally known to be the knowledge and ability that enables one to do something well which requires special training. Shukla (2005) defines skill as the capacity to perform particular tasks or to achieve particular goals, often required through long periods of training and practice. He maintains that skills are usually thought of in term of perceptual, perceptual-motor and mental skills. Skill is therefore an ability to perform a task or activity through required steps in a proper sequence.

Counselling is a helping relationship to assist individuals with academic or personal problems that interfere with their lives, which requires special and differing skills due to individual differences. According to McLeod and McLeod (2011), the idea that psychological processes and interpersonal behaviour can be viewed as skills can be traced to the 1950"s. During the period, psychologists came up with the idea ofbreaking down each task or function into a set of component skills, which could be learned separately and then build up into the final complete task sequence (McLeod &McLeod, 2011). They maintained that the model of skill that emerged emphasized the sequence of actions that the operator needed to go through, and the operator"s attention to feedback around whether each operation had been effective in achieving its intended goals. Counselling skills are therefore processes or acts of making sense of how to facilitate people in any walk of life to make a difference to the lives of individuals. It involves the process of breaking down each task or function of counselling into a set of component skills, which could be in form of task sequence to achieve a particular counselling goal. Hence, counselling skills are activities that come into play in the process of using various methods and strategies during counselling sessions. Counselling skills are key facilitators of counselling relationships.

Within the field of counselling, the late 1940s and 1950s saw a vast expansion of the psychological therapies in the USA, largely stimulated by the need to respond to mental health problems in returning service personnel (McLeod & McLeod, 2011).

Prominent among the skills developed then were directed towards client centered therapy, popularized by Carl Rogers. Hence, the emergence of nondirective, empathy and unconditional regard as formidable counselling skills as practiced today owe their root to the work of Rogers and others. With more therapists emerging, there are several counselling skills which practicing counsellors and counsellors in training ought to be conversant with. According to McLeod and McLeod (2011), all of severalof such skills were inspired by the work of Charles Truax and Robert Carkhuff. They reasoned that counselling skills will enable clients to be guided through a series of learning or skill-acquisition activities instead of handing them down a mere treatment procedure to their mental health problems.

8.4. TYPES OF COUNSELLING SKILLS

There are various types of counselling skills as there are various problems, theories, methods, techniques and strategies of counselling.

McLeod and McLeod (2011) list core counselling skills as attending, attunement, bodily awareness, boundary management, caring, challenging, checking out, naming, observing, offering feedback, process monitoring, providing information, questioning, reflecting, restating, reframing, remembering, self-disclosure, self-monitoring, structuring, using silence and witnessing. These skills are not mutually exclusive as several of them are interwoven and interrelated.

Listening Skill:

The first skill to be acquired by any practicing counselor is the listening skill. This involves paying attention to every statement involving body movement or sign that a client makes in a counselling encounter. Listening skill is a crucial skill that helps to establish core conditions of counselling like openness, trust, self- confidence, love and worthiness or belongingness. The counselor in the process of listeningattentively to his clients‟ presentations indulges in paraphrasing his statements, perception checks, reaction to sudden body movement, non-judgmental statements, restatements and clarifications. These are things that ensure the client that his/her counselor is responsive, empathic, and listening to his/her problems with a view to finding solutions that are appropriate. The counselor should avoid what the client did not say or omit what he/she said.

With any relationship, listening skills are needed to show that the counselor understands and interprets the information that their client gives them correctly. The counselor should do this by showing attentiveness in non-verbal ways, such as: summarizing, capping, or matching the body language of their clients.

Counsellors not only listen to the words spoken by the clients but also to the feelings, facial expression, emotion, gestures, and the unspoken thoughts of the clients. This means, when the client speaks the counselor must give full attention. Active listening is essential for arriving at an objective assessment of the client‟s problem and determining appropriate strategies for starting the healing process.

Attending Skill

In the counselling process, listening and attending skills go together. Active listening is possible only when the counsellor gives total attention to the client. Total attention giving behavior of the counsellor means using body language, facial

expression, eye contact, head nod and such other non-verbal expressions. If the counsellor is attending to phone calls, writing on the note pad, not looking at the client, sitting away from the client with crossed arms, showing no facial expression or such other cues would be perceived by the client as devaluing him/her. Leaning forward towards the client indicates an attending gesture. On the other hand, if the counsellor sits or leans too closely, the client may feel intimidated and withdraws instead of opening about the problem.

Questioning Skill:

This skill is basic and formidable skill of counselling relationships, which promotes greater client disclosure. There are two types of questioning: open-ended and close-ended questioning. In counselling, open-ended questioning seeks to elicit information from clients using "how" and "what" instead of "why". Open-ended questions can be answered in one word or in a phrase. The client is made to progress from generalizations to specifics with more detailed information and clarity of points. At the onset of counselling, an open-ended question can lead a client into telling a story in his/her own way. In a situation whereby a counsellor is interested in knowing the birth order of his/her client, he she can ask his client to him about his family. The close-ended question on the other hand places a lot of restriction on clients‟ responses and statements about his problems. In this case, the client supplies only the needed answer as required unlike in the open-ended questioning where the client provides the required answer and goes ahead to supply other information that might be useful later.

Counsellors ask questions for fact finding and engaging with the client. Fact-finding questions are used for collecting data such as age, occupation, family status etc. regarding a new client. Open-ended questions help in engaging and establishing a relationship with the client. Open-ended questions are used to elicit a response from the client, probe and expand a response given by the client or explore deeper into the client‟s problem.

Summarization Skill:

This is the ability to pick major points of a conversation to bring about corrections or confirmation of information. This is an important counselling skill as it assures the counsellees that the counselors usually hear the correct content of their problems. Summarization skill encourages clients to probe their points by themselves.It can be used in the beginning of a counselling session to bring a synergy between the previous counselling session and the current one or to reflect on the problem earlier presented by the client(s). Also, summarization can be applied in-between counselling sessions or midway into a counselling relationship to remind the counsellor and his client of what they have done so far or at the end of a counselling session to mark the end of the session.

After listening to a series of statements or at the end of a session, the counselor summarizes the content presented by the client. Through summarizing, the counsellor attempts to find out if s/he has properly understood the frame of reference of the client and also helps the client to place his/her problem in perspective.

Reframing Skill:

This is a skill used by counselors to give alternative statements or perspectives of what clients say. Reframing is used to keep clients at alert and to challenge their cognitions. Through positive or negative alternative expressions of what a client has said, the counsellor can manipulate the information presented. The counselor might

decide to reframe a client"s statement in a neutral version but in the end, the client is led through to full meaning and awareness of his problem. The client is also encouraged to explore the values of what he has said. For instance, a client might state that his major problem in school is distraction from friends during prep classes. In response to this, the counselor might reframe the statement by saying, "Your friends distract your studies and perhaps cause you to perform poorly in assessments".

Paraphrasing Skill:

Paraphrasing counselling skill is the ability to respond to client"s statements while expressing their problems in phrases. The counsellor uses phrases to build,blend and facilitate what the client says. It involves what the client has said and what he intends to say. This skill gives clients confidence and assurance that the counsellor is actively involved in their problems by listening attentively. Through this the clients correct misconceptions about certain information given about problems presented. One good thing about paraphrasing skill is that it facilitates reflective thinking, feelings and processing of information during counselling sessions. Additionally, it gives clients feedback and room for further exploration of thoughts and feelings. Like reframing skill, it enables clients to be led through feelings and cognitive challenges.It clarifies clients" problem-statements with a view to bringing a clearer picture of their intentions.

This technique will show clients that the counselor is listening to their information and processing what they have been telling them. Paraphrasing is also good to reiterate or clarify any misinformation that might have occurred.

Empathy Skill:

This is otherwise called reflection of feeling skill where the counsellor demonstrates to his/her clients that he/she is aware of their feelings and emotions. It covey"s the counsellor"s understanding of the clients" problems and feelings.

According to Onah (2002), empathy implies an attitude in which the counsellor is able to sense the hurt or pleasure as another person sees it; to perceive the causes of a client"s problems as he perceives them, but without ever losing the recognition that it is "as if" he was the person involved. She/he maintains that empathy facilitates counselling as it conveys to the client the message that much value is placed on him/her and that the feelings and meanings which he/she attaches to his experiences are respected and worth attending to. This no doubt makes a client in a counselling relation to feel a sense of belonging, reassurance, love and relaxation. In applying empathy skill, the counsellor needs to let his client understand that he too feels theway he, the client feels about his experience. If a student reports to his/her counsellor that he/she often feels rejected by his classmates, the counselor can respond bysaying, "it is like you are feeling lonely and isolated each time you are in the class" or "it sounds as if you are yet to make friends in your class".

This refers to the counsellor"s ability to sense what the client is feeling, experiencing and thinking. Empathic skill involves the use of attending, listening and interpersonal sensitivity of the counsellor.

Immediacy skill

Immediacy refers to the counsellor disclosing feelings about the client or the therapeutic interaction at that moment as it happens. For example, after listening to a student who suffered sexual abuse, the counsellor may share his/her feeling towards the student:

Counsellor: "*I appreciate you trusted me with one of the most traumatic experiences of your life. And I respect your courage for confronting the problem*".

Self-disclosure

This refers to the counsellor stating feelings about a similar situation as the clients presently in. For example, the counsellor disclosing to a student seeking help for dealing with public speaking phobia:

Counsellor: "*When I had to speak before the class, I used to stutter".*

The skills of self-disclosure and immediacy are closely associated. Self-disclosure promotes immediacy in your relationship with the client. Self-disclosure intervention should be used in appropriate context and time only. Self-disclosures should have the following features.

- *It should be concise.*
- *It should be devoid of self-indulgence.*
- *It should be used very conservatively.*

The counselor will make note when personal information is disclosed at certain points of therapy. This technique will help the counselor learn more about the client and use this information only to benefit them.

The counselor shares personal feelings, experiences, or reactions to the client. Should include relevant content intended to help them. As a rule, it is better to not self-disclose unless there is a pressing clinical need which cannot be met in any other way. Remember empathy is not sharing similar experiences but conveying in a caring and understanding manner what the client is feeling and thinking

Reflection of Meaning Skill:

This suggests attentiveness or intense listening with emphasis on literal meaning of clients‟ problems or experiences. This skill enables the therapist to understand the client‟s major concern, mood, feelings and expectations while it enables the client to learn that the therapist has heard not only the surface of his experience but also the inner or deeper meaning of it. The skill of reflection of meaning as a facilitator of counselling conveys information about clients‟ experience as well as the counsellor‟s perceptions of his situation.

This is restating or rewording the content (what is said by the client) back to the client. This should not be mere parroting the words back to the client. Paraphrasing involves reflection of the content and feelings of the client. Paraphrasing and reflection help in confirming with the client if the counsellor has understood the problem as narrated by the client.

Capping Counselling Skill:

This skill is similar to, but different from the skill of reflection of feelings (empathy). Here, the counsellor tries to move his/her client along from emotion-laden situations to cognitively restructured situations. She/he engages his/her clients in discussions that task their cognitions in order to realize themselves. The counsellor can introduce humor here but must be very careful, plain, sincere and natural in the counselling relationships. The counsellor‟s attribute of genuineness comes to play in this regard as whatever he/she says and feels must be reliable and the same over time.

Skills are acquired through training during the process of counsellor education in various training institutions. These are feelings, attitudes and competences acquired or internalized to assist clients in solving their problems which if applied appropriately, enable clients to feel relaxed, worthwhile and open during counselling sessions

Counselling is an extension of the helping relationship and the positive outcomes of the process depend largely on the helper. The counsellor"s personal as well as professional qualities influence the counselling process. Self-awareness, understanding of others, the ability to relate to others, academic training, and a set of professional skills are essential qualities of a counsellor. In this section, we will focus on the professional skills required to be an effective counsellor.

8.5. SUMMARY

Skills are attitudes and abilities employed in the process of achieving a task. Counselling skills are therefore facilitating abilities acquired by counselors to enable them solve their clients" problems. Such counselling skills range from listening, questioning, summarization, reframing, paraphrasing, empathy, reflection of meaning to capping counselling skills which are all discussed in this unit. To be successful counsellors therefore, it is important that counsellors in training should be equipped with several counselling skills that they can use when they are in counselling relationships with their clients

8.6. KEY WORDS

Attending, Reflecting, Paraphrasing, Self-Disclosure

8.7. SELF ASSESSMENT QUESTIONS

1. Explain in detail the Directive and Non-Directive Counselling Techniques
2. Discuss the Eclectic counselling technique
3. Lucidly explain the types of Counselling Skills

8.8. REFERENCE BOOKS

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LESSON-9
COUNSELLING AS A HELPING RELATIONSHIP – EMPATHY AS THE KEY TO COUNSELLING PROCESS

STRUCTURE

9.1. Introduction
9.2. Meaning and Definition
9.3. The Art and Science of Helping
9.4. Characteristics of a Counseling Relationship
9.5. Meaning and Definition of Empathy
9.6. Difference between Empathy and Sympathy
9.7. Uses for Empathy
9.8. Empathy across Counselling Theories
9.9. Scale to Measure Empathy
9.10. Types of Empathy
9.11. Empathy Barriers
9.12. Summary
9.13. Key words
9.14. Self Assessment Questions
9.15. Reference Books

9.1. INTRODUCTION

For many people within the social professions – social work, youth work and community work (Banks 2004: 1-3) – the notion of helping is tied up with counselling and guidance. People having to deal with difficult situations and choices, worrying feelings and/or a sense of having missed opportunities may well feel they needsomeone to listen and to assist them to make sense of what is going on, and to move on. Sometimes it will be others who judge that it is in the best interests of people that they receive such „help‟.

Gerard Eganhas argued that it involves two basic goals. Each of these is based in the needs of the person seeking help. The first relates to those they are helping to manage specific problems. It is to „help clients manage their problems in living more effectively and develop unused or underused opportunities more fully (1998: 7). The second helping goal looks to their general ability to manage problems and develop opportunities. It is to help „clients become better at helping themselves in their everyday lives‟ (Egan 1998: 8).

9.2. MEANING AND DEFINITION

Helping involves listening and exploring issues and problems with people; *and* teaching and giving advice; *and* providing direct assistance; *and* being seen as people of integrity. (Smith and Smith 2008: 14)

Helpers are concerned with learning, relationship and working with people to act on their understandings. However, they also step over into the world of counselling. They do this by being experienced as a particular kind of person and drawing upon certain skills, not by taking on the persona of counsellor (British Association for Counselling and Psychotherapy 2002; Higson 2004).

To reword Parker Palmer (2000: 11) good helping is rather more than technique;it comes from the identity and integrity of the helper‟ (Parker Palmer was talking about teaching). This means that helpers both need to know themselves, and seek to live life as well as they can. They need to be authentic.

Smith and Smith (2008) argue that helpers also need certain other qualities. When people search for someone to help them reflect upon and improve their lives, they tend to be drawn into relationship with those who are seen or experienced as caring, committed and wise. They are liable to look around for help from people whom they can approach easily and with confidence. They ask people they know who they would recommend and/or approach those they already know to offer helping relationships.

Rogers' Definition of the Counselling Relationship

According to Rogers (1942) the counselling relationship is comprised of:
Warmth, responsiveness, & unconditional positive regard, Freedom from judgement, pressure or coercion

"The skilful counsellor refrains from intruding his own wishes, his own reactions or biases, into the therapeutic situations".
"Advice, suggestion, pressure to follow one course of action rather than another - these are out of place in therapy".

Permissiveness regarding emotional expression
Once a relationship has been built, the client will feel free to express any emotion or thought.

Boundaries
Rogers notes that counsellors must maintain boundaries, such as ending sessions on time or intervening if a client imminently threatens another person.

Rogers believed that clients seek counselling as a result of incongruence. For example, when a client becomes aware that some aspects of what they are feeling and experiencing inside are incongruent with how they are presenting to the outside world. The counsellor then strives to be congruent in relation to the client through genuineness, honesty, unconditional positive regard, and communicating an empathetic understanding of the client‟s situation. If the client perceives the counsellor as being empathetic, then the proper conditions are created for the client to begin to become more congruent and actualized.

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

two individuals”. Shertzer and Stone (1971) have described the helping relationship as “the endeavor, by interaction with another person to contribute in a facilitating positive way to his improvement”. Rogers (1961) defines the helping relationship as one “in which at least one of the parties has the intent of promoting the growth, the development, maturity, improved functioning, and improved coping with life of the other”.

'Counselling' is a word used by many to describe what they do; dictionary definitions stress advice and mental exchange of ideas. H.B. and A.C. English in A Comprehensive Dictionary of Psychological and Psychoanalytical Terms define counselling as "a relationship in which one person endeavors to help another to understand and to solve his adjustment problems" - whether educational, vocational or personal. There are, however, different definitions of counselling which reflect some of the subtle differences that have been emphasized or have evolved over the years. Hence "Counselling is an interaction process which facilitates meaningful understanding of self and environment and results in the establishment and/or clarification of goals and values for future behaviour". In the security of the counselling relationship, the clients are able to explore the dynamics and interrelationships among their feelings, their values, their perceptions of others, their interpersonal relationships, their fears, and their life choices. From this exploration comes insight, self-understanding, role clarification, planning and changes in behaviour

Unconditional positive regard, also called acceptance is essential as it plays a role in creating a helping relationship in which the client feels safe to express any negative emotions or thoughts, paraphrasing and reflection of feelings, as well as non-verbal skills such as body-language and active listening are all used in order to allow the client to introspect and work with their problems in a safe environment, the role of the counsellor within the relationship being to support the client and help them to reach their true potential by expressing emotions and thoughts that they can"t express outside of the helping relationship, whether it be for fear of rejection or some other reason.

Every client is not the same. Each one brings with them not only their own issues but their own heritage and cultural background that influence their belief system, values and ideas that may be foreign to the therapist. A challenge that the therapist may face is in understanding how they feel about dealing with a person with a belief system different from their own. “Effective helpers come to understand the personal cultures of clients” (Eagen, 2002) and therefore should spend some time searching their own personal beliefs and values. A counsellor"s personal beliefs and value systems can influence the interactions that they have with their clients. Eagen (2002) speaks to this interaction and goes on to say that “understanding clients" different approaches to developing and sustaining relationships is important” knowing where one stands in their personal beliefs and being sensitive to those differences helps the counsellor enter the relationship without judgment to value and respect the individual.

A counsellor"s job is to listen to the client. To listen to not only what is being said, but by how it is said. Subtleties or changes in tone of voice, cadence, and body language all help the client to share their story. The therapist may find that the client is using emotional communication; or emotional language. This can contain both positive and negative feelings. Having an understanding that feelings are more than what is being said, “Familiarity with feeling synonyms can enhance . . . perception of the client"s emotional state” (Knapp, 2007).

The use of empathy, allows the client to understand that the counsellor is present and really focused on what is being said while validation and normalizing communicates to the client that they are in their own way unique, but not so unique that they are alone in whatever may be going on for them.

9.3. THE ART AND SCIENCE OF HELPING

One of the important issues discussed in counseling and psychotherapy is whether counseling is an art or a science. If it is an art, then it becomes part of the counselor"s innate affective and relational qualities. If it is a science, then it refers to the skills that the counselor has developed as a result of the training that he or she has taken in counseling. Such a skill seeks to spell out the process in the treatment so that others can utilize the same practices. In order to say that counseling is a science, it needs research based evidence in regard to its effectiveness in treating a client"s problem. There are a number of research studies that have shown that the counseling process as is being practiced is effective in treating the client"s problem. However there are also research evidences that show the contrary. Hence the question keeps cropping up whether counseling is an art or a science. The answer is that it is both. Counselors need to have key affective qualities and helping skills, knowledge of and competencies in the core functions, familiarity with legal and ethical issues, and grounding in various theoretical frameworks. Most importantly, they need to be able to establish a helpful therapeutic alliance with clients.

A good working relationship is the heart of effective counseling. The non-specific factors that contribute to this alliance are: 1) having a time/safe place to talk 2) feeling understood 3) a meeting of the minds 4) a sense of encouragement, coaching, teaching What does not work in counseling is attributing failure to the client, arguing with the client, passivity, hostility, negative confrontations, mechanical responses, and ignoring the client"s feelings. Fundamental to the therapeutic relationship is the client"s perception of that relationship. It is not how the counselor sees it, but how the client sees it. Is the counselor meeting the client at their stage of readiness? In what ways does the client gain hope of recovery from the counselor?

9.4. CHARACTERISTICS OF A COUNSELING RELATIONSHIP

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

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

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

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

relationship.

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

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

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

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

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

Time and again, research has shown that a handful of common factors cut across all of these theories to determine effectiveness in helping people:

1. Sustaining a strong relationship between the helper and client
2. Increasing the client"s enthusiasm and expectations that help is possible
3. Augmenting the client"s sense of capableness
4. Providing new learning experiences for the client
5. Regulating emotional arousal and expression
6. Providing occasions to practice new behaviours

According to Carl Rogers, one of the most prolific scholars in the art and science and psychotherapy, a therapist can achieve this by exhibiting three conditions:

Congruence. This is basically being genuine and consistent in one"s thoughts, feelings, and actions when interacting with a client. In other words, the therapist should be real.

Positive regard. This doesn"t mean that therapists have to like every client the same way they like and want to spend time with their friends and family. Instead, the therapist should respect and accept every client in all of his or her humanness, even if the therapist does not agree with all of the client"s actions.

Empathy. This is not the same as sympathy, which implies pity. Instead, empathy is a

true appreciation and effort to understand what the client is experiencing, particularly regarding the client"s feelings and worldview.

9.5. MEANING AND DEFINITION OF EMPATHY

Empathy is the ability to recognize and relate to other people"s emotions and thoughts. Empathic thinking is often characterized as the willingness and ability to place oneself in another person"s situation, to feel another person"s feelings, or to recognize that another person might experience feelings in the same way as oneself. Empathy on the part of the therapist for those in therapy is also an important characteristic of therapeutic relationships.

Empathy in counselling is about the counsellor seeing the client"s world as they see it.

Empathy is to respectfully perceive what the client is bringing from their frame of reference and to communicate that back in a way that makes the client feel they"ve been understood.

The empathic circle is only complete when the counsellor is able to communicate her understanding back, in such a way that the client feels they have been heard and understood. "Providing a therapeutic relationship will always involve deep caring, respect and empathy for the anxiety and suffering of another human being" (Cochran & Cochran, 2015, p. 17). And yet, expressing empathy within a counseling session involves more than just words; the counselor must communicate a deep understanding and display a personal connection with the client. It requires more than providing solutions. Focusing too early on what a counselor, can do to address the clients" problems may get in the way of sharing experiences and showing empathy. Empathy reflects an ability to understand and feel the client"s world "as if" stepping into the client"s shoes and the communication of that experience to the client (Barrett-Lennard, 1962).

The American Psychological Association confirmed that empathy, defined asa "sensitive understanding of the patient"s feelings and struggles; seeing them fromthe patient"s point of view," is one of several factors crucial to a strong therapeutic alliance (American Psychological Association, 2019).

Empathy is vital for all our valued relationships. Positive psychologist Tim Lomas and colleagues describe it as "the ability to communicate understanding of another person"s experience from that person"s perspective" (Lomas et al., 2014, p. 159).

The *Oxford Handbook of Positive Psychology* also recognizes its value in making lives worth living, defining empathy as "another oriented emotional response elicited by and congruent with the perceived welfare of someone else" (Snyder, Edwards, Marques, & Lopez, 2021, p. 418).

Rogers (1957) defined authentic empathy in the following way: Empathy is the ability to perceive the client's world as your own, without losing the "as if" quality and it appears to be vital to therapy. The situation we're attempting to express is the ability to perceive the client's rage, fear, or perplexity as if it were your own, but without becoming entangled in it. When the client's environment is like this, if the therapist's environment is clear to him and he is free to move around in it, he can both

express his comprehension of what the client knows and speak meanings in the client's experience that the client isn't aware of. Rogers' notion of empathy reflects a depth of knowledge of the client's situations and feelings that goes beyond introspective remarks, as seen by his definition.

Empathy is a natural response to being with another person. “Emotional empathy is responding to another‟s feelings” (Young, 2002). Empathy facilitates connections with a client because it shows that the therapist understands the person‟s viewpoint. It is an important part of the therapeutic process and is seen as “a basic value that informs and drives all helping behaviour” (Eagen, 2002). The use of empathy, allows the client to understand that the counsellor is present and really focused on what is being said while validation and normalizing communicates to the client that they are in their own way unique, but not so unique that they are alone in whatever may be going on for them. For example, a client comes into therapy stating that her son‟s constant negative reactions to her requests are beginning to make her feel like a failure. An empathic response would be to reflect back to the client what has been said, because the counsellor has listened to the experience and can reflect the emotion while describing the feeling, allowing the client to feel heard and understood.

9.6. DIFFERENCE BETWEEN EMPATHY AND SYMPATHY

Sympathy is different from empathy. Sympathy means we *feel sorry for someone* and empathy means we try to *fully understand how it feels for that person*. Feeling sorry for a person is not therapeutically useful, but empathy is as it shows the person we truly understand what they are going through. Empathy means having the ability or willingness to understand and reflect back the feelings of another. Sympathy means to feel pity and sorrow for someone else‟s misfortune.

Having the willingness to listen and seek understanding is the key to expressing empathy. When a person is hurting what they truly want is a friend who will acknowledge their pain and show that they are willing to listen and help, if needed. Empathy lets others know there are others who have had similar feelings and they are not alone. It helps people move toward resiliency. Most people clam up or shy away from people going through pain, sorrow or grief and resolve to expressing sympathy, rather than empathy.

9.7. USES FOR EMPATHY

Being able to experience empathy has many beneficial uses.

Empathy allows you to build social connections with others.

By understanding what people are thinking and feeling, you are able to respond appropriately in social situations. Research has shown that having social connections is important for both physical and psychological well-being.

Empathizing with others helps you learn to regulate your own emotions.
Emotional regulation is important in that it allows you to manage what you are feeling, even in times of great stress, without becoming overwhelmed.

Empathy promotes helping behaviors.
Not only are you more likely to engage in helpful behaviors when you feel empathy for

other people, but other people are also more likely to help you when they experience empathy.

9.8. EMPATHY ACROSS COUNSELLING THEORIES

The notion that the construct of empathy within the counselor-client interaction extends in some way across counselling theories, as Rogers hypothesized, has received a lot of support from research and theorists (Rogers, 1957). Relationship elements that match the idea of empathy are included in the body of literature regarding the common factors of counselling that appear across theoretical approaches. Empathy is also a key component of the therapeutic partnership.

Client-centered (Glauser & Bozarth, 2001; Hartley, 1995; Rogers, 1957) and existential theories (Hartley, 1995) both place a strong emphasis on counsellor empathy (Bohart & Greenberg, 1997; Duan & Hill, 1996; Eagle & Wolitzky, 1997; Hansen, 2000; Hartley, 1995; Henry et al., 1990), and psychoanalytic theory (Bohart & Greenberg, 1997; Duan & Numerous studies on empathy and related topics have also been conducted. associated constructs in psychodynamic therapy (Harriest, Quintana, Strupp, & Henry, 1994; Henry et al., Gestalt therapy (Pearson, 1999), and behaviour therapy (Harriest, Quintana, Strupp, & Henry, 1994; Henry et al., 1990).

Warmth, accurate empathy, and authenticity, according to Beck, Rush, Shaw, and Emery (1979), are significant contributors to counsellor efficacy in cognitive therapy. These constructs, according to Beck et al., are necessary but not sufficient for optimal therapeutic impact. They claim that "accurate empathy improves therapeutic partnership" by assisting the therapist in "making sense of the patient's unproductive actions and being less judgmental about them". Empathy, according to Beck et al., has both an intellectual and an emotional component. Empathy's role in cognitive therapy has also been studied by other researchers (Pearson, 1999; Persons & Bums, 1985).

Ellis's (1996) rational emotive behaviour therapy (REBT), a cognitive-behavioral therapy, highlighted Rogers' idea on the importance of the client-counselor interaction. REBT therapists, according to Ellis, are dedicated to assisting clients in overcoming their difficulties. Unconditional favorable esteem, in the sense that. Rogers' theory defines what is delivered to customers and how it is modeled for them. REBT therapists, according to Ellis, go a step further by actively and directively teaching clients how to unconditionally love themselves.

The therapist uses the client's relationship as a vehicle to teach him or her how to better relate to others. Although Ellis did not directly mention an empathetic experience of the client's environment, Rogers' essential requirements of unconditional positive regard and sincerity are defined in his REBT theory (Ellis, 1996). Empathy was a crucial concept for relational theorists (Gibson & Myers, 2000;Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Jordan (1991) penned the following:

Individuals suffering from a variety of falsifications and distortions of their self-perceptions seek ways to be recognized and understood, as well as to provide that for others. In the therapeutic interaction, feelings and actions that have been suppressed to avoid suffering or intensified to achieve approval can begin to emerge again. Through the improvement of empathy, therapy provides an opportunity to expand relational presence.

Relational therapists promote self-empathy and see empathy as a two-way process between the client and the counsellor that encourages the client to have a "corrective relational experience" (Jordan, 1991, p. 287). Empathy's use in constructivist and postmodern counselling theories demonstrates the concept's ubiquity in the field. According to proponents of responsive therapy and motivational interviewing (Gerber & Basham, 1999), counsellor empathy is an essential component of both theories, and solution-focused short treatment (Watts & Pietrzak, 2000) also relies on the concept of empathy. Empathy is mentioned frequently in the literature on multicultural counselling methods as an important component of the therapeutic relationship (Patterson, 1996).

These examples support Rogers' (1957) claim that his key conditions, particularly empathy, may be applied to a variety of counselling theories, including new views. Despite the fact that empathy is not a major component of every theory, there is significant evidence that it is particularly effective in the client-counselor connection.

9.9. SCALE TO MEASURE EMPATHY

Several scales have been developed to measure empathy. The Empathy Quotient test, for example, can measure how easily one picks up on the feelings of others and how much one is affected by those feelings. This test shows that women typically have greater empathy than men, and that those with Asperger‟s or high-functioning autism typically demonstrate a lower capacity for empathy.

Another test, Carkhuff‟s five-point scale, can be applied to all human relations, but it is effective at measuring the use of empathy by therapists in session. It is based on observable behavior and attempts to eliminate the ambiguity of previous scales.

Level 1 (nonempathic behavior): The therapist responds in a way that ignores the message of the person in treatment.
Level 2 (nonempathic behavior): The therapist attempts to understand and respond to the message but does so in a way that lessens the impact.
Level 3: The therapist responds to a stated message and surface expressions but ignores or is unable to hear the implicit message and feelings of the person in treatment. This may be an appropriate response at times, but if a therapist always responds at this level, he or she is generally not expressing deep empathy.
Level 4: The therapist‟s response adds to what the person has said, demonstrating that the therapist has understood both what was said and what may have been only implied.
Level 5: The therapist understands what the person in treatment meant, and the therapist‟s response adds to what the person has said in such a way that he or sheis able to accurately expand upon the person‟s thoughts without beginning to interpret or suggest new explanations.

9.10. TYPES OF EMPATHY

Empathy is multidimensional, involving both cognitive and affective processes (Duan & Hill, 1996).

Cognitive empathy

Improves our ability to communicate because it focuses on what the other person may be thinking. Researchers have defined cognitive empathy as “intellectually taking the role or perspective of the other person” (Gladstein, 1977) . Cognitive empathy entails being able to comprehend another person's psychological condition and what they could be thinking while going through thesame experience.

Cognitive empathy is the second type of empathy. This refers to a person's ability to recognize and understand the emotions of others. According to Hodges and Myers, cognitive empathy entails "having more full and accurate knowledge of the contents of another person's mind, including how the person feels." Cognitive empathy is more akin to a skill: humans learn to detect and understand the emotional states of others as a means of processing their own emotions and behaviors. While the specific mechanism through which people experience empathy is unknown, there is a growing corpus of research on the subject.

Emotional empathy

Emotional or „affective empathy‟ is our capacity to share what the other person is feeling. Taking on another‟s emotions can help us build stronger emotional connections with them. Affective or emotional empathy is a vicarious emotional response to the emotions of another person (Mehrabian & Epstein 1972). Affective empathy is defined as the ability to understand and respond appropriately to another person's feelings. Such fervent comprehension could make someone anxious for someone else's well-being, or it could make them feel agony in their own body.

According to Hodges and Myers, Emotional empathy is made up of three parts. "The first is sharing an emotion with another person... The second component, personal distress, refers to one's own distress as a result of witnessing another's suffering... "The most usually related with the study of empathy in psychology is the third emotional component, experiencing compassion for another person," they explain. It's vital to remember that the suffering experienced as a result of emotional empathy doesn't always reflect the other person's experiences. While empathic people are distressed when someone falls, they are not in the same bodily pain as the person who has fallen, according to Hodges and Myers. When it comes to issues about compassionate human behavior, this form of empathy is extremely important. There is a link between experiencing empathic concern and being eager to assist others. According to Hodges and Myers, "many of the noblest examples of human action, such as assisting strangers and stigmatized persons, are regarded to have empathic roots." The question of whether the desire to help is motivated by altruism or self- interest continues to be debated.

Compassionate empathy

Compassionate empathy or „empathic concern‟ is about helping the other person take the actions required to move forward. It might be about the client adopting coping mechanisms or working together to set goals.

Affective empathy from the counsellor appears to help clients develop better self-awareness and is crucial in the early stages of counselling (Gladstein, 1983), whereas cognitive empathy helps a counsellor communicate empathic understanding to the client. Both cognitive and affective components of empathy seem to be important for optimal counselling to take place. However, the counsellor‟s affective response (e.g. a gut feeling of anxiety) must also be managed such that it leads to a productive cognitive response (e.g. reflecting a feeling) which must be cultivated to provide effective

counselling services. In order to understand the client‟s world better and avoid judging him or her, the counsellor

9.11. EMPATHY BARRIERS

Empathy can be as limited by what we do as much as what we do not do:

1. Cognitive Biases

Sometimes the way people perceive the world around them is influencedby cognitive biases. For example, people often attribute other people's failures to internal characteristics, while blaming their own shortcomings on external factors. These biases can make it difficult to see all the factors that contribute to a situation. They also make it less likely that people will be able to see a situation from the perspective of another. How people perceive the world that surrounds them is influenced to a greater degree by many cognitive biases which make it difficult to see all the numerous factors that have created that specific situation. It is a common barrier to empathy and makes it difficult for a person to see a situation from the perspective of another person

2. Dehumanization

Sometimes, when another person has suffered a terrible experience, people make the mistake of blaming the victim for their circumstances. This is the reason that victims of crimes are often asked what they might have done differently to prevent the crime.

This tendency stems from the need to believe that the world is a fair and just place. It is the desire to believe that people get what they deserve and deserve what they get and it can fool you into thinking that such terrible things could never happen to you.

If a person is somehow different from others then people consider him an outcast and their way of looking at him and seeing things also become different. As

the other person is not feeling and behaving as he does that does not mean that he should be treated differently. The different perspective proves a barrier to empathy.

3. Victim Blaming

It is a basic human tendency to blame the victim instead of the person who has committed the crime. This is especially seen in rape cases where the rape victim has to go through terrible shame as if it was her fault. People need to rise above such tendencies as this mindset will always prove a barrier to empathy.

4. Quietening our minds

Unless we quieten our minds during client sessions, our thoughts will impede forming empathic therapeutic bonds. Practicing mindfulness can help us focus on the client‟s feelings and experiences rather than our inner chatter and self-doubt (Cochran & Cochran, 2015).

5. Inappropriate reflection

Repeating back to your client what you have understood is important. “When you feel strong emotion hit you from your client, let that be the prompt to reflect” (Cochran & Cochran, 2015, p. 43; Nelson-Jones, 2014).

6. Worrying

The therapeutic bond is vital in counseling. Yet, time spent wondering if the client likes us will not help reach a positive outcome – indeed, it may get in the way of building and maintaining empathy. After all, if your client is eager to share, they most likely already respect and value the bond created (Cochran & Cochran, 2015; Nelson- Jones, 2014).

9.12. SUMMARY

A professional helping relationship in counselling or psychotherapy has a fairly consistent nature. Deciding how one wants to practice, either privately or part of an organization, and determining the focus of the practice as well as the type of population one wants to serve is only the first step of building this professional helping relationship. It has a purpose and can be entered into for different reasons.

Every client is not the same. Each one brings with them not only their own issues but their own heritage and cultural background that influence their beliefsystem, values and ideas that may be foreign to the therapist. A challenge that the therapist may face is in understanding how they feel about dealing with a person with a belief system different from their own. "Effective helpers come to understand the personal cultures of clients" (Eagen, 2002) and therefore should spend some time searching their own personal beliefs and values. A counsellor‟s personal beliefs and value systems can influence the interactions that they have with their clients. Eagen (2002) speaks to this interaction and goes on to say that "understanding clients‟ different approaches to developing and sustaining relationships is important" knowingwhere one stands in their personal beliefs and being sensitive to those differences helps the counsellor enter the relationship without judgment to value and respect the individual.

Empathy is often defined as understanding another person's experience by imagining oneself in that other person's situation," according to Hodges and Myers in the Encyclopedia of Social Psychology. "One understands the other person's experience as if it were being experienced by the self, but without the self actually experiencing it." The boundary between self and other is maintained. Sympathy, on the other hand, is defined as "the sensation of being moved by another person or responding in tune with that person." In counselling, empathy is a statement of the respect and regard the counsellor holds for the client whose encounters might be very not quite the same as that of the counsellor. The client needs to feel "held", comprehended as well as regarded. To hold a client remedially implies the guide is fit to acknowledge and uphold the client through any issues, concerns, issues she/he can bring. The capacity to empathize with one more is improved by a ready mindfulness of looks, non-verbal communication, signals, instinct, quiets, etc. Empathy is defined as the ability to understand another person's feelings without passing judgment on whether or not they are appropriate.

9.13. KEY WORDS

Empathy, sympathy, trust, cognitive bias, emotion

9.14. SELF ASSESSMENT QUESTIONS

1. Explain the meaning and Definition of helping and discuss the art and science of

Helping
2. Define Empathy, its uses and scale to measure Empathy
3. Discuss the various types and barriers of Empathy

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LESSON-10
CHILDREN WITH LEARNING AND BEHAVIOURAL PROBLEMS

OBJECTIVES

1. To provide an overview of the various counselling procedures involved with learning and behavioural problems in children.
2. To study the interventions for children with mental retardation based on their needs.
3. To understand the nature of adolescence and counselling them for betteradjustment.

STRUCTURE

10.1 Introduction
10.2 Counselling children with learning problems
    10.2.1 Interventions for Specific Learning Disabilities
10.3 Counselling children with behavioural problems
10.4 Counselling for the mentally retarded
    10.4.1 Assessment
10.5 Counselling adolescents for better adjustment
10.6 Summary
10.7 Technical Terms
10.8 Self Assessment Questions
10.9 Reference Books

10.1 INTRODUCTION

Counselling children and adolescents often necessitates counselling for the adults who are in control of the younger person with the problem. Sometimes it is the adult's disturbed behaviour that could be the cause of the problem or aggravating the misbehaviour of the child. At times it could happen that the adults are not really responsible for the abnormal behaviour in the child but the emotional burden of accommodating and controlling the child's behaviour takes a toll on the psychological wellbeing of the adult.

In the present lesson we will be discussing the challenges that parents face in handling special and gifted children, and also adolescents. Adolescence is a transition from childhood to adulthood where adolescent are required to assume the responsibilities of adults but cannot have their privileges, which often lead to conflict between parents and children. Relation problems, emotional disturbances and problems in the academic environment that require counselling for better adjustment in adolescents has been discussed in the lesson.

10.2 COUNSELLING CHILDREN WITH LEARNING PROBLEMS

Some students are unable to learn reading, writing, and spelling or do arithmetic, in spite of good intelligence, good health, no psychopathology and a relatively happy home. These set of learning disabilities are a syndrome or cluster of characteristics symptoms that are exhibited by children that lead to all sorts of related problems. In a culture that emphasizes heavily on academic rewards, the punishment that awaits the non-learners is nothing short of ostracism from the mainstream of cultural life, including educational advancement job opportunities and even recreation.

The term "learning disability' (LD) emerged from a need to identify and serve students who continually fail in school and yet are not mentally retarded. The concept of LD has undergone distinct phases of development in history. Strauss and colleagues in the early 1940s were pioneers in studying learning disabilities. The termthey used for these children was 'Brain -injured children. In 1960s a shift in terminology occurred with the introduction of the term Minimal Brain Dysfunction (MBD)'. Kirk in 1962 coined the term Learning disability. The DSM IV definition is as follows: Learning disorders are diagnosed when individual's achievement on individually administered, standard testing in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence.

There is no single cause to explain the origin of learning disabilities. A variety of factors have been linked with its occurrence such as biophysical factors thatinclude genetic, chemical imbalances, head trauma, brain injuries, fatal distress, unfavourable uterine environment and environmental deprivation. Family disintegration, poverty, social class discriminations and other negative social and cultural factors can also give rise to learning problems. Educational factors such as crowded classrooms, poor study habits, inadequate and inappropriate teaching canalso give rise to learning problems.

Children with LD have academic problem in the area of reading, writing, spelling and mathematics. Characteristics of LD include difficulties in area of perception, cognition, memory, attention, emotions and fine motor skills. A student with learning problem may show a combination of the above-mentioned factors. Counsellors and academicians have tried to come up with techniques that would help teachers in dealing with children with various kinds of scholastic problems.

10.2.1 Interventions for Specific Learning Disabilities

The treatment methods emphasize both the **psychological** processes and abilities that underlie learning and the behavioural orientation that stresses on the skills of academic tasks. The psychological processes, which interfere with learning, are to be assessed and remediated in the first approach. There is a greater maladjustment, immaturity and inadequacy among underachievers leading to behavioural and emotional problems manifested in aggressive or withdrawn behaviours. Counselling essentially focuses on building positive thinking.

Behavioural orientation involves manipulation of the environment, rather than on the internal processes of the child. Many children experience difficulty in reading. Lack of word processing efficiency has been identified in poor readers. They are poor in recognizing simple common words and have difficulty in exploiting the system of phonetics.

The target for remedial education would include- improving their basic sight words and improving their phonic skills. For improving spelling, it is necessary that children with learning disability learn decoding of words and letter-sound combinations through phonic rules. Errors learning disabled children with writing disabilities can be attributed to improper holding of pen, wrong positioning of the writing illegibility of some letters, incorrect spacing, errors in punctuation, omission of words, adding new words overwriting and illegible writing under pressure of speed. To improve the speed of writing, behavioural charts that monitor the progress of the child can be made.

Arithmetic problems are common at all age levels. The errors developed by children are the result of incomplete concept formation. The principals involved for remedial math offer writing specific objectives to deal with specific problems, arranging regular practice sessions, providing immediate positive feedback during practice sessions, providing for concrete learning experiences, keeping an accurate record of error levels and response rates, encouraging children to set goals, asking questions and diagnosing errors regularly. For teaching basic operations of addition, subtraction, multiplication and division it is advisable to use concrete operations, then semi-concrete operations and then abstract operations.

10.3 COUNSELLING CHILDREN WITH BEHAVIOURAL PROBLEMS

The behavioural problems exhibited by children are subsumed under the headings of externalizing and internalizing syndromes. Behaviours included under the externalizing syndromes are conduct disorders, or juvenile delinquency, and are primarily reflected in conflict with the environment. Among the problems, which are listed under this category, are aggressiveness, temper tantrums, lying, stealing, and truancy. Hyperkinesia is also included under this category because the manifest symptoms of impulsivity and over activity are overt behaviours. The internalizing syndromes are problems of depression, withdrawal, anxiety, fears, obsessions, somatic complaints and schizoid features.

It is evident that children are likely to experience learning problems due to behavioural problems, emotional disturbances and interpersonal difficulties. Both multimodal and behavioural approaches to individual counselling although different in scope and focus have their roots in behaviourism. Counsellors often employ behavioural strategies to alleviate behaviour problems. Behavioural counselling includes learning or learning behaviours that are important for success in the social environment, be it in school or with the family. Counsellors reinforce appropriate behaviours and eliminate maladaptive behaviours by well-established procedures known as positive reinforcement accompanied by a procedure known as extinction. Other strategies include

- Shaping which includes new behaviours by reinforcing behaviours that approximate the target behavior.
- Modelling which exposes children to respected individual, either in real life or on tape who demonstrate behaviours that they are expected to learn.
- Role-playing which engages children in simulations to practice appropriate behaviours.
- Desensitization helps to eliminate anxiety and fear by progressively involving the pairing of relaxing responses with incompatible, anxiety-producing stimuli to gradually eliminate the anxiety that inhibits the desirable behavior.

10.4 COUNSELLING FOR THE MENTALLY RETARDED

The DSM-IV defines mental retardation as "significant sub average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in certain skill areas such as self-care, work, health and safety. Mental retardation is thus defined in terms of level of intellectual behavioural performance usually occurring before the age of 18."

The psychological situation of person who has acquired a pronounced impairment of intellectual functioning after 17 must be considered as dementia rather than mental retardation. This distinction highlights the impairment of intellectual functioning after attaining maturity as different from that of a person whose intellectual resources were subnormal throughout all most of his/her developmental.

Mental retardation has also been used as a defining characteristic or symptom of other disorders such as Down syndrome and Prader Willi syndrome. It usually occurs among children and is a challenge and potential source of stress to the family as an economic and social burden on the community. From identification through treatment or education, families struggle with questions about cause and prognosis as well as guilt about a sense of loss and disillusionment about the future. This section focuses on providing information related to assessment and common interventions involved in the treatment of mental retardation.

10.4.1 Assessment

As mental retardation is defined in terms of both intellectual and social competence, it is essential to assess both these characteristics before labelling aperson mentally retarded. Assessment for mental retardation also establishes the eligibility for special educational and psychological services needed by child and the family. Assessment process includes an evaluation of the child's cognitive and adaptive function, including behavioural concerns and an evaluation of the family, home, and classroom establishes goals, resources and priorities.

A variety of assessment instruments are criticized for insensitivity to cultural differences and accused of resulting in misdiagnosis. However assessment has many valid users. They allow for the measurement of change and evaluation of the effectiveness of a program. They also provide a standard for evaluating how well all children have learned the basic cognitive and academic skills for survival in our culture. It is therefore necessary to understand assessment and its purpose so that tools that are available can be used correctly and the results interpreted in a valid way.

The use of more than one assessment procedure provides a wealth of information about the child, permitting the evaluation of the biological, cognitive, social and the interpersonal variables that affect the child's current behaviour. In the diagnostic assessment of children it is importance to obtain information from parents and significant individuals in the child's environment. For school age-children, teachers are an important additional source of information. Discrepancies among the findings must be resolved before any diagnostic decisions or recommendations are made.

In mental retardation, attempts to define varying levels of impairments have tended to rely on measurements by means of standardized intelligence (IQ tests). The DSM IV recognizes four degrees severity of mental retardation based on the IQ ranges as mild, moderate, severe and profound. In assessing children's cognitive functioning a

number of instruments have been used. These include

• Bailey‟s scales of Infant Development (2 months -3.5 years)
• Mullen Scales of Early Learning (birth -68 months)
• The deferential ability scales (2.5 years-17 years)
• Wechsler Preschool & Primary Scale of Intelligence (WPPSI 3-7 years)
• Wechsler Intelligence Scale for Children-III (WISC 6-16 years)
• Wechsler Adult Intelligence Scale (WAIS-II for age range of 16 years O months -89 years)
• Stanford Binet 2 years-23 years

Adaptive behaviour is an important and necessary part of the definition and diagnosis of mental retardation. It is the ability to perform daily activities required for personal and social functioning. There more than 200 adaptive behaviour measures and scale. The most commonly used scale is the Vineland Adaptive Behaviour Scale. Vineland Adaptive Behaviour Scale is a revision of Vineland Social Maturity Scale designed by Doll in 1953 and it assess the social competence of individuals with and without disabilities from birth to age 19 ears. It is an indirect assessment where someone familiar with the individual behaviour (like the mother) is questioned. This scale measures four domains that include communication, daily living skills, socialization and motor.

Intelligent tests are predictors of scholastic achievement however Achievement tests are dependent on formal learning, and culturally bound and tend to sample more specific skills than do intelligence tests. Among the achievement assessment tools Peabody Picture Vocabulary Test, Revised (PPVT-R) is appropriate for individuals between the ages of 2.5 and adulthood and measures receptive knowledge and vocabulary. It is a multiple-choice test requiring only a pointing response and no reading ability.

Based on assessment, interventions can be planned that can be psycho-educational, social interpersonal or psychopharmacological based on the needs of the children or a combination of all. The needs of the child are determined by the team of professionals based on the priorities and concerns of the Interventions

Psycho-educational services to infants and toddlers can be home based or centre based. The services include assistive technology, intervention for sensory impairments, family counselling, occupational therapy and physical therapy. Pre-school children can have center based services where an individual plan can be developed for intervention that aims for improving the child's skills. Services to such children include special education by counselling, occupational therapy, physical therapy, language therapy, recreational activities and parent training or counselling.

Social and interpersonal interventions can be both preventive and therapeutic. A variety of group activities are included in the child's educational programs such as birthday parties, attendance at recreational activities (such as games, movies, participation in youth sport activities and visits to community sites. The goal of these activities is to teach appropriate social skills relevant to group participation andbuilding self-esteem. Parents also benefit as they get respite from providing care to address their own needs. Parents can be much more effective when their own needs have been met. Therapeutic intervention with the children and families may include family therapy,

individual child behaviour therapy, parent training and group therapy for mild mental retarded children that focus on developing appropriate social skills. Child behavioral interventions can be used to teach self-care and survival skills.

Psychopharmacological intervention should be considered only when particular psychiatric condition is known to benefit from a particular drug co-exists with Mental Retardation. Drug treatment should be used as only one component of an overall treatment approach and not as a form of chemical restraint. Most important the child's family should be involved as an invaluable resource in evaluating and treating children with mental retardation. Family forms an integral part of decision-making regarding treatment or management of the child's problems. Counselling involves understanding families and their concerns relating to the development of the child. Family should be educated and provided knowledge relating to the disability and the service and treatment options. Involving families in the treatment of mentally retarded children can ultimately be rewarding and beneficial for all involved.

10.5 COUNSELLING ADOLESCENTS FOR BETTER ADJUSTMENT

The developmental needs of young people‟s span a variety of areas termed as "BASIC ID" by psychologist Arnold Lazarus (1985). He outlined the domains of psychological functioning with the acronym, BASIC ID that stands for the following: Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal relations, and Diet/ physiology. The transition to adulthood is a stressful period for adolescent boys and more so for girls as it involves physical, mental and emotional phases of adjusting behaviour as well as habits of work and attitudes towards situations and obstacles. In such a context, they may be at risk for the exacerbation of emotional disorders within the relational matrix. Problems need to be understood within the relational context, including both, past and current relationships. The counselling relationship provides a meaningful experience to explore the strengths and weakness in the family system and tries to bring a harmonious relationship between the two. Counselling involves problem solving and preventive interventions that are an attempt to prevent negative outcomes by training individuals in social skills.

Emotional disturbances in adolescents have been associated to the confusion between the morality learned by the child and the ethics to be developed by the adult. As described by Erikson adolescence of role identity versus confusion, where some adolescents might isolate from close relationships. Individual counselling by a non-judgmental and empathic counsellor can lead to self-disclosure and identify /evaluate their emotions. Counsellors in brief counselling affirm the clients' strengths and resources and attempt to help clients establish clear and concrete goals that are achievable Individual counselling focuses on personal issues including presenting concerns about relationships, self-esteem and identity, loss and recovery issues.

The multimodal framework is a particularly useful model by which counsellors help students function effectively in the academic environment. The following are some aspects of human functioning that requires the attention of the counselors.

•Behaviour- adolescent students need to listen carefully in class also need to respect teachers. They must be willing to ask for help with difficult subject matter. Counsellors and teachers can make use of role models to promote appropriate learning behaviours Affect- student should have positive feelings about school and about themselves as

individuals. Students also should feel comfortable in academic environment but should understand that learning might create some necessary tension and anxiety. Counsellors should encourage students to express feelings openly.

• Sensation -the classroom environment should be stimulating place to learn where students become aware of how to use their senses in the learning process. Counsellors may help relieve some of the tension involved in learning through relaxation activities involving various senses.

• Imagery- students need to be aware of the creative aspects of education. Counsellors can make god use of the students mental imagery to stimulate learning, creativity and also to 'relieve academic stress

• Cognition - students need to think positively about what they are learning and their learning abilities. They need to get rid of irrational beliefs about failure. Counsellors can promote success by helping students to learn from mistakes and build on achievements

• Interpersonal relations- learning involves working with others. Students need to experience cooperative educational activities with one another and also teachers in the learning process without fear of unnecessary punishment and disgrace. Counsellors can serve as models for cooperation in various classroom activities.

• Diet/physiology- students need to have nutritious food, get sufficient sleep and exercise regularly. Counsellors should monitor student's physical well-being and recommend changes when necessary.

Holistic counselling or promoting wellness involves a multidimensional schema that values balancing the various tasks of life such as vocation; family; recreation; spirituality; and physical, emotional, social, and intellectual health. Wellness counselling may be another way of saying "whole person counselling which incorporated integration of mind, body and spirit. These programs may take various forms such as stress management and assertiveness skills training.

10.6 SUMMARY

Learning disorders are diagnosed when individual's achievement on individually administered. Standard testing in reading, mathematics or written expression substantially below that expected for age, schooling and level of intelligence.

A variety of factors have been linked with its occurrence such as biophysical factors, social and cultural factors and educational factors such as crowded. classrooms that give rise to learning problems. Children with LD have academic problem in the area of reading, writing, spelling and mathematics. Interventionsinclude psychological and behavioural models that stresses on the skills of academic tasks and on-building positive thinking.

Behavioural problems exhibited by children are subsumed under the headings of externalizing and internalizing syndromes. Multimodal and behavioural counselling that include procedures such as positive reinforcement, extinction, shaping and modelling Role playing and desensitization help to promote desirable behaviours in children with both externalizing and internalizing syndromes.

Mental retardation is defined as significant sub average general intellectual functioning accompanied by limitations in adaptive functioning such as self-care and safety, occurring before the age of 18. Based on assessment, interventions can be planned that can be psycho-educational, social and interpersonal or psychopharmacological based on the needs of the children or a combination of all.

The transition to adulthood is a stressful period for adolescents as it involves physical, mental and emotional phases of adjusting behaviour as well as habits of work and attitudes towards situations and obstacles. Problems associated with the period of adolescence include emotional disturbances associated in relational matrixand academic environment.

The counselling relationship explores the strengths and weakness in the family system and brings a harmonious relationship between the two. It involves problem solving and preventive interventions, such as multimodal or holistic counselling that integrate integration of mind, body and spirit.

10.7 TECHNICAL TERMS

Desensitization: Helps to eliminate anxiety and fear by progressively involving the pairing of relaxing responses with incompatible, anxiety-producing stimuli to gradually eliminate the anxiety that inhibits the desirable behaviour.
Externalizing syndromes: Behaviours seen in children presented as conduct disorders, or juvenile delinquency, and are primarily reflected in conflict with the environment are externalizing syndromes.
Holistic counselling: Counselling that promotes wellness involving a multidimensional schema for balancing the various tasks of life.
Internalizing syndromes: Behaviours of depression, withdrawal, anxiety, fears, obsessions, somatic complaints and schizoid features observed in children can be called as internalizing syndromes.
Learning disorders: A cluster of characteristics exhibited by children with individual's achievement on individually administered, standard testing in reading, mathematics or written expression is substantially below than expected for age, schooling and level of intelligence.
Modeling: Behavioural techniques which exposes children to respected individual, either in real life or on tape who demonstrate behaviours that they are expected to learn.
Role-playing: Behavioural technique which engages children in simulations to practice appropriate behaviours.
Shaping: Behavioural technique which includes new behaviours by reinforcing behaviours that target behavior.

10.8 SELF ASSESSMENT QUESTIONS

1. What are counselling techniques involved for children with learning and behavioural problems?
2. Briefly explain the interventions included for treating children with mentally retardation.
3. How can counsellors promote better adjustment in adolescents?

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LESSON-11

PRE & POST MARITAL COUNSELLING AND FAMILY COUNSELLING

OBJECTIVES

The objective of the lesson is to explain premarital counselling and family counselling.

STRUCTURE

11.1 Introduction
11.2 Premarital Counselling
11.3 Pre-marriage Preparation and Counselling
11.4 What to look for in Pre-Marriage Programmes and Counselling?
11.5 Family Counselling
11.6 Family Therapy
11.7 Family Therapy a form of Psychotherapy
11.8 Who can benefit from Family Therapy?
11.9 How does Family Therapy work?
11.0. How to choose a family Therapist?
11.11 Basic Techniques in Marriage and Family Counselling and Therapy
11.12 Summary
11.13 Key words
11.14 Self-Assessment Questions
11.15 References

11.1 INTRODUCTION

Marriage and family, the two Social institutions also called the domestic institutions are considered the significant institutions in any society. These two institutions are going through rapid changes in the contemporary Indian society. Premarital counselling aids the prospective couple to face the challenges of marriage and help them cope up with the demands of marriages. It prevents unhappy marriages since premarital counselling addresses the normal issues and challenges that all couples face in the course of their marriage.

Families can be torn apart by illness, divorce or other problems that create conflict and stress. Family counselling can help families identify and resolve problems. Family is the greatest Source of support, comfort and love. But it can also be the greatest source of pain and grief. A health crisis, work problems or teenage rebellion

may threaten to tear the family apart.

Family counselling may help the family weather the storm. It can help patch strained relationships among family members and improve the functioning of the family. Whether it's an individual, his partner a child or even a sibling or parent, family counselling can help all to relate more harmoniously and live life in an effective manner.

11.2 PREMARITAL COUNSELLING

Getting married without pre-marriage preparation is like starting a business or any important venture without preparing. Half of all marriages end in divorce, and only half of those that endure are truly happy in the long run. Many happy engaged couples assume that they won't be contributing to these statistics. But, if you just wing it and count on your luck to make your marriage a success, your odds are only one in four. There is another way.

Most couples just don't realize that good, skill-based pre-marriage counselling or classes can reduce the risk of divorce by up to thirty percent and lead to a significantly happier marriage according to marriage research. It can also reduce the stress of the pre-wedding period. Just a little effort now can make your odds a whole lot better over the long run. You want to do everything you can to ensure that your dreams of a great marriage and a great life are realized.

Pre-marriage preparation is based on the reality that it's important to strengthen your relationship and prepare constructively for future challenges and conflicts that everyone will inevitably face at some point in their marriage, now while you have so much fresh positive energy in your relationship. Don't stick your head in the sand. The research shows that there is a window of opportunity during the year before the wedding and the six months or so after when couples get the optimum benefit from marriage preparation. Later, under stress, negative habits and relationship patterns may become established and be much harder to resolve.

Couples now face more demands and have fewer supports than ever before. The typical complex marriage - managing two careers while rearing children -really requires that couples have very strong, well-established abilities to communicate, resolve issues, maintain mutuality and set goals. Without this foundation, it's easy to feel overwhelmed by stress and time pressures. Problems can intrude much more easily than most couples realize. As much as it's important to come to terms with unrealistically positive expectations, those who grew up with divorced or unhappily married parents may find that they have unacknowledged and unexplored expectations that their marriage, too, may become unhappy. Marriage preparation functions as an immunization the boosts your capacity to handle potential difficulties. Couples need every advantage to succeed in today's marriages.

11.3 PRE-MARRIAGE PREPARATION AND COUNSELLING

Most commonly, those couples who do receive some premarital counselling get it from their religious adviser. This can range from one or two meetings to an extended series of sessions sometimes an assessment inventory and skills training are included, often they are not. Non-religious professional counsellors also provide premarital

counselling services. Again, the content and amount of service depends on the orientation of the counsellor and what you ask for. Often doesn't cover all the preparation that couples need.

Marriage preparation classes or workshops are an alternative or supplementary approach to educating engaged couples and newlyweds in the skills, habits, attitudes, and enrichment techniques that research show lead to happy, enduring marriages. Such marriage preparation programs, is education, not therapy. Like premarital counselling some of these classes have religious sponsors while others are secular.You might consider them in many ways analogous to career counselling. They address the normal issues and challenges that all couples face in the course of their marriage. Some people think that marriage preparation is well on the way to becoming as commonplace as driver's training or test preparation.

Susan Piver's, The Hard Questions: 100 Essential Questions to Ask BeforeYou Say I Do is on the bestseller list. A marriage preparation program can give couples the benefit of a supportive environment and framework in which to ask these questions and some skills to deal with the answers.

Whatever marriage preparation program couples choose - religion-based or religion-neutral the counselling or class should include activities to give them real skills, real expectations a real knowledge of self and partner to face the inevitable challenges of a committed relationship.

11.4 WHAT TO LOOK FOR IN PRE-MARRIAGE PROGRAMMES AND COUNSELLORS

Here's a concise list of seven relationship skill and knowledge areas that research has shown to contribute to the success and endurance of marriage:

- Compatibility
- Expectations
- Premarital Counselling
- Conflict resolution
- Personalities and families-of-origin
- Communication
- Intimacy and sexuality
- Long-term goals

Make sure that the pre-marriage counselling or preparation you choose covers all of these. Here are some questions to help you select the pre-marriage prep that's right for you:

- Does it include an assessment inventory to help you understand your areas of compatibility and strength, as well as areas you may need to address?
- How many couples will attend the class or workshop? A small group setting is higher quality, more engaging and individualized than large classes. On the other hand, it can also be more comprehensive, systematic and skill-based than most pastoral or couples counselling. A group experience can also be more involving and stimulating than individual counselling.
- Does the program focus specifically on the needs of engaged couples and newly-weds? Some marriage skills programs mix troubled couples from later stages of

marriage in the same class. This can detract from the experience for engaged couples and newlyweds.

- Is the class or counselling approach flexible enough to allow for your relationship and learning style or is it a one-size-fits-all program? t's best to practice specific communication, Conflict resolution and goal-setting skills and strategies, and then select those skills and strategies that are most congruent with your relationship style and best meet your needs.
- Is the content based on marriage research?
- The counselling or class help you and your partner agree on goals and strategies for managing and continuing to work on your most important unresolved issues?

The answers to these questions will help you approach selecting your premarital classes counselling as an educated consumer.

If a couple's premarital counselling with a religious advisor or lay professional does address some important areas, the couple should think about supplementing with a program that does. Many couples use marriage prep and counselling in combination, covering the foundation issues and skills in a class or workshop, then focusing on religious or other special issues in their counselling.

11.5 FAMILY COUNSELLING

Family counselling services include a variety of activities taken up by the counsellor during the counselling sessions which are spread over a period of time depending upon the client's needs. A family counsellor provides individual, marital, and family counselling services to adults and children, to assist clients to identify personal and interactive problems, and to achieve effective personal, marital, and family development and adjustment: He collects information about clients (individuals, married couples, or families), using interview, case history, and observation techniques funnel approach, and appraisal and assessment methods, analyses information collected to determine advisability of counselling or referral to other specialists or institutions. He reviews notes and information collected to identify problems and concerns. He consults reference material, such as textbooks, manuals, and journals, to identify symptoms, make diagnoses, and develop therapeutic or treatment plan. He counsels clients, using counselling methods and procedures, such as psychotherapy and hypnosis, to assist clients in gaining insight into personal and interactive problems, to define goals, and to plan action reflecting interests, abilities, and needs. Further he evaluates results of counselling methods to determine reliability and validity of treatment used and interacts with other professionals to discuss therapy or treatment, new resources or techniques and to share information.

11.6 FAMILY THERAPY

Family therapy, also referred to as couple and family therapy and family systems therapy and earlier generally referred to as marriage therapy, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view these in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. As such, family problems have been seen to arise as an emergent property of systemic interactions, rather than to be blamed on individual members.

Family therapists may focus more on how patterns of interaction maintain the problem rather than trying to identify the cause, as this can be experienced as blaming by some families. It assumes that the family as a whole is larger than the sum of its parts.

Most practitioners are "eclectic", using techniques from several areas, depending upon the client(s). Family therapy practitioners come from a range of professional backgrounds, and some are specifically qualified or licensed/registered in family therapy (licensing is not required in some jurisdictions and requirements vary from place to place). In the UK, family therapists are usually psychologists, nurses, psychotherapists, social workers, or counsellors who have done further training in family therapy, either a diploma or an M.Sc..

- Multicultural and inter-cultural approaches are being developed.
- Family therapy has been used effectively where families, and or individuals in those families experience or suffer:
- serious psychological disorders (e.g. schizophrenia, addictions and eating disorders);
- interactional and transitional crises in a family's life cycle (e.g. divorce); as a support of other psychotherapies and medication.

Methodology

- It uses a range of counselling and other techniques including:
- Psychotherapy
- systems theory
- communication theory
- systemic coaching

The number of sessions depends on the situation, but the average is 5-20 sessions. The basic theory of family therapy is derived mainly from object relations theory, cognitive psychotherapy, systems theory and narrative approaches. Other important approaches used by family therapists include intergenerational theory (Bowen systems theory, Contextual therapy), EFT (emotionally focused therapy), solution-focused therapy, experiential therapy, and social constructionism.

A family therapist usually meets several members of the family at the same time ("conjoint family therapy' is used in the approach of Virginia Satir.) This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family. These patterns frequently mirror habitual interaction patterns at home, even though the therapist is now incorporated into the family system. Therapy interventions usually focus on relationship patterns rather than on analysing impulses of the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do.

Family therapy is really a way of thinking, an epistemology rather than about how many people sit in the room with the therapist. Family therapists are relational therapists; they are interested in what goes between people rather than in people.

Depending on circumstances, a therapist may point out to the family interaction patterns that the family might have not noticed, or suggest different ways of

responding to other family members. These changes in the way of responding may then trigger repercussions in the whole system, leading to a more satisfactory systemic state.

A novel development in the field of couples therapy in particular, has involved the introduction of insights gained from affective neuroscience and psychopharmacology into clinical practice. There has been particular interest in use of the so-called love hormone- oxytocin- during therapy sessions, although this is still largely experimental and somewhat controversial.

In the United States Prior to 1999 in California, counsellors who specialized in this area were called Marriage, Family and Child Counsellors. Today, they are known as Marriage and Family Therapists (MFTs) and work variously in private practice, in clinical settings such as hospitals, institutions, or counselling organizations. MFTs are often confused with Clinical Social Workers (CSWs). The primary difference in these two professions is that CSWs focus on social relationships in the community as a whole, while MFTs focus on family relationships.

Since issues of interpersonal conflict, values, and ethics are often more pronounced in relationship therapy than in individual therapy, there has been debate within the profession about the values implicit in the various theoretical models of therapy and the role of the therapist's own values in the therapeutic process, and how prospective clients should best go about finding a therapist whose values and objectives are most consistent with their own. Specific issues that have emerged have included an increasing questioning of the longstanding notion of therapeutic neutrality, a concern with questions of justice and self-determination,connectedness and independence, „functioning' versus 'authenticity‟, and questions about the degree of the therapist's 'pro-marriage/family' versus 'pro-individual' commitment.

11.7 FAMILY THERAPY A FORM OF PSYCHOTHERAPY

Family therapy is a type of psychotherapy. It helps families or individuals within a family understand and improve the way family members interact with each other and resolve conflicts.

Family therapy is usually provided by therapists known as marriage and family therapists. These therapists provide the same mental health services as other therapists, simply with a different focus family relationship.

Family therapy is often short term. You usually attend one session a week, typically for three to five months. In some cases, though, families may need more intensive treatment.

11.8 WHO CAN BENEFIT FROM FAMILY THERAPY?

In general, anyone who wants to improve troubled relationships can benefit from family therapy. Family therapy can help with such issues as:

- Marital problems
- Divorce
- Eating disorders, such as anorexia or bulimia
- Substance abuse

- Depression or bipolar disorder
- Chronic health problems, such as asthma or cancer
- Grief, loss and trauma
- Work stress
- Parenting skills
- Emotional abuse or violence
- Financial problems

Family therapy may be an addition to other types of treatment, particularly for certain mental disorders that require more in-depth treatment. Family therapy shouldn't substitute for other necessary treatments. For instance, family therapy can help family members cope if a relative has schizophrenia. But the person with schizophrenia should continue with his or her individualized treatment plan, such as medication and possibly hospitalization.

In some cases, family therapy may be ordered by the legal system. Adolescents in trouble with the law may be ordered into family therapy rather than serving jail time, for instance. Violent or abusive parents are sometimes spared jail if they enter family therapy. Divorcing couples may also be required to attend family therapy.

11.9 HOW DOES FAMILY THERAPY WORK?

Family therapy often brings entire families together in therapy sessions. However, family members may also see a family therapist individually, and family therapy may include non-family members, such as school teachers, other health care providers or representatives of social services agencies.

Working with a family therapist, you and your family will examine your family's ability to solve problems and express thoughts and emotions. You mayexplore family roles, rules and behaviour patterns in order to spot issues that contribute to conflict. Family therapy may help you identify your family's strengths, such as caring for one another, and weaknesses, such as an inability to confide in one other.
For example, say that your adult son has depression. Your family may not understand the roots of his depression or how best to offer help. Although you're worried about your son's health, you have such deep-rooted family conflicts that conversations ultimately erupt into arguments. You're left with hurt feelings, decisions go unmade, and the rift grows wider.

Family therapy can help you pinpoint your specific concerns and assess how your family is handling them. Guided by your therapist, you'll learn new ways to interact and overcome old problems. You'll set individual and family goals and work on ways to achieve them. In the end, your son may be better equipped to cope with his depression, you'll understand his needs better, and you, your spouse and your son may all get along better.

11.10 HOW TO CHOOSE A FAMILY THERAPIST?

Like other psychotherapists, family therapists are licensed mental health professionals. Although different states have different licensing or credentialing requirements, most require advanced training, including a master's or doctoral degree,

graduate training in marriage and family therapy, and training under the supervision of

other experts. Most family therapists work in private practice. They may also work in clinics, mental health centers, hospitals and government agencies

How do you find a family therapist who's right for you? The same way you'd find a psychiatrist, psychologist or other therapist: Ask lots of questions. Among them:

- Are you a clinical member of the Association or licensed by the state, or both?
- What is your educational and training background?
- What is your experience with my type of problem?
- How much do you charge?
- Are your services covered by my health insurance?
- Where is your office, and what are your hours?
- How long is each session?
- How often are sessions scheduled?
- How many sessions should | expect to have?
- What is your policy on cancelled sessions?
- How can l contact you if I have an emergency?

Ask your primary care doctor for a referral to a marriage or family therapist. Family and friends also may give you recommendations based on their experiences. Your health insurer, employee assistance program, clergy or state or local agencies also may offer recommendations.

11.11 BASIC TECHNIQUES IN MARRIAGE AND FAMILY COUNSELLING AND THERAPY

The area of marriage and family counselling/therapy has exploded over the past decade. Counsellors at all levels are expected to work effectively with couplesand families experiencing a wide variety of issues and problems. Structural, strategic, and trans generational family therapists at times may seem to be operating alike, using similar interventions with a family. Differences might become clear when the therapist explains a certain technique or intervention. Most of today's practicingfamily therapists go far beyond the limited number of techniques usually associated with a single theory.

Techniques:

The following select techniques have been used in working with couples and families to stimulate change or gain greater information about the family system. Each technique should be judiciously applied and viewed as not a cure, but rather a method to help mobilize the family. The when, where, and how of each intervention always rests with the therapist's professional judgment and personal skills.

The Genogram:

The genogram, a technique often used early in family therapy, provides a graphic picture of the family history. The genogram reveals the family's basic structure and demographics. (McGoldrick& Gerson, 1985). Through symbols, it offers a picture of three generations. Names, dates of marriage, divorce, death, and other relevant facts are included in the genogram. It provides an enormous amount of data and insight for the therapist and family members early in therapy. As a informational and diagnostic tool, the genogram is developed by the therapist in conjunction with the family.

The Family Floor Plan:

The family floor plan technique has several variations. Parents might be asked to draw the family floor plan for the family of origin. Information across generationsis therefore gathered in a non-threatening manner. Points of discussion bring out meaningful issues related to one's past.

Another adaptation of this technique is to have members draw the floor plan for their nuclear family. The importance of space and territory is often inferred as a result of the family floor plan. Levels of comfort between family members, space accommodations, and rules are often revealed Indications of differentiation, operating family triangles, and subsystems often become evident. Used early in therapy, this technique can serve as an excellent diagnostic tool (Coppersmith,1980)

Reframing:

Most family therapists use reframing as a method to both join with the family and offer a different perspective on presenting problems. Specifically, reframing involves taking something out of its logical class and placing it in another category (Sherman& Fredman, 1986). For example, a mother's repeated questioning of her daughter's behaviour after a date can be seen as genuine caring and concern rather than that of a nonrusting parent. Through reframing, a negative often can be reframed into a positive.

Tracking:

Most family therapists use tracking. Structural family therapists (Minuchin & Fishman, 1981) see tracking as an essential part of the therapist's joining process with the family. During the tracking process the therapist listens intently to family stories and carefully records events and their sequence. Through tracking, the family therapist is able to identify the sequence of events operating in a system to keep it the way it is. What happens between point A and point B or C to create D can be helpful when designing interventions.

Communication Skill-Building Techniques:

Communication patterns and processes are often major factors in preventing healthy family functioning. Faulty communication methods and systems are readily observed within one or two family sessions. A variety of techniques can be implemented to focus directly on communication skill building between a couple or between family members, listening techniques including restatement of content, reflection of feelings, taking turns expressing feelings, and non-judgmental brainstorming are some of the methods utilized in communication skill building.

In some instances the therapist may attempt to teach a couple how to fight fair, to listen, or may instruct other family members how to express themselves with adults. The family therapist constantly looks for faulty communication patterns that can disrupt the system.

Family Sculpting:

Developed by Duhl, Kantor, and Duhl (1973), family sculpting provides for recreation of the family system, representing family members relationships to one another at a specific period of time. The family therapist can use sculpting at any time

in therapy by asking family members to physically arrange the family. Adolescents often make good family sculptors as they are provided with a chance to nonverbally communicate thoughts and feelings about the family. Family sculpting is a sound diagnostic tool and provides the opportunity for future therapeutic interventions.

Family Photos:

The family photos technique has the potential to provide a wealth of information about past and present functioning. One use of family photos is to go through the family album together. Verbal and nonverbal responses to pictures and events are often quite revealing. Adaptations of this method include asking members to bring in significant family photos and discuss reasons for bringing them, and locating pictures that represent past generations. Through discussion of photos, the therapist often more clearly sees family relationships, rituals, structure, roles, and communication patterns.

Special Days, Mini-Vacations, Special Outings:

Couples and families that are stuck frequently exhibit predictable behaviour cycles. Boredom is present, and family members take little time with each other. In such cases, family members feel unappreciated and taken for granted. "Caring Days' can be set aside when couples are asked to show caring for each other. Specific times for caring can be arranged with certain actions in mind (Stuart, 1980).

The Empty Chair:

The empty chair technique, most often utilized by Gestalt therapists (Perls, Hefferline, & Goodman,1985), has been adapted to family therapy. In one scenario, a partner may express his or her feelings to a spouse (empty chair), then play the role of the spouse and carry on a dialogue. Expressions to absent family, parents, and children can be arranged through utilizing this technique.

Family Choreography:

In family choreography, arrangements go beyond initial sculpting; family members are asked to position themselves as to how they see the family and then to show how they would like the family situation to be. Family members may be asked to reenact a family scene and possibly resculpt it to a preferred scenario. This technique can help a stuck family and create a lively situation.

Family Council Meetings:

Family council meetings are organized to provide specific times for the family to meet and share with one another. The therapist might prescribe council meetings as homework, in which case a time is set and rules are outlined. The council should encompass the entire family, and any absent members would have to abide by decisions. The agenda may include any concerns of the family. Attacking others during this time is not acceptable. Family council meetings help provide structure for the family, encourage full family participation, and facilitate communication.

Strategic Alliances:

This technique, often used by strategic family therapists, involves meeting with one member of the family as a supportive means of helping that person change. Individual change is expected to affect the entire family system. The individual is often

asked to behave or respond in a different manner. This technique attempts to disrupt a circular system or behaviour pattern.

Prescribing Indecision:

The stress level of couples and families often is exacerbated by a faulty decision-making process. Decisions not made in these cases become problematic in themselves. When straightforward interventions fail, paradoxical interventions often can produce change or relieve symptoms of stress. Such is the case with prescribing indecision. The indecisive behaviour is reframed as an example of caring or taking appropriate time on important matters affecting the family. A directive is given to not rush into anything or make hasty decisions. The couple is to follow this directive to the letter.

Putting the Client in Control of the Symptom:

This technique, widely used by strategic family therapists, attempts to place control in the hand of the individual or system. The therapist may recommend, for example, the continuation of a symptom such as anxiety or worry. Specific directives are given as to when, where, and with whom, and for what amount of time one should do these things. As the client follows this paradoxical directive, a sense of control over the symptom often develops, resulting in subsequent change.

The techniques suggested here are examples from those that family therapists practice. Counsellors will customize them according to presenting problems. With the focus on healthy family functioning, therapists cannot allow themselves to be limited to a prescribed operational procedure, a rigid set of techniques or set of hypotheses. Therefore, creative judgment and personalization of application are encouraged.

11.12 SUMMARY

Premarital counselling and family counselling are the two important tools in preventing unhappy marriages as well as helping clients come up with the changing demands of the families in the present society. Family counselling is a psychotherapy practice in serving the clients encountering problems in life. Family counsellingproves to be a specialized service in helping children, adolescents, adults and families find real solutions to improve their lives.

Family counsellors believe that problems are a part of life. It is not thepresence of problems that determines our health and well-being, but what we do when we encounter them. The objective of family counselling is to help the clients find solutions that will lead to personal joy and healthy relationships. Family counselling is an effective tool in helping many people finds solutions to difficult life situations.

11.13 KEY WORDS

1. Premarital counselling
2. Family counselling
3. Family therapy
4. Psychotherapy

11.14 SELF-ASSESSMENT QUESTIONS

1. What is premarital counselling? Discuss the significance of premarital preparation and counselling.
2. Write an essay on family counselling.
3. Discuss the basic Techniques in Marriage and Family Counselling and Therapy

11.15 REFERENCES

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LESSON-12
COUNSELLING AND PSYCHOTHERAPY

OBJECTIVES

The objective of this lesson is to explain the concept meaning of social pathology and social stigma.

STRUCTURE

12.1. Introduction

12.1.1 Definition

12.2. Meaning of Social Pathology

12.3. Scope of Social Pathology

12.4. Importance of Social Pathology

12.5. Concept of Social Problem

12.6. Social stigma

12.7. Summary

12.8. Keywords

12.9. Self-Assessment Questions

12.10. Reference Books

12.1. INTRODUCTION

Social pathology is intended to Biology. The science of Zoology has its Branch Medical Pathology. Botany has its branch plant pathology, in the same way sociology has as its branch social pathology. In anatomy we study the structure of body and its function is physiology. In pathology we study abnormalities and diseasesof the body. In the same way the sociologists study the functional aspects of the society. We study the abnormal functions of social relations and deviations of normal social relations. The branch of study is called social pathology.

The society has a definite structure; but the structure of society and other structures are not alike. There are fundamental differences between these. The social structure, unlike bodily structure, is not concrete and it is abstract. The various biological structures show a definite relationship between its sub structures; these relations are not only definite but also are relatively fixed and stable. But the relationships between social structure and its sub-structures are neither fixed nor definite. It is dynamic and fluid. Society is a dynamic organisation in which changes are constantly occurring.

Social pathology

12.1.1 Definition:

John Lewis Gillion and John Phillip Gillin define social pathology, “By social

pathology we mean such serious maladjustments between the various elements in the cultural configuration so as to endanger the survival of the group or as seriously to interfere into the satisfactions of the fundamental desire of its members, wite the result that social cohesion is destroyed".

John Lewis Gillen in his book „Social Pathology‟ has defined social pathology thus "Social pathology is the study of man‟s failure to adjust himself and his institutions to the necessities of existence to the end that he may survive and meet family with the felt needs of his nature".

12.2. MEANING OF SOCIAL PATHOLOGY

Every society has its own unique culture. Each culture has many components and aspects. It is impressive that there should be harmony among the various parts; components and aspects of culture. The absence of harmony is bound to generate conflicts and tensions. It these conflicts and tensions persist, they start undermining the very foundations of the society. The various components of the structure of society (institutions, groups etc.,) are not independent of each other. They are interactive and affect each other. For example, problems in sexual relations between young persons may make them incapable of having fruitful marriage. Conflict in sexual relations may lead to divorce. This may threaten the very institution of marriage and family whenever there is maladjustment in sexual relations between wife and husband , the marital bliss is ruined. Whenever there is maladjustment of relations, the social pathology results. If communalism or economic exploitation is widely prevalent in the society, its cohesion is disturbed and maladjustments ensue. The people will mistrust each other. Unless maladjustments are eradicated and „status quo‟ restored or new readjustment is made, the social pathology envelops the whole society.

Social pathology studies the social structure and sub structures, institutions, groups and cultural elements in so far these exhibit disintegration and imbalance. The purpose of social pathology is to determine the factors which lead to imbalance, maladjustment and consequently disintegration. If we know what ails a group and what the factors which generate tension and conflict are, we can restore readjustment by adopting remedial measures. Social pathology is a diagnostic science like medical pathology: both try to determine the causes, general and specific of disease. Social pathology includes all problems related to maladjustment and social disorganization.

12.3. SCOPE OF SOCIAL PATHOLOGY

Some sociologists opine that the study pathology is not within the purview of sociologists. It is a subject matter of interests to social reformers. The sociologist must not regard any behaviour, however deviant as pathological; he should avoid undue intrusion of moralism in his study. This exclusive view was valid in the early stages of social research, when the distinction between normal and abnormal was based on moralistic considerations. Now the social researchers study such emotional and difficult problems as rape, incestuous relations, the sociology of crime etc., with most impartiality and normal attitude. Moreover social research has developed definiterules which obviate moral intrusion. The formation of hypothesis, collection, tabulation and interpretation of data and their inference of conclusions are considered tentative and subject to verification. These set of rules and procedures were not adopted earlier and conclusions were by personal prides and prejudices. Now the sociologists follow the

scientific techniques and procedures of social research. On the basis of social investigations sociologists believe that social organisation and social disorganization are the two processes or aspects of a single social function.

In society, interactions and interrelations between various units of the social structure are constantly going on. These interactions and interrelations generate associative and dissociative processes. The modern sociologist regards society as a dynamic process and not as a static structure. In society new ideas and inventions are being born every now and then. These new ideas and inventions disturb its equilibrium. Social adjustments cannot be taken for granted; these are under constant pressure of change. Unless suitable changes and modifications are forthcoming, the equilibrium cannot be restored and the maladjustments and conflicts cannot be averted. In fact crisis between old and new ideas and ways of life reflects progress andhealthy change. According to Giddings, an eminent sociologist, in a progressive and dynamic society, maladjustment is inevitable. It is the price which has to be paid for progress.

Social pathology is an essential part of sociology. Without understanding it, our understanding of the society will not be complete. We can born an adequate picture of society by complete understanding of the society. Any study what is incomplete without including the pathological aspects and remedial measures. Necessary is readjustment of maladjustment. One cannot understand the machinery without knowing about its breakdown and repair. So also we cannot understand the society without the knowledge of social pathology. The study of social pathology is of great value and useful to social scientist. It is also of great practical value to many professions and great value and useful to social scientist. It is also of great practical value to many professions and walks of life.

12.4. IMPORTANCE OF SOCIAL PATHOLOGY

1. Social Reforms:

The social reformer acts as the doctor of the society who works for the prevention, cure and eradication of the social ills and diseases. An adequate knowledge of social pathology is of utmost importance for the success of a social reformer.

2. Government:

Any government has to maintain social order and peace. If there is disorder and lawlessness, the government cannot continue in power for long. Hence the government has to keep a strict watch on social dynamism, and changing patterns of social relations. If there are serious conflicts, the government should try to prevent such a state of affairs. Our government pursued a policy of peace and non-violence and paid less attention to the need for powerful military organization. Its neglect of army resulted in a powerful attack by china on western and eastern boarders. The zeal and sacrificial spirit of people coupled with foreign help forced china to stop its adventure. India is a multireligious and sexually unpermissive society. The government has to keep close watch on religious books so as to avoid opinions offensive to any community. Regarding religious and sexual aspects, the government maintains a film censor Board to remove objectionable scenes in the films.

For Common Man:

Knowledge of social pathology is useful to the common man for understanding

the problems in human relations and to have successful adjustments in the society, particularly in marital relations.

Pathological situations in modern society:

The industrialization has brought a revolution in social life. It has affected the family life, standards of living and the stability of the social structure. The industrialization has increased urbanisation. It has affected the joint family system and the ties have loosened. It has intensified the sense of individualism. Women have become emancipated and they want to be independent economically and socially. It has gave rise to the problems of accommodation and commercialization of entertainment.

Scales of social pathology:

The sociologists devised certain scales to evaluate and measure the extent and intensity of social pathology. The following are the scales of social pathology.

1. Simple Rates:

An increase in the incident of suicides Juvenile delinquency, crimes, divorces, desertions, poverty and unemployment proportionately increases the rate of social maladjustments.

2. Composite devices:

Some sociologists are of the view that simple rates are inadequate. In their place composite indices are required.

3. Composition of Population:

The composition of population that is the relative strength of male and female of different age groups affect the social maladjustment. If the number of young peopleis much higher than that of the old, the chances of maladjustment are more.

4. Social distance:

The more the social distance, the more the chances of maladjustment.

5. Participation:

The greater the participation of individuals in various social activities, the greater is the chance of appropriate adjustment.

12.5. CONCEPT OF SOCIAL PROBLEM

Social problems arise when large number of persons is not playing their expected social role. The central main role in our family system is that of bread winner. It is not possible for many people to fulfil this role adequately on account of mass unemployment. Hence the resulting situation is considered as social problem. Discrepancies in social structures are defined as social problems. A hanging calls forth new adjustments many of which may conflict with established value patterns. The result is a social problem.

Social Values are normal group beliefs, either of a positive or a negative character pertaining to the important institutional relationships of a society.Democracy, monogamy and capitalism are some of the patterns of social values. Social values constitute the core of the social problems. Without these the problem would never exist.

Values are transmitted from generation to generation. The values are the ways of the group that have come to be accepted as desirable. There may be changes in the value judgement; the disport between values may cause a social problem. Conflict between sovereign states threaten the values of both which often lead to war. War is considered a social problem.

Social values may conflict. Social values may give rise to confusion as to whether or not a situation‟s actually a social problem. There are various situations that are defined as problems by some groups and not by others. The employment of children less than 15 years is considered social problems by some and not by others. Two sets of social values produce conflicts in the definition of the situation.

Social problems are the result of social change. Social problems are the heritage of a dynamic, democratic society where change is rapid. We may define a social problem as a condition believed to threaten a social value and capable of change by constructive social action. And the three elements of social problems are:-

1. The social situation
2. The value judgement
3. The appropriate social action

Social behaviour is variously defined by the group. Some behaviour is tosocial welfare and hence encouraged by the group. Other behaviours permitted by the group but not encouraged. This is morally prohibited category. Other behaviour is believed to jeopardize the basic values of the group and is also believed susceptible for amelioration by social action. Social problems fall in this category. Some values are more important than others. Hence some behaviour is considered more seriousthan other behaviour. For example murder is more serious than alcoholism.

Some problems involve both objective and subjective considerations. The objective elements include overt human behaviour. Crimes known to the police come under this category. The subjective aspects of problems involve social values. The situation must be defined before it is a social problem. The values define the situation. This is the subjective consideration. The values differ from society to society. Many white collar crimes are not defined as crimes by many people. Social problems are what the people think they are.

A society facing social problems is also a disorganised society. Social problems and social disorganization are not synonymous. Social disorganization is a process whereby, the group is broken, when the relationships are broken. The breakdown of traditional family is an example of social disorganisation. Many persons view these situations as social problem. Other view the emergence of nuclear family as a desirable change, that is hoe there is difference between social problems and social disorganization.

12.6. SOCIAL STIGMA

Social stigma is severe social disapproval of person‟s characteristics or beliefs that are against cultural norms. Social stigma often leads to marginalization. Examples of existing or historic social stigma can be physical or mental disabilities and disorders, as well as illegitimacy . Homosexuality or affiliation with a specific nationality, religion (or lack of religion) or ethnicity, such as being a jew , an African American, or

a gypsy. Likewise, Criminality carries a strong social stigma.

Stigma comes in three forms. Overt or external deformations; Examples of physical manifestations anorexia nervosa, leprosy, disabilities. Second, the known deviations are personal traits. For example, drug addicts, alcoholics and criminals are stigmatized in this way. Third, "Tribal stigmas" are traits of race, nation, or religion that constitute a deviation from the normative race, nationality, or religion, for example, Jewish people in Nazi Germany.

Although the specific social categories that become stigmatized can vary across times and places the three basic forms of stigma(Physical deformity, poor personal traits, and tribal out group status) are found in most cultures and timeperiods, leading some psychologists to hypothesize that the tendency to stigmatize may have evolutionary roots.

Conceptualizing Stigma:

Social science research on stigma has grown dramatically over the two decades, particularly in social psychology, where researchers have elucidated theways in which people construct cognitive categories and link those categories to stereotyped beliefs. In the midst of this growth, the stigma concept has been criticized as being too vaguely defined and individuality focused. In response to these criticisms, we define stigma as the co-occurrence of its components labelling, stereotyping, separation, status loss, and discrimination and further indicate that for stigmatization to occur, power must be exercised. The stigma concept we construct has implications for understanding several core issues in stigma research, ranging from the definition of the concept to the reasons stigma sometimes represents a very persistent predicament in the lives of persons affected by it. Finally, because there are so many stigmatized circumstances and because stigmatizing processes can affect multiple domains of people‟s lives, stigmatization probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, are interested in understanding the distribution of such life chance and the life itself. It follows that social scientists who should also be interestedin stigma.

Combating HIV/AIDS Stigma:

Mandatory testing policies affect individuals applying for jobs or insurance. HIV testing should be encouraged and even routinely offered via workplaces, however, not to qualify for employment. Workplace HIV programmes are critical tools in combating HIV/AIDS, especially programmes that includes safeguards to protect individual‟s confidentiality and livelihoods.

Another approach has been to create very visible imagery and commentary of people living with HIV/AIDS(PLWHA). This helps to normalize the fact that PLWHA are just like everyone else. If we can increase access for treatments PLWHA can live healthy and productive lives. We should diminish the stigma of HIV/AIDS and raise the real understanding of what it is by making PLWHA more visible. This has to be done through social marketing and communications programmes, behaviour change, changing policy and all kinds of visibilities activities.

They include trying to create more advocates at the community level so stigma is not something You can get away with – that you confronted if you engage in stigmatizing behaviour.

We have to educate young people who do not know about HIIV/AIDS- related deaths. Educations and prevention continue to be critical tools in combating stigma.

There is no cure for HIV/AIDS; but eliminating stigma will go long way to creating an environment for motivating individuals at -risk to know their serostatus. If they find out that they are HIV/AIDS-Positive, a stigma- free environment will also have fewer barriers.

We can eliminate stigma. Once in the world, polio carried much of the same kinds of stigma as HIV/AIDS does now. Even before we had effective vaccine, we had improved knowledge and awareness, understanding of risk factors, compassion and support for those infected increased access to treatment- we have to get to thesame place with AIDS.

How is HIV/AIDS Stigma Manifested

HIV/AIDS stigma is changing, but not fast enough. People have lost jobs,been kicked out of their homes, and generally ostracized by loved ones, colleagues and society. Stigma often takes the form of discrimination-acts that separate people living with virus from those who are HIV/Negative.

People who know that HIV/AIDS is not transmitted through sharing eating utensils, but would still segregate utensils. There is a fear factor around AIDS that is very rational, but it has to be addressed.

In U.S.A the individuals are still weary of disclosing their HIV/ status for fear of being ostracized by their families or loved ones.

HIV/AIDS Stigma:

HIV/AIDS stigma is manifested in many ways. People have lost their jobs, been kicked out their homes, and generally ostracized by their loved ones, colleagues and society. We should diminish the stigma of HIV/AIDS and raise the real understanding of what it is by making PLWHA more visible. This has to be through social marketing and communications programmes, behaviour change, changing policy and all kinds visibilities activities.

12.7. SUMMARY

In pathology we study abnormalities and diseases of the body. In the same way the sociologists study the functional aspects of the society. We study the abnormal social relations.

There should be harmony among the various parts, components and aspects of culture. The absence of harmony is bound to generate conflicts and tensions. The purpose of social pathology is to determine the factors which lead to imbalance, maladjustment and consequently disintegration.

In society new ideas and inventions are being born every now and then. These new ideas and inventions disturb its equilibrium.

Social pathology is of great practical value to many professions and walks of life. An adequate knowledge of social pathology is of utmost importance for the success of social reformer. The government has to keep a strict watch on social

dynamism and patterns of relations.

Knowledge of social pathology is useful to the common man to get successful adjustments in the society. Social stigma is severe social disapproval of personal characteristics or beliefs that are against culture norms.

12.8. KEY WORDS:

a. Stigma
b. Pathology
c. Social Problem
d. HIV/AIDS Stigma

12.9. SELF-ASSESSMENT QUESTIONS

1. Discuss the importance of social pathology
2. Explain the concept of social problem
3. Discuss the concept and the implications of social stigma

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LESSON-13
COUNSELLING FOR STRESS, BURNOUT AND DEPRESSION

OBJECTIVES

To provide an over view of counselling for anxiety related problemsand to comprehend the dynamics of counselling for stress and burnout

STRUCTURE

13.1 Introduction
13.2 Counselling Anxiety
  13.2.1. Types of Anxiety
  13.2.2. Cognitive Behavioural Counselling For Anxiety
13.3 Counselling Stress
  13.3.1. Stress and Stressors
  13.3.2. Coping with Stress
  13.3.3. Counselling for Stress Problems
13.4 Counselling burnout
13.5 Summary
13.6 Technical Terms
13.7 Self Assessment Questions
13.8 Reference Books

13.1 INTRODUCTION

Anxiety is a state of emotional tension characterized by apprehension and fearfulness leading to stress, which threatens to upset the organismic equilibrium. Stress is regarded as an external force perceived as threatening by the individual. The most common mental component of harmful stress is abnormal anxiety. Harmfulstress is so crippling that it stops a person from doing anything. Burnout is brought about by unrelieved work stress. In this lesson we shall learn about counselling for anxiety related problems, stress and burnout.

13.2 COUNSELLING ANXIETY

Anxiety Occurs when a person thinks there is some kind of threat. This may take the form of a physical danger such as a fear of having a heart attack or a social danger such as a fear of being rejected. Anxious thinking concerns future events- often "what if.." thinking Lazarus first identified two Stages of appraisal when a person becomes anxious. First the person judges whether the situation one is confronting is a threat. The person estimates the probability of the harmful outcome occurring and assesses the degree of potential harm. At the second stage the person estimates his or her ability to cope and deal with the threat. The degree of anxiety experienced is

therefore determined by how threatening the situation seems to be and by the person's confidence in ones ability to cope with the situation. When a person has an anxiety disorder the person functions like an oversensitive alarm system and tends to overestimate danger and under estimate coping resources. In all anxiety problems, there is a tendency for the person to overestimate the probability of bad things occurring and to catastrophise about the consequences of the predicted bad event.

13.2.1 Types of Anxiety

Anxiety problems tend to fall into patterns of disorder and each disorder is characterized by certain types of anxious thinking. In **panic disorder**, the client experiences recurrent, distinct periods of intense fear. In **agoraphobia** there is a central fear of being trapped in places from which it is difficult to leave. In **social phobia** a person is anxious about any situation in which he or she may be scrutinized by others. **Generalized anxiety disorder** is characterized by persistent experiences ofanxiety and worry about his or her life circumstances. In counselling clients with problems related to anxiety **cognitive behavioural counselling** is effective.

13.2.2 Cognitive Behavioural Counselling For Anxiety

Anxiety can be divided into three inter related components or systems: the cognitive, behavioural and somatic. The cognitive component refers to the client's anxious thinking and imagery. The behavioural component refers to the client's avoidance of facing up to the problems and somatic component concerns the client's physical symptoms such as tension or dizziness.

Cognitive aspects of anxiety involve handling of fear. A key part of this strategy is to tackle the client's self-defeating beliefs about his anxiety. The client is usually frightened by his symptoms and may have all sorts of anxious beliefs about his anxiety (fear of being ridiculed because of his anxiety) which has to be tackled in the beginning of the counselling. The counsellor helps the client to weigh up the evidence for and against his self-defeating inferences and evaluations. The counsellor should not jump in with reassurance that the feared outcome will not occur but should help the client to question the inference. Using the question technique the counsellor can help the client to deal with embarrassment, which may mean that he or she is not an awful person. Clients find it easier to challenge unrealistic inferences when he is removed from the feared situation. It is helpful if the counsellor anticipates this obstacle and makes suggestions about how the problem can be overcome. An **imagery exercise** that involves an exercise called time projection is a useful tool in helping the client to imagine him or herself perhaps two or three years hence and whathe would be feeling then. Helping the client to see the possibilities will reduce his or her hopelessness.

In the **behavioural aspects of anxiety**, avoidance is a very common feature of anxiety problems. The client may try to ignore a problem situation hoping that it will go away. In helping the client to counter avoidance the counsellor needs to identify the negative beliefs that underlie avoidance. The most common reasons for avoidance are fear of negative evaluation by others and fear of failure. The client should then be challenged behaviourally. **Graded exposure** is one method to overcome avoidance. In this method the client is assisted to put together a list of situations that the client avoids. The client then rates the degrees of difficulty on a scale of 0-100, where a score of „0‟ would mean 'no difficulty and a score of 100 would mean the most difficult', The

counsellor and the client put the situation in the order of difficulty and then choose the easier situations and gradually move into the difficult situations for the client to master.

Somatic aspects of anxiety include feeling breathlessness, dizziness, quickened heartbeat and tingling sensations. The client usually interprets these unpleasant feelings as losing control and becomes even more anxious. The client is taught to modify his breathing by means of exercises. Physical tension is a common feature of anxiety problems and this can be relieved by means of relaxation methods.

Relaxation is taught in the form of exercises derived from Jacobson (1938) in which the client systematically relaxes and tenses groups of muscles throughout the body. Alternative forms of exercise include thinking relaxing imagery or concentrating on counting breaths. Anxiety is often the client's major problem. It can also be a secondary feature of other major difficulties, such as depression.

13.3 COUNSELLING STRESS

There is a wide spread use of the term **stress** in everyday conversation. Most of us have more than first-hand experience with stress. In the following section let us examine what is stress and what can be done to moderate stress.

13.3.1 Stress and Stressors

Stress can be defined as a negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioural changes that are directed either toward the stressful event or accommodating to its effects. Stressful events are called as stressors. Events such as crowding, a bad relationship, a round of job interviews or commuting to work may be considered as stressors. Some of the experiences mentioned here might be stressful to some people but not to others. How one perceives potential stressors determines whether or not one will experience stress. So it is the relationship between the individual and the environment that determines stress. Stress. is the consequence of a person's appraisal processes; the assessment of whether their personal resources are sufficient to meet the demands of the environment. Stress produces many changes, including adverse emotional reactions, cognitive responses and physiological changes.

The most important contribution to the field of stress is **Hans Selye's** work on the general adaptation syndrome. According to this concept when an organism confronts a stressor it mobilizes itself for action. This mobilization effort is directed by the adrenal glands. The response itself is non-specific with respect to the stressor. That is regardless of the cause of the threat the individual will respond with the same physiological pattern of reactions. Over a period of prolonged exposure to stress, there will be wear and tear on the system. The general adaptation syndrome consists of three phases. The **alarm phase** is the first phase where the individual becomes mobilized to meet the threat. In the second phase, resistance, the organism makes efforts to cope with the threat through confrontation. The third stage, **exhaustion**, occurs if the organism fails to overcome the threat and depletes all its physiological resources in the process of trying.

Lazarus is a chief proponent of the psychological view of stress. He maintains that when individuals confront a new or changing environment they engage in a primary appraisal to determine the meaning of the event. Events may be perceived as

positive, neutral or negative in their consequences. Negative events are further appraised for their possible harm, threat or challenge. Once primary appraisal has occurred secondary appraisal is initiated which is the assessment of one's coping abilities and resources. Although people can adapt to stress to a certain degree, highly stressful events remain so over a period of time. The daily hassles in life can also affect health adversely as can chronic exposure to stress. **Occupational** stress includes work overload, work pressure, role conflict and ambiguity, inability to develop satisfying job relationships that can lead to increased illness, job dissatisfaction, absenteeism and tardiness. Multiple tasking or role combination may enhance self-esteem but on the other hand, lack of control and role overload may produce psychological distress and have adverse health implications.

13.3.2 Coping With Stress

People respond very differently to stress. Some may throw up their hands in despair when the slightest thing goes wrong with their plans while some are able to meet obstacles and failures by bringing their personal and social resources to cope with the problem. **Coping** is the process of managing demands that are appraised as taxing or exceeding the resources of the person. Coping involves efforts that are both action-oriented and intrapsychic to manage environmental and internal demands and conflicts among them. Coping efforts are guided by internal resources (personality factors -- negativity, hardiness, optimism and control) and external resources (time, money, the presence of other simultaneous life stressors and social support). Coping styles consist of predispositions to cope with stressful situations in particular ways. Avoidance, confrontation and catharsis are some styles of coping. Coping efforts may be directed at solving problems or at regulating emotions. Most stressful events evoke both types of coping strategies.

13.3.3 Counselling for stress problems

Counselling stress related problems involve three stages. In the first stage clients learns what stress is and how to identify stressors in their own lives. In the second phase they acquire and practice skills in coping with the stress. In the final phase they practice these stress management techniques in the targeted situations.

Cognitive behavioural counselling is highly effective stress management. A wide range of stress management techniques are used to combat stress such as self-monitoring, the modification of internal dialogues, goal setting, homework assignments, positive self-talk, self-instruction and contingency contracting (rewarding for appropriate behaviour). **Meichenbaum** developed **stress inoculation training** that enables people to confront stressful events with a clear plan in mind and several techniques of stress management so that the individual has a broad set of skills to choose. In this manner and individual can discover the skills that work best for him or her. The individuals can thereby **inoculate** (immunize) themselves against stress.

Most of these techniques are designed to provide cognitive insights into the nature and control of stress. Another set of techniques - **relaxation techniques**- are designed to affect the physiological experience of stress by reducing arousal. Relaxation training includes progressive muscle relaxation training, guided imagery, transcendental meditation and other forms of meditation such as yoga and hypnosis. These techniques can reduce heart rate, skin conductance, muscle tension, blood pressure, energy utilization, self-reports of anxiety and tension.

13.4 COUNSELLING BURNOUT

In recent years increasing attention has been paid to the phenomenon of burn out in human service professions. Burnout appears to be a response to interpersonal stressors in the job in which an overload of contact with people results in changes in attitudes and behaviour towards them the next section we will be dealing with this debilitating psychological condition brought about by unrelieved work stress.

Burnout is not simply excessive stress. Rather, it is a complex human reaction to ongoing stress, and it relates to feeling that one's inner resources are inadequate for managing the tasks and situations presented to them. The signs and symptoms of burnout are similar to those of stress, but burnout includes an emotional exhaustion and an increasingly negative attitude toward your work and, perhaps, one"s life. Paine (1982) has observed that Burnout Stress Syndrome (BOSS), the consequence of high levels of job stress, personal frustration and inadequate coping skills, have major personal, organizational and social costs. Burnout can be defined as:

- A state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations
- A state of fatigue or frustration brought about by devotion to a cause. way of life, or relationship that failed to produce the expected reward

Exhaustion and disillusionment are the most destructive components of burnout. There can be four types of consequences a) depletion of energy reserves, b) lowered resistance to illness, c) increased dissatisfaction and pessimism, d) and increased absenteeism and inefficiency at work. Burn out can be defined as the end result of stress experienced but not properly coped with, resulting in symptoms of exhaustion, irritation, ineffectiveness, discounting of self and others and problems of health. Burnout occurs at an individual level and is an internal psychological experience involving feelings, attitudes, motives and expectations. It is a negative experience for the individual, in that it concerns problems, distress, discomfort, dysfunction and negative consequences of depression or unhappiness that eventually threatens the person's job, relationships and health. Burnout is associated with situations in which a person feels:

- Overworked
- Underappreciated
- Confused about expectations and priorities
- Concerned about job security
- Over committed with responsibilities
- Resentful about duties that are not commensurate with pay

Knowing the signs of unmanaged stress and burnout can help reduce the risk of burnout. Identifying the causes of stress, recognizing one's limited control of any given situation, and taking care of oneself emotionally and physically can help avoid burnout. Also learning to manage stress will help find greater enjoyment in life and career. Burnout proceeds in stages that blend into one another that a person might not realize what is happening until he/she is in a state of despair and physical andemotional breakdown.

To prevent or treat burnout, one must become familiar with its symptoms and should try to identify possible causes and make changes so as to improve theirphysical,

mental and social well-being. To address the physical effects of burnout the individual must have a through physical check-up with your doctor and discuss the symptoms noticed. One must ensure that one gets the sleep that the body desperately needs. The person needs to inculcate healthy eating habits that help sustain energy throughout the workday and should also begin exercising or practice yoga relaxation.

Burnout often occurs when life feels out of balance feeling that one is giving too much of their life to jobs or others and are constantly in a state of stress and anxiety without any time to relax and enjoy life. To address the psychological effects of burnout they can develop coping skills for dealing with stress including using muscle relaxation techniques, mental imagery and positive self-talk. By understanding and being self-aware of one's strengths and weaknesses they can deal with day-to-day stress. Symptoms of depression need to be checked and medically treated. To help the individual develop control over work and home life, they must consider taking more time off, scheduling more frequent breaks while at work, or delegating tasks. Setting realistic goals will add direction, clarity and focus to their lives. The person experiencing burnout symptoms need to establish personal meaningful goals, and divide them into short- and long-term, and establish a plan for achieving them and setting new ones. Striving, learning and reaching for new accomplishments will give a real sense of purpose.

Maintaining a balanced life also means spending time cultivating relationships with others. Poor relationships can contribute to burnout, but positive relationshipscan help prevent or reduce it. Steps one can take to improve social relationships include: Nurturing closer relationships with partner, children or friends that can help restore energy and alleviate some of the psychological effects of burnout, such as feelings of being under appreciated. Joining a religious, social, or support group can give a place to talk to like-minded others about how to deal with daily stress. Expressing feelings to others who will listen, understand and not judge as in an empathic counselling situation would help ventilating emotions out in healthy, productive ways.

13.5 SUMMARY

Anxiety is a state of emotional tension characterized by apprehension and fearfulness leading to stress, which threatens to upset the organismic equilibrium. Stress is regarded as an external force perceived as threatening. Burnout is a state of physical and emotional exhaustion caused by long term involvement in emotionally demanding situations, in particular at the work place.

Anxiety occurs when a person thinks there is some kind of threat, which may take the form of a physical danger such as a fear of having a heart attack or a social danger such as a fear of being rejected. In counselling clients with problems related to anxiety cognitive behavioural counselling s effective

Stress is defined as a negative emotional experience accompanied by predictable biochemical. physiological, cognitive and behavioural changes that are directed either toward the stressful event of accommodating to its effects. Cognitive behavioural counselling is highly effective stress management. To recover from burnout, one should learn to cultivate methods of personal renewal, self-awareness, and connection with others, and focus on creating a balance in your life. To enjoy a healthy, sustainable life, it involves physical, psychological and social well-being.

13.6 TECHNICAL TERMS

Anxiety: Anxiety occurs when a person perceives threat which may be a physical danger such as fear of having a heart attack or a social danger such as fear of being rejected.

Agoraphobia: In agoraphobia there is a central fear of being trapped in places from which it is difficult to leave.

Burnout: It is a debilitating psychological condition brought about by unrelieved work stress.

Coping: Coping is the process of managing demands that are appraised as taxing or exceeding the resources of the person.

General adaptation syndrome: Hans Selye's general adaptation syndrome consists of three phases. The alarm phase is the first phase where the individual becomes mobilized to meet the threat. In the second phase, resistance, the organism makes efforts to cope with the threat through confrontation. The third stage, exhaustion, occurs if the organism fails to overcome the threat and depletes all its physiological resources in the process of trying

Graded exposure: A method to overcome avoidance where situations that are anxiety provoking are arranged in the order of difficulty and then the easier situations are chosen while relaxing by the client and gradually the difficult situations are mastered

Imagery exercise: An imagery exercise involves time projection which helps the client to imagine two or three years hence and what he/she would be feeling then. Helping the client to see the possibilities will reduce his or her hopelessness.

Panic disorder: In panic disorder, the client experiences recurrent, distinct periods of intense fear.

Relaxation techniques: Techniques such as progressive muscle relaxation and yoga that are designed to affect the physiological experience of stress by reducing arousal are called relaxation techniques

Social Phobia: In Social Phobia a person is anxious about any situation in which he or she may be scrutinized by others.

Stress: A negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioural changes that are directed either toward the stressful event or accommodating to its effects.

Stress inculcation training: It is a stress management program where individuals have a broad set of skills to choose and discover the skills that work best for them where in they can immunize themselves against stress.

Stressors: Stressful events are called as stressors.

13.7 SELF ASSESSMENT QUESTIONS

1. Examine the various counselling approaches for anxiety related problems.
2. Discuss briefly the issues involved in counselling for stress and burnout

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LESSON-14
DEPRESSION

OBJECTIVES

To understand depression within a counselling framework and to learn techniques of counselling for depression

STRUCTURE

14.1 Introduction
14.2 Assessing depression
14.3 Depressive themes
14.4 Counselling for depression
- **14.4.1. Basic aims of Counselling**
- **14.4.2. Cognitive Counselling**
- **14.4.3. Cognitive distortions**

14.5 Behavioural techniques
- **14.5.1. Collaborative Empiricism**
- **14.5.2. Monitoring and recording**
- **14.5.3. Awareness Training**
- **14.5.4. Behavioural Approaches**

14.6 Summary
14.7 Technical Terms
14.8 Self Assessment Questions
14.9 Reference Books

14.1 INTRODUCTION

Depression affects us in many different ways, and symptoms forming a pattern are spread over different aspects of functioning. It is predominantly an affective state and changes can be observed in a variety of dimensions:

- **Motivation:** Apathy, loss of energy and interest. Things seem pointless and the future hopeless.
- **Affective:** depressed mood, guilt, anxiety, anger. The capacity for positive emotions is reduced and the person may lack the capacity to experience pleasure. Negative feelings can increase and there can be heightened experiences of anger or resentment, anxiety, shame, envy and guilt.
- **"Behavioural:** decreased activity, reduced coping, social skills deficits. The person stops engaging in behaviours that have been enjoyable or pleasurable in the past, and there is an increasing withdrawal from social activities.
- **Cognitive:** negative thinking, indecisiveness, poor concentration. Memory can also be affected and cognitive contents become negative, with negative ideas about self, the world, and the future.

- **Biological:** sleep disturbance, loss of appetite, decreased sexual interest. Commonly observed are physiological changes in stress hormones and neurotransmitters such as serotonin and noradrenalin.

A prominent part of depression is **negative thinking** the depressed person thinks negatively about ongoing experiences, the future, and him/herself. The predictable thought pattern includes unhappiness with present life situation, feelings of inability to alter the situation, and an inability to understand how the present situation can change in the future. The person"s negative thinking tends to centre on the theme of loss or failure to achieve a desired goal.

14.2 ASSESSING DEPRESSION

Depression is a sequence of interacting processes that spiral a person downwards, and all interventions (drugs, psychological and social support) are aimed at breaking into this spiral. As mentioned earlier, depression affects various domains of functioning, and assessment typically focuses on the psychological, social and biological areas of functioning of the individual.

The most commonly used self-report scale for depression is the Beck Depression Inventory (BDI), which enables the counsellor to gain an overall impression of the pattern or symptoms and to monitor recovery. The inventory also allows the counsellor to gauge the risk for suicide and indicates that further exploration is required. Apart from the BDI, the counsellor"s assessment of depression must also focus on the following key areas:

Psychological

i. What does the client think and feel about himself? What are his attribution styles?
ii. What does the client think and feel about the future?
iii. What are the client's current life circumstances?
iv. How long has the client felt depressed?
v. Is the depression a change from his normal mood state or an accentuation of more chronic low mood? Is there a loss of previously enjoyed activities?
vi. Does the client see his depression in psychological and/or relationship terms, oris there a belief that he/she is physically ill?

Social

i. Are there any major life events or upsets that might have triggered the depression?
ii. What are the client's perceptions of social relationships? Have there been any major losses? Is the home environment aggressive or neglectful? Does the client have feelings of hostility to others and/or feelings of being let down?
iii. What are the sources of social support, friends, and family relationships? Can the client use these if available or have they gradually withdrawn from social contact?
iv. Does an unstimulating social environment play a role?
v. Are there major practical problems that may need other sources of help?

Biological

i. Is there any sleep disturbance?
ii. Are there major changes in appetite and weight?
iii. How serious is fatigue and loss of energy?
iv. Are there any psychomotor changes -especially agitation and retardation?

v. Would a trial of antidepressant drugs help to break up a depressive pattern?

14.3 DEPRESSIVE THEMES

The internal self-evaluations and self-schema that clients bring into the counselling relationship need to be focused on to understand how they view themselves. 'Negative views of self may be inherent or may be activated by life events. Understanding how depressed people think and feel about themselves is essential in counselling.

Some of the key self-focused themes involved in depression are approval, achievement, self-worth, social comparison, self-criticism, efficacy, defeat and affect management. For each theme, there are three issues:

- how people judge themselves,
- how they judge others and
- How they think others will judge them.

The basic self-other beliefs which people have help to organize social behaviour and relationship style. For instance, believing one is inferior to others may lead to inhibited and cautious or anxious social behaviour.

14.4 COUNSELLING FOR DEPRESSION

Heinz. Kohut stressed on the importance of **internal experiences** and the client's need to feel valued and approved (mirroring), the need to have others whom he/she can turn to and feel comforted (idealizing), and the need to feel like others (belonging).

Kohut explains depression as the loss of external inputs or the internal positive dimensions of self-experience that facilitate positive feelings about the self. The goal of counselling therefore is to facilitate and develop the client's contact with internal positive self-objects. Kohut places importance on helping the client express his/her sense of disappointment of unrealistic aspirations. Miss interpretations or unmet needs.

14.4.1 Basic aims of Counselling

Counselling for depressed clients follows a structure that is discussed below:

Developing Rapport: Rapport and a good working relationship need to be established in order to enable the depressed client gain a sense that someone is going to work with her and take her views and feelings seriously. It is also the counsellor‟s role to do what he/she can to put the client at case while acknowledging that depressed clients have a heightened sense of powerlessness and inferiority. The counsellor must appear as non-threatening as possible to the client; interpersonalskills such as smiling, sitting in an open posture, and creating an informal, relaxed atmosphere will reassure the client.

Exploring fears, concerns and expectations: Many of the fears of the depressed person relate to shame. Depressed clients are usually too frightened to discuss their fears with the counsellor as they are worried about what the counsellor may think of them. Fears of being seen as inadequate weak or bad can be addressed in the early sessions of counselling. The counsellor must clarify these fears and doubts verbally and nonverbally by reassuring and offering unconditional positive regard to the client.

Shared meaning: For the client, the feeling of being understood comes from being given an opportunity to tell how bad things are. The counsellor must make contact with the reality of the client's experience. For example, if sleep disturbances are the most troubling symptom to the client, and the counsellor does not address this, he counselling is not proceeding according to the client's experience.

Exploring the story: The counsellor will need to use directive and closed-ended questions in order to obtain the full story. When the counsellor has a general idea of the life events, he/she may focus the discussion and share the difficult problems. It is also essential to gather information about the key relationships in the, client's life, and the attitudes and beliefs that may have formed in these relationships. At this stage, itis also important to gain information on how the client evaluates the self (negative self-evaluation is a key theme in depression).

Sharing therapeutic goals: This means establishing with the client an agreed focus for work, and agreeing that there is a potential for change. Asking the client about therapeutic goals allows him/her to begin the process of working toward change. The counsellor needs to be extremely skilful in guiding the client towards goals that are workable and helpful.

Explaining the therapeutic rationale: After the first few sessions, the counsellor introduces and educates the client about the rationale of the particular approach that he is using with the client. This is usually important as it enables the client tounderstand and take an active part in counselling and to make the therapeutic goals clearer. Further, it helps clients when they learn that there are things that they can doto help themselves and that the counsellor will guide them in these issues.

Increasing awareness: Once the counsellor is sure that the client has understood the approach, he/she can begin to use various techniques to increase awareness and challenge dysfunctional thoughts. The counsellor can begin to challenge the thoughts one by one by looking at the evidence for the thought, and/or exploring alternatives.

Challenging and moving to alternative frameworks: To help develop alternatives,it is important to help the client recognize that their self-attacking is often triggered by disappointment. The crux of the counsellor's focus should therefore enable the client to reconsider the self-attacking cycle, and recognize his/her genuine emotions. At this stage, the counsellor explores images, feelings or memories, enabling the client to gain deeper insight into how disappointment and emptiness triggers the self-attack. The counsellor's empathy for the disappointment is important in the healing process.

Monitoring internal feelings and cognitions: A major aspect of all therapies is to increase awareness outside the counselling situation. Cognitive counsellors talk about developing the observing self - depressed clients can distance themselves from their thoughts and look at themselves as a third person, which has been found to be helpful. This process of increasing self-awareness via self-monitoring can be very helpful with some clients. Teaching self-awareness and increasing the activity of the observing self helps put a buffer between the thoughts and the affect associated with them.

Homework and alternative role enactments: Cognitive counsellors firmly believe that helping clients make changes in their actual social behaviour is more important than waiting for it to happen. The value of homework depends to a great extent on the client's collaboration. rather than his/her compliance.

14.4.2 Cognitive Counselling

Cognitive counselling focuses on our thoughts and. styles of interpretation of the environment and social events, and also the implications we derive about ourselves. The three basic concepts of cognitive counselling are:

1. **Automatic thoughts**: these are the immediate ideas and interpretations that spring to mind. In depression, they are often self-evaluative and carry implications for the future.
2. **Rules for living and basic attitudes**: these are the ideas and beliefs that guide our lives and set us in particular styles of living. Basic attitudes are not easily accessible and the client may hardly be aware of them.
3. **Self-other schemata**: these represent internal organizing systems that form the basis of our self-judgements and experiences on one hand, and our judgements and experiences of other people on the other.

Many times, we are not fully aware of our automatic thoughts, and only experience emotions. Cognitive counselling begins with thought catching - increasing our awareness of our thinking. Depressed clients are taught to attend to their automatic thoughts, changes in moods or feelings, and become attentive to these changes. Thought catching is a key aspect of the cognitive approach as the typical way people interpret situations is the focus of therapy.

The **ABC model** of cognitive therapy is used to highlight the relationship between events, thoughts and emotions. The client is encouraged to list out the **A**ctivating event, the **B**eliefs and meanings attached to the event, and the **C**onsequences in terms of emotions and behaviour. Linking thoughts and feelings in this manner helps in identifying how the interpretation of an event is associated with emotional, behavioural and biological changes.

Automatic thoughts are meaningful. Thus, an important procedure of cognitive counselling is to explore the immediate (automatic) thoughts, teach how to recognize these thoughts as they occur and how to challenge them.

Once depressed clients understand the link between thoughts and feelings, it is possible to deepen the exploration by searching for some underlying, deeper meanings and extreme evaluations and beliefs. Through the technique of **guided discovery**, inference chain or laddering is used to enable the client to associate one idea or outcome to another. Inference chains are the ways our thoughts and interpretations are linked together.

The cognitive counsellor is **active** and **directive** in the use of questions. In exploration, the counsellor does not suggest ideas, but lets the client discover by himself, with the belief that self-discovery works better than interpretation. Cognitive counsellors use Socratic type questions ('what' or open questions) in two basic ways:

- To probe the ways people are reasoning, to explore their basic constructs, and to illuminate the links in the chains of their reasoning.
- To stimulate people to **challenge** and **reflect** on this reasoning and see if it holds well. Socratic questioning aims at seeking information that a person can give, providing help in redirecting attention and refocus on the nature of the problem,

and moves from the specific to the more general in order to help the client develop skills to challenge and change key beliefs.

Depressed clients are often vague about trigger that trigger mood changes and need to become more focused. Cognitive counselling is thus concerned about the specificity of events and he eliciting situations. Specificity helps to target interventions and focus the client on the fact that things can become manageable and controllable.

Writing thoughts down is an activity that engages the client in thought catching and in tracing out the linkages between his/her thoughts and feelings. Thought records are usually used to enable the client maintain a record of his/her thoughts.

14.4.3 Cognitive distortions

As clients link ideas together there can be various distortions in their thinking. This may be because they focus on negative details and exclude positive alternatives. Beck (1979) suggests that there are particular types of distortions in the reasoning and automatic thoughts of depressed clients:

1. **Arbitrary inference** - drawing a negative conclusion in the absence of supporting data.
2. **Selective abstraction** - focusing on a detail out of context, leaving out more relevant information.
3. **Overgeneralization** - drawing conclusions over a wide variety of things on the basis of single events.
4. **Magnification and minimization**- making errors in evaluating the importance and implications of events
5. **Personalization** - relating external (negative) events to the self when there is little reason for doing so.
6. **Absolutistic, dichotomous thinking** - thinking in polar opposites (black andwhite).

Something is all good, or totally bad and a disaster.

Some depressed people derive a sense of self-worth by **social comparison**. In depression, people tend to look upwards and compare themselves with others who are superior to them in some way. As they don't feel as good as those they compare themselves with, they often feel like failures.

Negative social comparisons can. often trigger feelings of disappointment in the self and self-criticisms. It is thus necessary for the counsellor to check out how the client compares him/herself with others, the targets they choose to compare themselves with, and the emotional consequences of such comparisons.

14.5 BEHAVIOURAL TECHNIQUES

We have looked at the basic cognitive concepts in dealing with depressed clients. We will now focus on the techniques used for bringing about change. The very first step involved before implementing change strategies is to psycho-educate the client to recognize that depression affects people at many different levels which interact with each other, and how the strategies used in counselling will help to tackle his/her depression.

Cognitive counselling is not about positive thinking, looking on the bright side, ignoring negative or social realities or painful dilemmas. It involves exploring personal

meaning and attempting to change states of mind through a process of exploration, growth and change. Described below are some of the techniques used to bring about a change in the depressed client.

14.5.1 Collaborative Empiricism

Cognitive counselling for depression is based on collaborative empiricism - first, continually checking with the person that you have a mutual understanding and engaging the person to become involved in the process of change. Second, there is a focus on the evidence and the nature of interpretation of that evidence. Collaborative approaches require the counsellor to be sensitive to the client's issues, fears and abilities, and the interpersonal style of the client.

14.5.2 Monitoring and recording

Clients need to understand what is going on in the counselling, and his/her understanding involves him in the process. Various methods of monitoring include **self-monitoring** (becoming aware of and then monitoring his/her thoughts/feelings/emotions), **journal** (a díary of the client's thoughts each day), **agenda setting** at the beginning of the session (monitoring feelings and thoughts of previous session, checking mood, homework, and areas to be covered in present session).

14.5.3 Awareness Training

This involves helping the depressed client gain an increased awareness of the role of their beliefs and personal meanings in their depression. Fantasies can be an inspiration, a way of escaping reality, or our projections into the future. Once the client is made aware of his/her fantasies, the video play technique can be used to obtain information on actual or imagined sequences or scenes, enabling the client to modify the thoughts, feelings or behaviour in the scene to more adaptive methods. Role play is a useful way of eliciting affect and involves the re-enactment of previous distressing episodes and subsequently includes alternative behaviours and cognitive responses.

14.5.4 Behavioural Approaches

Activity scheduling can be worked out collaboratively between the client and counsellor. Clients can learn to schedule activities on an hourly or daily basis, focusing on the doable and increasing the difficulty level. Activities should ideally include things that the client finds rewarding. **Homework** is an essential part of cognitive counselling to develop new skills and expectancies. Homework should be challenging, not overwhelming and should aim at getting better, not feeling better. The counsellor should avoid "disqualifying achievements" as simple or easy to do.

The counsellor must also help the client to select short-term, obtainable changes or tasks. A depressed client's goals can be quite unrealistic and over- idealized. Thus, in collaboration with the client, the counsellor sets **long-term and short term goals for change**. For depressed clients who have difficulties in interpersonal skills, instructions and behavioural practice known as **social skills training** can prove to be very helpful.

The role of behavioural practice, homework, and social skills training in the form of developing new social and interpersonal behaviours or becoming more assertive, offers depressed clients a sense of regaining a measure of control over their

lives. Blending these behavioural techniques into the counselling session is not an easy task to achieve, but offer powerful means by which we can engage a depressed person's self-experience and help him/her shift out of these states of mind.

14.6 SUMMARY

Depression is predominantly an affective state and changes can be observed ina person's motivation, affect, behaviour, cognition, and biological states.

Counselling for depression aims to break the downward spiral consisting of how people judge themselves, how they judge others and how they think others will judge them.

Cognitive and behavioural techniques have been found to be successful in counselling clients with depression.

14.7 TECHNICAL TERMS

Negative thinking: negative thoughts a person has about on-going experiences,the future, and him/herself.

Cognitive counselling: focuses on thoughts and styles of interpretation of the environment and social events.

Collaborative empiricism: mutual understanding between counsellor and client to a engage the person to become involved in the process of change.

14.8 SELF ASSESSMENT QUESTIONS

1. What are the themes of depression?
2. Briefly explain cognitive techniques of counselling for depression.
3. Explain Kohut's and Rogers' view of depression.

14.9 REFERENCE BOOKS

1. Scott, M. J., Stradling, S. G., & Dryden, W. (1995). Developing Cognitive-Behavioural Counselling. London: Sage Publications.
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LESSON-15

COUNSELLING FOR SEXUAL HEALTH AND HIV/AIDS

OBJECTIVES

The objective of this lesson is to explain concepts, such as S.T.D., A.I.D.S., Sexual Health Education and its objectives, the role of school, home and media and social stigma.

STRUCTURE

15.1 Introduction

15.2 Nature and Definition of HIV Counselling

15.3 Sexually Transmitted Diseases (STD)

15.4 AIDS

15.5 Sexual Health Education - Concept and Objectives

15.6 Summary

15.7 Key Words

15.8 Self-Assessment Questions

15.9 Reference Books

15.1. INTRODUCTION

We are living in an era when healing sciences have to devote more attention to the mental health along with effort for physical well - being. A sound sexual health education or emotional integration is the basis of mental health. HIV / AIDS patients are facing lot of problems and social stigma is one of the key issues that deserves attention. Attention to sexual health education is the need of the hour as sex is regarded as a taboo or something sinful. In this context, home, school and media playa key role in promoting sexual health education.

15.2. NATURE AND DEFINITION OF HIV COUNSELLING

There have been significant developments in the treatment of HIV in recent years. This progress and up to date knowledge about HIV and the epidemiology of HIV infection has informed new guidelines on counselling and testing for HIV.

New guidance is prefaced by a number of important assertions:

- It is possible with the advent of new and improved treatment for the majority of

those living with HIV to remain fit and well on treatment.

- A significant number of people in the United Kingdom are unaware of their HIV infection and thereby put at risk their own health and the health of others by transmitting infection unknowingly.
- Late diagnosis is the most important factor associated with HIV-related morbidity and mortality in the UK. For example in the UK 24% of deaths in HIV-positive patients in 2006 were directly attributable to late diagnosis of HIV
- Patients should therefore be offered and encouraged to accept HIV testing in a wider range of settings than is currently the case.
- Patients with specific indicator conditions should be routinely recommended to have an HIV test.
- The consensus is that doctors, nurses and midwives should be able to obtain informed consent for an HIV test in the same way that they currently do for any other medical investigation.

15.2.1. Epidemiology

Some of the following points may be of value to the patient:

Men having sex with men (MSM) remain the group in the UK at highest risk of acquiring HIV with evidence that transmission is continuing at a substantial rate.

The estimated number of people infected through heterosexual contact within the UK has increased from 540 new diagnoses in 2003 to 960 in 2007, and has doubled, from 11% to 23%, as a proportion of all heterosexual diagnoses during this period.

In 2005, 70% of diagnoses were in people aged 15 to 39 and 73% of heterosexual cases were in people of African origin or were acquired there.

The Health Protection Agency estimates that 77,400 people were living with HIV in the UK at the end of 2007, of who over a quarter (28%) were unaware of their infection.

In 2005, 34% of newly diagnosed patients were diagnosed late with serious immunosuppression and 11% had progressed to AIDS. The figure for late diagnosis was 31% in 2008.

15.2.2. HIV in India

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV. There was recognition, though, that this would not be the case for long, and concerns were raised about how India would cope once HIV and AIDS cases started to emerge.

Later in the year, India's first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu. It was noted that contact with foreign visitors had played a role in initial infections among sex workers, and as HIV screening centres were set up across the country there were calls for visitors to be screened for HIV. Gradually, these calls subsided as more attention was paid to ensuring that HIV screening was carried out in blood banks.

In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among Injecting Drug Users (IDUs) in Manipur, Mizoram and Nagaland – three north-eastern states of India bordering Myanmar (Burma).

At the beginning of the 1990s, as infection rates continued to rise, responses counselling for HIV/AIDS were strengthened. In 1992 the government set up NACO (the National AIDS Control Organisation), to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan, the National AIDS Control Programme (NACP) for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS Control Societies (SACS) in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety.

By this stage, cases of HIV infection had been reported in every state of the country. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as ‘low-risk’, such as housewives and richer members of society

In 1999, the second phase of the National AIDS Control Programme (NACP II) came into effect with the stated aim of reducing the spread of HIV through promoting behaviour change. During this time, the prevention of mother-to-child transmission (PMTCT) programme and the provision of free antiretroviral treatment were implemented for the first time. In 2001, the government adopted the National AIDS Prevention and Control Policy and former Prime Minister Atal Behari Vajpayee referred to HIV/AIDS as one of the most serious health challenges facing the country when he addressed parliament. Vajpayee also met the chief ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention.

The third phase (NACP III) began in 2007, with the highest priority placed on reaching 80 percent of high-risk groups including sex workers, men who have sex with men, and injecting drug users with targeted interventions. Targeted interventions are generally carried out by civil society or community organisations in partnership with the State AIDS Control Societies. They include outreach programmes focused on behaviour change through peer education, distribution of condoms and other risk reduction materials, treatment of sexually transmitted diseases, linkages to health services, as well as advocacy and training of local groups. The NACP III also seeks to decentralize the HIV effort to the most local level, i.e. districts, and engage more non-governmental organisations in providing welfare services to those living with HIV/AIDS.

As for current estimates, in 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV. In 2008 the figure was

estimated to be 2.31 million. In 2009 it was estimated that 2.4 million people were living with HIV in India, which equates to a prevalence of 0.3%. While this may seem low, because India's population is so large, it is third in the world in terms of greatest number of people living with HIV. With a population of around a billion, a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million.

15.2.3. Who should be offered a Test?

Universal HIV testing (where all individuals are offered and recommended an HIV test routinely but can refuse testing) is recommended in all the following:

1. Sexual health clinics
2. Antenatal services
3. Termination of pregnancy services
4. Drug dependency programmes
5. Healthcare services for those diagnosed with tuberculosis, hepatitis B, hepatitis C and lymphoma.
6. HIV testing should be routinely offered and recommended to the following patients:
7. All patients presenting for healthcare where HIV, including primary HIV infection, enters the differential diagnosis (see article on primary HIV infection)
8. All patients diagnosed with a sexually transmitted infection
9. All sexual partners of men and women known to be HIV positive
10. All men who have disclosed sexual contact with other men
11. All female sexual contacts of men who have sex with men
12. All patients reporting a history of injecting drug use
13. All men and women known to be from a country of high HIV prevalence (>1%*)
14. All men and women who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence (see up to date UN AIDS list in Internet and Further Reading section below)
15. HIV testing should also be routinely performed in the following groups in accordance with existing Department of Health guidance:
16. Blood donors
17. Dialysis patients
18. Organ transplant donors and recipients

An HIV test should be considered more widely when there is a particularly high HIV prevalence in the local population. Local PCT data should be consulted. If the HIV prevalence exceeds 2 in 1000 population then testing should be offered to all registered patients. The introduction of universal HIV testing should be considered in such circumstances.

15.2.4. How Often to Test?

Repeat testing should be provided for the following: All individuals who have tested HIV negative but where a possible exposure has occurred within the window period (the time between infection and a positive test result).

Men who have sex with men (MSM) – annually (more frequently if clinically Counselling for HIV/AIDS suspect seroconversion or ongoing high risk exposure).

Injecting drug users – annually (more frequently if clinically suspect seroconversion)

15.2.5 Antenatal Care

If HIV test at booking is refused a further offer of testing should be made
If they decline again a third offer of a test should be made at 36 weeks.

Women presenting to services for the first time in labour should be offered a Point Of Care Test (POCT).

A POCT test may also be considered for the infant of a woman who refuses testing antenatal.

In areas of higher seroprevalence, or where there are other risk factors, women who are HIV negative at booking may be offered a routine second test at 34–36 weeks' gestation.

15.2.6 Which Test to Use?

Testing including confirmation should follow the standards laid out by the Health Protection Agency. All acute healthcare settings should expect to have access to:

Urgent HIV screening assay result within eight hours (definitely within 24 hours), to provide the best support for exposure incidents.

15.2.7 Routine Results within 72 hours

There are two methods in routine practice for testing for HIV involving either venipuncture or a screening assay where blood is sent to a laboratory for testing or a rapid Point of Care Test (POCT).

Blood tests

The recommended first-line assays:

Fourth generation assay tests for HIV antibody and p24 antigen simultaneously and have the advantage of reducing the time between infection and testing HIV positive to one month.
Third generation assay detects antibody only and has the disadvantage of giving a positive result after a longer (6 to 7 week) interval.

The better fourth generation tests are not offered by all primary screening laboratories.

HIV RNA quantitative assays (viral load tests):

These are not recommended as screening assays because of the possibility of false positive results. They offer only marginal advantage over fourth generation assays for detecting primary infection.

HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus is passed from one person to another through blood to blood and sexual contact. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Most of these people will develop AIDS as a result of their HIV infection.

15.2.8 Body Fluids that Spread HIV

The body fluids that have been proven to spread HIV are given below:

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Other body fluids containing blood
- These are additional body fluids that may transmit the virus that health care workers may come into contact with:
- Cerebrospinal fluid surrounding the brain and the spinal cord
- Synovial fluid surrounding bone joints • Amniotic fluid surrounding a fetus.

The HIV and AIDS pandemic in many low-and middle-income countries is growing, and it is estimated that fewer than 20 per cent of people living with HIV and AIDS know their status. Most people have a test too late, often only finding out their positive status when they already have an AIDS-related illness. People who do not know their positive status may not be able to take sufficiently early action to mitigate the effects of the disease. They will also not be aware of the need to alter their behaviour to avoid the risk of infecting others or reinfection themselves.

Provider Initiated Testing and Counselling (PITC) have been suggested as a possibility for dramatically scaling up testing. This is opt out, rather than opt in testing. For example, everyone attending a GP's surgery could be tested unless they requested otherwise (opted out) if it were part of a full package of HIV and AIDS services. PITC would mean a much higher percentage of people living with HIV and AIDS would be aware of their status and would therefore be able to access treatment, care, support and prevention information and services.

It refers to a process where in support and strength is provided to individuals, couples, families or groups by competent persons to help them cope with the knowledge that they are infected or affected by HIV. It is an ongoing process that allows the individuals to develop a sense of responsibility in meeting challenges posed by their infection. Counselling should also be given to HIV negative individuals to promote behaviour change and condom use.

One of the core elements in a holistic model of health care is counselling in HIV and AIDS. In counselling HIV and AIDS, psychological issues are recognized as integral to patient management. HIV and AIDS counselling has two general aims: (1) the prevention of HIV transmission and (2) the support of those affected directly and indirectly by HIV.

HIV counselling should have these dual aims because the spread of HIV can be

Counselling for HIV/AIDS prevented by changes in behaviour. One to one prevention counselling has a particular contribution in that it enables frank discussion of sensitive aspects of a patient's life. Such discussion may be hampered in other settings by the patient's concern for confidentiality or anxiety about a judgmental response. Also, when patients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through a fear of rejection, social stigma, disease progression, and the uncertainties associated with future management of HIV.

Good clinical management requires that such issues be managed with consistency and professionalism, and counselling can both minimize morbidity and reduce its occurrence. All counsellors in this field should have formal counselling training and receive regular clinical supervision as part of adherence to good standards of clinical practice.

15.3. SEXUALLY TRANSMITTED DISEASES (STD)

Sexually Transmitted Diseases (STD) are also called as Venereal Diseases (V.D). Sexually Transmitted Diseases dependence on sexual intercourse for its transmission of all the Sexually Transmitted Diseases, Gonorrhea is the commonest followed by syphilis. The three minor venereal diseases are chancroid, granuloma inguinal and lymph granuloma venereum.

Gonorrhea and syphilis are increasingly prevalent among teenagers, and young adults. S.T.D. diseases are different from other diseases. Intimately related to human behaviour they create their own peculiar problems in society; we are often asked, are they really so prevalent in our country? Are not these diseases confined more or less to the west?

According to the World Health Organization at the time, Bombay ranks among the ten most highly infected cities in the world. Gonorrhea is far more prevalent than syphilis. People in the age group of 15-25 years account for more than half of the total number of freshly acquired, Venereal infections. In India we have established key clinics in metropolitan cities to address to the issue of STDs vey recently.

STDs don't always cause symptoms or may only cause mild symptoms. So it is possible to have an infection and not know it. But you can still pass it on to others.

- If there are symptoms, they could include:
- Unusual discharge from the penis or vagina
- Sores or warts on the genital area
- Painful or frequent urination
- Itching and redness in the genital area
- Blisters or sores in or around the mouth
- Abnormal vaginal odor
- Anal itching, soreness, or bleeding
- Abdominal pain
- Fever

Syphilis:

Syphilis is caused by Treponema Pallida and is transmitted by sexual intercourse with a person who is suffering from the disease. It could also be transmitted by kissing

an infected person with mouth lesions. Rarely transmission through blood transfusion has also been known to occur.

Infants may also be affected in 'Utero' through the placenta of the infected mothers, and if she is left untreated, severe deformities and even death of the child can occur. Every couple before marriage should have a blood test to rule out S.T.D. and also to determine blood groups. The incubation period is usually from 4-6 weeks. The history, physical and serological examination of the patient is important in establishing a diagnosis of syphilis. However a man who has syphilis can clearly see the ulcer or chance on his organ.

Gonorrhea:

Gonorrhea is an acutely infectious Venereal disease due to Neisseria, gonococci. The incubation period is about 3-6 days. It is transmitted by sexual intercourse with an infected person. New-born babies may acquire a very serious infection of the eyes, called "ophthalmic neonatorum" from their mothers which may result in blindness if left untreated. In Gonorrhea where purulent secretions are available, the smear is an effective means of diagnosis. Very often the purulent secretions are available; the smear is an effective means of diagnosis. Very often the condition goes undetected in women as it is mistaken for the normal vaginal discharge.

Factors Contributing to STD:

Although correct statistical data is not available, the factors responsible for the persistence of these two common, venereal diseases are:

1. More cases are treated by private physicians and hence no proper record is maintained.
2. Moral laxity and sexual promiscuity has increased to a great degree in recent years.
3. Antibiotics used to check these conditions are freely available.
4. Increased use of contraceptives in illicit intercourse may prevent pregnancy but not S.T.D.
5. Lack of 'Contact' training (i.e. source of the disease in the contacts of infected person).

15.4. AIDS

What are AIDS and HIV?

AIDS in the abbreviated form is Acquired Deficiency Syndrome. As the name implies it is a condition caused by a deficiency in the body's immune system. It is a syndrome because it encompasses a pattern of different symptoms with varied manifestations in different cases. It is acquired because AIDS is an infectious diseases caused by a virus which is spread from person through a variety of routes. This makesit different from other immune deficiency conditions due to genetic causes or due to the use of anti - cancer drugs and immune system suppressing drugs given to persons who undergo transplant surgery, etc.

HIV is the abbreviation for Human Immune Deficiency Virus, the virus that causes AIDS. Previously HIV was known by a variety of names such as LAV, and HTLV 111

How does HIV spread?

HIV can spread in different ways:

- Through unprotected sex with a person with HIV. This is the most common way that it spreads.
- By sharing drug needles.
- Through contact with the blood of a person with HIV.
- From mother to baby during pregnancy, childbirth, or breastfeeding.

Who is at risk for HIV infection?

Anyone can get HIV, but certain groups have a higher risk of getting it:

- People who have another sexually transmitted disease (STD). Having an STD can increase your risk of getting or spreading HIV.
- People who inject drugs with shared needles.
- Gay and bisexual men.
- Black/African Americans and Hispanic/Latino Americans. They make up a higher proportion of new HIV diagnoses and people with HIV, compared to other races and ethnicities.
- People who engage in risky sexual behaviors, such as not using condoms.

Factors such as stigma, discrimination, income, education, and geographic region can also affect people's risk for HIV.

What are the symptoms of HIV/AIDS?

The first signs of HIV infection may be flu-like symptoms:

- Fever
- Chills
- Rash
- Night sweats
- Muscle aches
- Sore throat
- Fatigue
- Swollen lymph nodes
- Mouth ulcers

These symptoms may come and go within two to four weeks. This stage is called acute HIV infection.

If the infection is not treated, it becomes chronic HIV infection. Often, there are no symptoms during this stage. If it is not treated, eventually the virus will weaken your body's immune system. Then the infection will progress to AIDS. This is the late stage of HIV infection. With AIDS, your immune system is badly damaged. You can get more and more severe infections. These are known as opportunistic infections (OIs).

Some people may not feel sick during the earlier stages of HIV infection. So the only way to know for sure whether you have HIV is to get tested.

How do I know if I have HIV?

A blood test can tell if you have HIV infection. Your health care provider can do the test, or you can use a home testing kit. You can also use the CDC Testing Locator to find free testing sites.

What are the treatments for HIV/AIDS?

There is no cure for HIV infection, but it can be treated with medicines. This is called antiretroviral therapy (ART). ART can make HIV infection a manageable chronic condition. It also reduces the risk of spreading the virus to others.

Most people with HIV live long and healthy lives if they get and stay on ART. It's also important to take care of yourself. Making sure that you have the support you need, living a healthy lifestyle, and getting regular medical care can help you enjoy a better quality of life.

Can HIV/AIDS be prevented?

You can reduce the risk of spreading HIV by:

- Getting tested for HIV.
- Choosing less risky sexual behaviors. This includes limiting the number of sexual partners you have and using latex condoms every time you have sex. If your or your partner is allergic to latex, you can use polyurethane condoms.
- Getting tested and treated for sexually transmitted diseases (STDs).
- Not injecting drugs.
- Talking to your health care provider about medicines to prevent HIV:
- PrEP (pre-exposure prophylaxis) is for people who don't already have HIV but areat very high risk of getting it. PrEP is daily medicine that can reduce this risk.
- PEP (post-exposure prophylaxis) is for people who have possibly been exposed to HIV. It is only for emergency situations. PEP must be started within 72 hours aftera possible exposure to HIV.

HIV and AIDS in India:

In India the first cases of AIDS were detected in the cities of Madras and Bombay. Both these are port cities with a large migrant populations along with a large population of brothel based sex workers. Another focus of HIV infection is in Manipur where infection of drugs such as heroin is common. HIV infection has been detected throughout India.

Probable sources of infections in India:

The probable sources of infections in India are given below:

1. Heterosexuality Category Promiscuous.
2. Blood Transfusion
3. Blood Product Infusion
4. Homosexual Contact
5. Spouse of AIDS Patient / Seropositive
6. Intravenous Drug Addicts.

15.5. SEXUAL HEALTH EDUCATION - CONCEPT AND OBJECTIVES

We are living in an era when healing sciences have to devote more attention to the mental health along with efforts for physical well - being. A sound sex education or sexual health education is the basis of mental health. Attention to this neglected phase of human life deserves immediate attention. But unfortunately, even now talking about sex is regarded as a taboo or something very sinful. The present day, attitude is a persuade against giving any information to young people on sex life. Parents have neglected to treat the matter in a serious and straight forward manner. Teachers ignore it, textbooks and school courses to which the subject should naturallybelong. Some of the important reasons for this state of affairs are:

1. False sense of prudency on the part of the adults.
2. Ignorance of importance of sex knowledge for happiness of family life.
3. The belief that innocence and purity are achieved through ignorance of these facts and such innocence should be preserved as long as possible.

A number of orthodox educationists believe that if we were to give education of this nature we should probably start something.

Sexual Health Education - Concept:

Sexual health education refers to the educational programme designed to provide learners with adequate and accurate knowledge about human sexuality - its biological, psychological, cultural and moral dimensions. Sexual health education focuses largely through exclusively on the individual, on self-awareness, personal relationship, human sexual development, reproduction and sexual behaviour- It helps people to understand their sexuality, to learn to respect others as sexual beings and not make responsible decisions about their behaviours.

Objectives of Sexual Health Education: The primary objectives of sexual health education are:

1. To impart correct, factual knowledge, skill, abilities and understanding regarding sex and reproduction to the child according to its age.
2. To prepare young adolescent girls to expect norms physical and psychological change at puberty.
3. To develop in young adults a wholesome positive attitude towards sexual behaviour compatible with the customs and traditions of their society not a negative one based on fear of venereal disease, shame or divine retribution.
4. To inculcate into the adults that marriage is a unification, not only of bodies but of ideas and ideals and not the sexual intercourse is mere tax - free entertainment.
5. To teach them to accept each other for what they are and not to try to dosomething from each other which neither of them could give and to each other giving rather than thinking.
6. To install into parents the necessity of a correct child - parent relationship and the responsibilities of parenthood.
7. To impart training for home-making and for successful participation in family life.

15.6. SUMMARY

It goes without saying that there exists an urgent need for a coordinated systematized, concerted effort to impart essential sexual health knowledge to all the people - children and adults, male and female. But majority or us are still ignorant of

what sexual health education or education for family life means. Parents, teachers and media play a crucial role in educating the masses on this vital issue of sex, sexuality and sex related diseases.

15.7 KEY WORDS

1. Sexually Transmitted Diseases
2. Acquired Immuno Deficiency Syndrome
3. Human Immuno Deficiency Virus
4. Media
5. Social stigma
6. Sexual Health Education.

15.8. SELF-ASSESSMENT QUESTIONS

1. What is STD? Discuss the factors contributing to STD.
2. What is AIDS? Explain the role of family, teachers and media in preventing AIDS.
3. Social Stigma is a major issue in the context of HIV/ AIDS - Comment.
4. Discuss the significance of sexual health education.

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LESSION-16

COUNSELLING FOR THE ALCOHOLIC AND DRUG ABUSE

OBJECTIVES

To study counselling interventions involved in alcoholic de-addiction and comprehend the dynamics of drug abuse and their treatment modalities.

STRUCTURE

16.1 Introduction
16.2 Alcoholism
16.2.1. What leads to Alcoholism?
162.2. Treatments oriented toward abstinence
162.3. The Multimodal relapse prevention model
16.3 Drug Abuse
16.3.1. Drugs that are abused
16.3.2. Screening individuals for substance abuse
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16.3.4. Prevention Programs in Educational institutions
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16.7 Reference Books

16.1 INTRODUCTION

In the past few decades there has been tremendous change in the socio-economic conditions of the youth. There is growing frustration in the faith and value of education. During this stage young people also experience unrest, stress and strain. This vulnerable stage often makes them victims of drug addiction and often use of drugs becomes a means of escape from feelings of emptiness and helplessness. In the early decades of the twentieth century, alcoholism posed a serious social problem involving adults and older persons while experimenting with drugs is fashionable among adolescents and youth.

16.2 ALCOHOLISM

Alcohol abuse accounts for thousands of deaths each year and severe economic loss and treatment costs. Originally characterized as a social ill, alcoholism is now recognized as disease. As a health issue alcohol is linked to a number of disorders, including cirrhosis of liver, cancer, foetal alcohol syndrome and physiological abnormalities that arise out heavy drinking.

Alcoholism encompasses a variety of specific behaviour patterns that have physiological and psychological needs. These include increasing stereotyped drinking, drinking that maintains blood alcohol at a particular level, the ability to function at a level that would incapacitate less tolerant drinkers, experiencing increased frequency and severity of withdrawal, drinking earlier in the day and in the middle of the night, a sense of loss of control over drinking and subjective craving for alcohol. These characteristics can occur with or without physical and psychological dependency.

16.2.1 What leads to Alcoholism?

Several theories have been offered to address the origins of alcoholism. One approach maintains that biological and genetic factors, such as predisposition to addiction, account for alcoholism. However the process that acknowledges the interdependent roles of physiological, behavioural and sociocultural variable in maintaining alcoholism seems to meet the criteria for alcohol use and abuse.

For years alcohol abuse was regarded as resistant to intervention. Relapse is a major difficulty in statement for alcohol abuse. Craving for alcohol is one of the outstanding features of alcoholism that many alcoholics experience expressed as nervousness, restlessness, fatigue and depression. Craving appears to valve an interrelated set of psychological, physiological, behavioural and biochemical response.

16.2.2. Treatments oriented toward abstinence

Treatment approaches to alcoholism deal with the full complexity of alcohol abuse. Alcohol abuse spends not only on personal attitudes but also social and cultural environments. Drinking occurs in circular environments and those environments can elicit and maintain drinking behaviours.

Decades of research and treatment programs reveal that alcohol abuse can be modified. A number of alcoholics "mature out" of alcoholism cutting down or eliminating their alcohol intake in the later years their lives. The most promising approaches in the treatment of alcohol dependence are

- Motivational enhancement therapy suggests that when the individual is motivated to change he will muster his intrinsic resources to deal with the problem behaviour.
- Skills training hold that training in behavioural skills is necessary for abstinence from alcohol as most individuals are deficient in refusal skills and assertiveness.
- Relapse prevention focuses on cognitive behavioural model of relapse prevention.

16.2.3 The Multimodal relapse prevention model

By themselves each of the three models are not self-sufficient. A **multi-modal approach** combining several treatment modalities has the advantage of being more comprehensive than any one model of treatment. Multimodal and broad-spectrum cognitive behavioural therapy also treats biological environmental factors. The goals of these approaches are to decrease the reinforcing properties of alcohol, to teach people new behaviours that are incompatible with alcohol abuse and to modify environment to include positive reinforcement for activities that do not involve alcohol. Multimodal approaches combine various methods of cognitive behavioural change to modify drinking behaviour and environment in which it occurs. Theyidentify the life problems

that may be related to alcohol abuse and deal with them by instilling a broad range of coping skills. Relapse prevention techniques are astomarily built into these programs to enhance long-term maintenance.

In treating alcoholic abuse the first phase of treatment is **detoxification**. Since this can produce were symptoms and health problems, it is typically conducted in a carefully supervised and medically monitored setting. Then the therapy begins which is a short term, intensive, and inpatient treatment allowed by a period of outpatient treatment. Some patients attend follow-up sessions, whereas others are discharges to supervised living arrangements.

A variety of behaviour modification techniques have been incorporated into alcohol treatment programs. The aversion therapy is one such technique that follows the classical conditioning of pairing alcohol with an aversive agent, a chemical called **Emetine**. The ingestion of emetine and alcohol produces nausea and vomiting. Some programs pair alcohol consumption with electric shock or other chemical arguments such as **Antabuse.**

Transition back into their family. Despite these programs relapse is quite common. However relapses shows not be considered as setbacks in along the way. Relapse could be perceived best as an important toward maintenance and as an opportunity for intervention rather than as failure or lack of self-control.

Thus an effective approach to alcohol abuse appears to be one in which biological environmental factors are acknowledged and treated simultaneously. Combining aversion therapy with supporting restructuring of the patient's environment as well as long-term relapse prevention skills approach to be the most successful approach. The multimodal or broad-spectrum approaches have proven to successful but complete abstinence occurs in very small percentage of drinkers.

16.3 DRUG ABUSE

Both legal and illegal drugs pose potential health hazards. However, illicit drug create many serious problems as they have impurities and they have no insurance and they can also be dangerous. For anyone to have an effect it must intervene in biological processes. All drugs have potential hazards, but don‟t termed safe are tested by the federal Food and Drug Administration (FDA) and are termed safe. They consider a drug safe if its potential benefits outweigh its potential hazards. Many drugs such as antibiotics have been approved even though they produce severe side effects in some people.

Many psychological aspects of drug addiction represent non-adjustive behaviour that so individuals resort to. Broadly speaking the reactions of drug addicts fall under the category of characterised disorders. In the last three decade the phenomenon of drug abuse has assumed enormous proportions has become a serious threat to order and society's survival. Many of these drugs provide the kind experience emotional and psychotic reactions. They make the users progressively depressed and be about severe physiological states of drug craving which makes them desperate for drugs. This lead to indulgence in all kinds of crimes and delinquency.

The dynamics of drug use are complex and involve a number of socio-cultural and psychological factors. The personality traits of drug addicts suggest impulsiveness,

rebelliousness and dependency they are also characterized by low frustration tolerance, inability to endure tension, feelings of inadequacy of self-devaluation. Many addicts are immature and dependent individuals with unrealistic levels aspirations and are unable to face failures. Using drugs is a kind of reaction formation so that it alleviations their insecurities, anxieties and tensions even though for a short while.

It is beneficial for counsellors working in medical settings to have sometraining in addictions to substance abuse. All counsellors should have Basic knowledge of addiction such as physical and psychosocial effects of substance abuse

- Knowledge and skills to screen clients for addiction
- Knowledge of community treatment programs and support groups for referral purpose.

Some of the drugs that are frequently abused along with the physical and psychosocial effects presented in this section

16.3.1 Drugs that are abused

Sedatives are drugs that induce relaxation and sometimes intoxication by lowering the activity in the brain, the neurons, the muscles, and the heart by slowing the metabolic rate. In high doses these cause loss of consciousness and can result in coma and death due to inhibitory effect on the brain that controls respiration. Sedatives include barbiturates, tranquilizers, opiates and methadone, but commonly used drug is alcohol. Depressant effects are a major problem with sedative drugs and that effects are additive when taken in combination. The effects of mixing two or more drugs can be danger relatives when mixes with other depressant provides a lethal combination that do not nullify each other triggers both sets of effects.

Barbiturates are synthetic drugs used medically to induce sleep. Barbiturates produce effects far to alcohol and produce tolerance and dependence. People who take barbiturates as sleeping pills on regular basis are not able to sleep without them and manifest withdrawal symptoms when they stop taking. Withdrawal is similar to that from alcohol and includes tremors, nausea, vomiting, sweating and disturbances and some hallucinations and deliriums.

Tranquilizers are chemical compositions of benzodiazepine group. The effects are not severe and all if taken in small quantities but large amounts of these drugs can cause disorientation, confusion and rage, a paradoxical effect for a tranquilizer.

Another category of depressants is the **opiates**, drugs derived from the opium poppy. Opium can be refined into morphine, which can be further chemically treated to produce heroin, which is popular thing young adults and high school students. Synthetic compounds, including methadone are similar to opiates and produce similar effects. Opium has been used for centuries for both medical and recreational purposes, It can be ingested by swallowing, sniffing, smoking or injecting under the skin, into muscle or intravenously making it one of the most versatile drugs for transmission into the body. The principal medical use of opiates is to relieve pain where the person's subjective experience of pain finishes.

Stimulant drugs tend to make some people feel more alert and energetic, able to concentrate and to work long hours. They make other users feel jittery, anxious and

unable to stand still. Stimulants induce alertness, reduce feelings of fatigue, elevate mood and decrease appetite. It is mostly students who are stimulants. **Amphetamines** are stimulant drugs that are abused for their mood altering effects. They produce physical symptoms as increased blood pressure, slower heart rate and relaxation of bronchial muscles. The effects of this drug can be dangerous to the cardiovascular system. The psychological effects this drug include hallucinations and paranoid delusions. Amphetamines produce undesirable affects such dependence and tolerance, **Cocaine** is another stimulant capable of blocking neural transmission and it is used for its anaesthetic effects in medical surgery. The use of Crack, a form of freebase cocaine is manly used by college students and young adults because it is cheap and widely available.

Marijuana produces the psychological effects of euphoria; a sense of well-being, feeling relaxed heightened sexual responsiveness. Its potential for serious health consequences is still debated. wreathless any drug used chronically and in heavy doses poses a danger to health. Thus marijuana has the potential to impair health and is frequently used would be harmful to the respiratory system.

Many athletes have been banned from participation in competitions because of doping. Use of **steroids** increases muscle bulk and decreases body fat that make them attractive to athletes and body builders despite their harmful effects that include prevention of normal functioning of adrenal gland secretes endogenous steroids, risk for coronary diseases, altering reproductive functioning, abnormal functioning and producing severe mood and psychotic impairments.

Most people believe that some drugs are acceptable and even desirable because of their medical benefits but most of them are potentially harmful to health asthey have the capacity for tolerance or dependence. Treatment for the use and abuseof illegal drugs is similar to treatment of alcohol abuse. The all of treatment for all types of illegal drug use is total abstinence.

16.3.2 Screening individuals for substance abuse

According to the Substance Abuse and Mental Health Services Administration (1998) publication. Addiction Counselling Competencies, the following competencies are deemed necessary for screening individuals for substance abuse:

1. Establish rapport including management of crisis situation and determination of need for addiction professional assistance.
2. Gather data systematically from the clients and other available sources using screening instruments. Data should include current and history of substance abuse, health, mental health, mental status a current social, environmental and economic constraints.
3. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms, aggressions danger to others; potential for self-inflicted harm or suicide; and coexisting mental health problems.
4. Assist the client in identifying the impact of substance abuse on his/her current life problems and the effects of continues harmful use or abuse.
5. Determine the client's readiness for treatment and change as well as the needs of others involves the current situation.
6. Review the treatment options that are appropriate for the client's needs, characteristics, goals and financial resources.

7. Apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.
8. Construct with client and appropriate others an initial action plans based on client need preferences and resources available.
9. Based on initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.

16.3.3 Interventions for drug abuse

Interventions may involve medical, psychological and sociological procedures. **Medical procedures** include drug therapy that helps in alleviating psychotic and neurotic symptoms it however do not resolve inner conflicts or personality change. Therefore there may be a relapse when treatment withdrawn. **Psychological** treatment aims at alleviating the individual's maladjusted behaviourand striving to bring about personality change to foster more effective adjustment. Psychological treatment includes three types.

Supportive psychotherapy aims at helping the individual feel more adequate to face his problems confidently.

Behaviour modification aims at modifying the individual's maladaptive behaviour through substitution more effective coping techniques.

Re-educative psychotherapy helps gain an insight into oneself such that one is able to modify and change faulty assumptions and attitudes, paving the way for fundamental change in personality organization would also be necessary to deal with the individual's social environment and his or her adjustment to its Conditions of stress in the individual's life situations that interfere with his adjustment should also modified.

In most cases, changes in **family** situation help make more effective adjustment possible. An effective program of treatment should include medical, psychological and sociological approaches. Psychological preventive measures need attention in public education, concerning the detection and correction of pathological tendencies at the earliest stage. Rehabilitation of the weaned drug addicts is of vital importance as relapse is quite common among those who have quit.

16.3.4 Prevention Programs in Educational institutions

As mentioned earlier it is mostly the youth who succumb to drug abuse therefore it is essential for implementing effective substance abuse prevention program in schools and colleges under the guidance of school counsellors. In **education institutions, curriculum integration** is a substance abuse prevention approach that school counsellors can employ to further guidance and involve greater numbers of teachers in the total process. For example an English teacher might teach spelling and integrate knowledge of the risk of marijuana smoking using a spelling listof words such as carcinogen. Similarly, a social studies teacher might teach personal decision-making steps in relationship to critical decisions made at some point in history. This integration does not require additional time to achieve the objective of counselling for substance abuse and also allows the substance abuse prevention program components such as - decision making, social skills, coping skills, assertive skills and the like to overlap as a

part of a comprehensive developmental guidance program.

16.4. COUNSELLING INTERVENTIONS FOR ALCOHOLIC AND DRUG ADDICTION (AOD)

1) Motivational interviewing: Motivational interviewing (MI) is an evidence-based clinical intervention originally introduced into the AOD field over three decades ago by Bill Miller. It is not a comprehensive treatment in itself, but rather an integrated set of person-centred interviewing skills aimed at resolving ambivalence around change. It is relatively brief (most often tested in 1–4 sessions or in a brief format of 15 minutes or less), generalizable across problem areas such as diet, exercise, management of cardiovascular disease, gambling and HIV risk behaviour (Rollnick, Miller, & Butler, 2008), and complementary to other treatment methods, for example, CBT (Miller & Rollnick, 2013). It appears to increase treatment retention and reduce relapse rates (Burke, Arkowirz, & Menchola, 2003; Hettema, Steele, & Miller, 2005), and foster positive change and deepen engagement (Lundhal, Kunz, Brownell, Tollefson, & Burke, 2010). Outcomes are similar to those for other specific treatments, but MI usually achieves positive results in a shorter time (Lundhal et al., 2010).

2) Problem-solving: Encountering and successfully negotiating problems is a part of everyday life. When clients are attempting to change their AOD use, encountering problems that may delay or threaten changes is a frequent occurrence. Therefore, ensuring that clients have adequate problem-solving skills is an important aspect of treatment and reduces the risk of relapse. Teaching problem-solving skills is associated with better treatment outcomes.

Many people with psychological, social or AOD issues have poor problem-solving skills. At the same time, most clients have solved problems in their lives and counsellors should encourage clients to recognize and value the skills they already have. A way of doing this is to ask clients what steps they have employed in the past in order to solve problems.

A variety of techniques is beneficial when teaching clients problem-solving skills. Verbal instruction, written information and skill rehearsal can all be useful. People with CI or conditions affecting their executive function, such as fetal alcohol spectrum disorder, schizophrenia, depression and ADHD may find problem-solving a difficult exercise and can require a lot of practice, repetition and simple information (Snyder, Miyake, & Hankin, 2015). For suggestions on techniques to use with cognitively impaired clients, see the chapter on Cognitive impairment
The goals of problem-solving are to assist clients to:

- recognize the existence of a problem
- generate potential solutions to the problem
- choose the most effective option and plan how to implement it
- Implement this option and evaluate how effective the approach was.

The aim of problem-solving is not for the counsellor to solve the client's problems, but rather for the counsellor to teach the client a method with which they can solve their own problems. Problem-solving steps, based on D'Zurilla and Goldfried (1971), are outlined in the following section.

3) Goal-setting: Goal-setting is a technique derived from CBT. It entails the client and counsellor using information gathered during the assessment to develop a plan for achieving mutually agreed outcomes.

Goal-setting:

- provides directions for treatment planning (see chapter on Treatment planning)
- clarifies the client's expectations of counselling
- clearly establishes what can and cannot be achieved in counselling
- provides a basis for selecting and using particular therapeutic techniques and strategies
- enables progress to be measured over time, which allows clients to experience success
- Ensures that counselling remains client focused and directed, irrespective of the theoretical orientation of the counsellor.

Although AOD use goals will be central to most AOD treatment programs, clients present with a range of goals relating to various aspects of their lives (e.g. relationships, social functioning, study, work, criminal behaviour, physical and/or mental health). Therefore, as well as acting as a source of motivation for clients, goals assist in determining whether the counsellor and/or service meets the client's needs in working towards their goals and whether referrals for additional services are likely to be required (see chapter on Referral). A client's particular AOD use goals are also relevant to the suitability of a particular service, treatment approach, or counsellor. For example, if a client's goal is controlled AOD use or opioid pharmacotherapy use, then an abstinence-based program will not be suitable.

4) Relapse prevention and management: It has been estimated that up to 90% of individuals will lapse (at least one drink or one occasion of other drug use after a period of abstinence) within the first year of abstaining from AOD use (Allsop, 1990). A lapse frequently turns into a relapse (a return to pre-treatment levels of AOD use), and research indicates that between 40% and 60% of clients will end up relapsing (National Institute on Drug Abuse, 2009). For example, an American longitudinal study of methamphetamine users found that 61% relapsed within 12 months of finishing treatment, and 14% relapsed in the 2–5 years after treatment (Brecht et al., 2014). Consequently, the probability of relapse needs to be considered with all clients.

It is important to consider some of the factors associated with AOD relapse. The literature suggests the following:

- clients are more likely to relapse when they have support systems that are not conducive to abstinence clients are more likely to relapse when they do not believe that they can achieve their goals
- clients with complex psychological issues are more likely to relapse when their underlying psychological issues such as co-occurring mental health conditions or trauma are not dealt with
- clients with CI are more likely to relapse
- young people are extremely likely to relapse
- relapse is often dependent on the quality of the post-change lifestyle
- Clients with disease model beliefs are more likely to relapse.

Relapse prevention strategies can be applied to any goal. They are simply strategies that enable the client to feel a sense of control over their decisions and activities, as well as giving them the sense of active involvement in the change process.
The goals of relapse prevention are to:

- prevent an initial lapse and maintain abstinence, reduced use or harm reduction
- Manage a lapse if it occurs and prevent it continuing to become a relapse.

5) Harm Reduction: Under the National Drug Strategy (2017–2026), harm reduction is defined as "reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community" (Department of Health, 2017, p.1).

Harm reduction can include population-based prevention activities such as raising awareness of strategies to reduce harms, for example, drink-driving campaigns; targeted approached to at-risk groups, such as NSPs for people who inject drugs; and education about harm reduction strategies with individual clients who use AOD.

Harm reduction recognizes that while not using alcohol or other drugs is the most effective way of reducing AOD related harms, people continue to use them. For this reason, when working with clients it is important to discuss harm reduction strategies.

6) Brief intervention: A brief intervention (BI) is a short client contact delivered in the normal course of a workers' day-to-day work, lasting from 1–4 sessions of 5–60 minutes (Heather, 2012, 2014). BIs have been applied to a range of health issues including smoking cessation, changing dietary and exercise habits, weight management, and reducing alcohol consumption or cholesterol levels (Nilsen, Kaner, & Babor, 2008). BIs involve the worker making the most of any opportunity to raise the issue of a client's AOD use and offer a change intervention to those reporting risky or high-risk use. AOD BIs can take place in a range of settings including AOD services, primary health care, GP clinics, allied healthcare, and mental health, community-based, welfare and corrections settings (Heather, 2012, 2014; Webb, Bertoni, & Copeland, 2015).

BI can be part of specialist treatment, such as a routine assessment using a universal tool to screen a client's AOD use, followed by further assessment if dependence is evident. Alternatively, a BI can be opportunistic (an OBI) when delivered to people not seeking treatment but asked about their AOD use as part of a health check at hospital or in the community (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Nilsen et al., 2008).

BIs aim to engage the person in a conversation about the health issue, such as smoking or alcohol use, to determine their level of concern about their current risky or high-risk pattern of use. The intervention can include a combination of brief advice and a brief motivational interview (BMI) (DiClemente et al., 2017; Heather, 2014; Rollnick, Miller, & Butler, 2008). BIs can also be used as part of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model as described by Madras et al. (2009) and Young et al. (2014).

Because a BI requires minimal worker time and training they can have more client contact in different settings with a greater reach in reducing AOD risk and harms (Heather, 2014). A BI can be cost-effective from a public health perspective, but this

depends on the client's level of risk and readiness to change. However, this is only if supported by widely disseminated and routinely implemented policy within a workplace (Heather, 2012; McCambridge & Saitz, 2017; Nilsen et al., 2008).

After nearly three decades, BIs and screening are well established as effective strategies in reducing risky or harmful alcohol consumption, especially in primary health care (Kaner et al., 2018; McCambridge & Rollnick, 2014). BIs for smoking cessation have been well researched and shown to be effective in reducing smoking related harms (Centre for Population Health, 2015; Stead et al., 2013).

DiClemente et al.'s (2017) review supported the use of BMIs or motivationally enhanced interventions in alcohol and tobacco BIs. Further, Young et al.'s (2014) systematic review confirmed the effectiveness of the SBIRT model and demonstrated BIs as effective in reducing alcohol and tobacco use, while Kaner et al. (2018) concurs with this finding when comparing BIs to minimal or no intervention.

BI for illicit drugs including cannabis, opioids and ATS have been less well studied and evidence for their effectiveness is inconclusive (Bernstein et al., 2009; Young et al., 2014). Webb and colleagues (2015) studied very brief interventions (VBIs) for cannabis, with positive results for interventions 10–20 minutes in duration. Further research is recommended for VBIs less than 10 minutes. Nonetheless, BI consisting of a single session enables a worker to raise the issue of AOD use with clients, including young people, and discuss strategies for reducing use and harms (Bernstein, 2014; McCambridge & Strang, 2004; Stockings et al., 2016).

Rollnick, Mason and Butler (1999) stated that a BI should be delivered in a sensitive and non-judgmental manner as a client may not previously have considered their AOD use an issue. Using a BMI style can help the worker engage the client in a conversation about their risky or high-risk AOD use that may support them to think about change (DiClemente et al., 2017; Heather, 2014).

7) Group work: Group work is a common and useful treatment approach in the AOD field. There are many types of groups, including support groups, task-focused and educative groups, as well as therapeutic community groups. The intricacies of group work are beyond the scope of this guide. Instead, this chapter provides an overview of the broad issues underpinning basic group work and information applicable to group work in general.

As the Center for Substance Abuse Treatment ([CSAT] 2005) noted, group work can be highly effective and has many benefits, including:

- providing peer support
- offering inspiration
- enhancing motivation
- reducing feelings of isolation and inadequacy
- providing role models – people who have overcome similar issues
- offering opportunities for clients to practice communication skills
- allowing a single treatment professional to help several clients at the same time

8) Relaxation strategies: There is a strong association between AOD use and feelings of anxiety and stress. People often begin to use drugs to reduce these feelings. Over time these feelings become triggers for AOD use and are strongly associated with relapse.

The efficacy of relaxation training in reducing anxiety has been established (Manzoni, Pagnini, Castelnuovo, & Molinari, 2008; Pagnini, Manzoni, Castelnuovo, & Molinari, 2010). Further, relaxation training has been found to decrease cravings in people recovering from substance use disorders (Chang & Sommers, 2014) and ex-smokers (Cropley, Ussher, & Charitou, 2007). Relaxation training can therefore play an important role in a client's treatment program. Clients who suffer very high levels of anxiety and stress may find relaxation training particularly beneficial.

Note that traumatized clients can have unpredictable and at times negative reactions to relaxation strategies (e.g. flashbacks, dissociation), so when introducing relaxation strategies all clients must be given permission to halt the process if they are feeling uncomfortable. Grounding strategies (see chapter on Grounding) can be more useful for some traumatized clients and are recommended for traumatized clients in moments of extreme distress.

Some of the most popular relaxation techniques are described below. Their success will vary from one individual to another. The client and counsellor can work together to find acceptable and useful relaxation strategies. Relaxation training can also be delivered effectively in a group format (Manzoni et al., 2008).

9) Mindfulness: Mindfulness therapies have become popular over the past 15 years, but their origins hark back to the teachings of the Buddha over 2500 years ago. Mindfulness is a form of awareness that emerges from "paying attention on purpose, in the present moment, and non-judgmentally" to ongoing experience (Williams et al., 2007). All thoughts and feelings, whether pleasant or unpleasant, are accepted as they are. Mindfulness can help clients to be less reactive to thoughts and feelings related to using and emotional distress.

Mindfulness can be practiced in both formal and informal ways. Formal practice involves the systematic application of mindfulness through specific exercises such as mindfulness of breath, sitting meditation, body scan meditation or walking meditation. Informal practice involves the application of mindfulness skills to everyday situations, bringing an open, accepting and discerning attention to the activities of day-to-day living such as driving, reading or eating.

Several reviews have examined the efficacy of mindfulness interventions for AOD problems (Li, Howard, Garland, McGovern, & Lazar, 2010; Sancho et al. 2017; Zgierska et al. 2009). The most recent of these reviews (Sancho et al., 2017) found that mindfulness-based therapies were successful at reducing dependence, craving and other addiction-related symptoms by improving mood state and reducing emotional deregulation.

10) Challenging unhelpful thinking: Cognitive restructuring (challenging unhelpful thinking) is based on the idea that our behaviours and feelings are a result of our unconscious or automatic thoughts. In turn, our thoughts are related to our deeply held beliefs about ourselves, others and the world, also termed 'schemas' (core beliefs). While experiencing unhelpful automatic thoughts is very common in the general population, people with anxiety, depression, trauma and other psychological difficulties can experience these unhelpful automatic thoughts more intensely and often (Williams & Garland, 2002). When these unhelpful automatic thoughts occur frequently, almost becoming a default response, they can be considered unhelpful thinking styles.

Cognitive restructuring is a CBT technique based on the premise that changing unhelpful thinking can change clients' emotions and behaviours (Larsson, Hooper, Osborne, Bennett, & McHugh, 2016). It involves clients identifying and then challenging automatic thoughts and the underlying core beliefs that result in negative feelings and unhelpful behaviours. As automatic thoughts are challenged and disputed using cognitive restructuring exercises, their ability to cause negative feelings and unhelpful behaviours is weakened.

The benefit of cognitive restructuring is that as well as reducing the frequency and intensity of unhelpful thinking, clients can learn to distance themselves from their thoughts and view thoughts as "psychological events" (Larsson et al., 2016, p. 453).

11) Anger management: Many clients who use AODs experience difficulties related to managing anger (Walitzer, Deffenbacher, & Shyhalla, 2015). Novaco (2016) stated:

Anger is a normal and adaptive human emotion. Anger is an affective (mood or feelings) response to survival threats or otherwise stressful experiences. It is a primary emotion having adaptive functions linked to survival mechanisms that are biological, psychological, and social in nature. (p. 285).

Anger may become problematic when it occurs frequently, at high intensity, and leads to secondary problems (DiGiuseppe & Tafrate, 2007). These secondary problems can include aggressive behaviour (including family and domestic violence), risk-taking, self-harm, health problems, and high levels of stress and/or psychological distress (Scanlan, Parker, & Montague, 2016). It can cause significant personal distress, such as feeling out of control, guilty and ashamed (Deffenbacher, 2011). Problematic anger, and associated behaviours, can also lead to negative consequences such as strained relationships, difficulties in the workplace and legal issues. In addition, problematic anger is associated with increased AOD problems, problem gambling, self-harm and suicidal ideation. Research also shows that it is associated with depressive and anxiety disorders (Scanlan et al., 2016).

Anger is a highly stigmatized emotion and myths about anger can make it harder for clients to seek help for anger related problems (Scanlan et al., 2016). Anger is often confused with aggression, but aggression is a behaviour that is intended to cause harm through threats, verbal abuse or violent acts. Anger is an emotion which does not automatically lead to aggression (Reilly & Shopshire, 2013).

Problematic anger is often linked to previous experiences that have left people feeling powerless, lacking in self-worth, or threatened by others (Novaco, 2016). Problematic anger is included in the diagnostic criteria of numerous psychological disorders, including some personality disorders, depressive and anxiety disorders (American Psychiatric Association, 2013). Problematic anger is commonly part of a more complex clinical presentation, and clients presenting with it should undergo a comprehensive clinical assessment.

Not all clients will be motivated to manage their anger and client readiness has a major impact on the effectiveness of an anger management intervention (Howells & Day, 2003). Anger management strategies should not be incorporated into treatment until the client starts to consider the management of their anger a desirable goal. MI can be a very useful technique for clients who demonstrate ambivalence about their anger management.

It is important to normalize the client's experience of anger, which is a common and often appropriate, understandable emotional reaction. This can reduce the client's sense of shame about their anger. It can encourage them to discuss the intensity and frequency with which they experience problematic anger and any inappropriate behaviours that have occurred. It is also important to distinguish between the feeling of anger and how this is expressed (Scanlan et al., 2016). The client's difficulties with problematic anger can be framed in terms of the way it is expressed (e.g. violence, aggression) and what triggers it (e.g. misinterpretations of situations). Learning how to express anger in a healthy way with skills such as assertiveness and problem-solving may be protective against depression and anxiety (Scanlan et al., 2016).

12) Assertiveness training: There is evidence of a relationship between low assertiveness and social phobia (Chambless, Hunter, & Jackson, 1982), general anxiety (Orenstein, Orenstein, & Carr, 1975), and substance abuse relapse (Marlatt & Gordon, 1980). Meanwhile, there is evidence that assertiveness training can increase self-esteem (Temple & Robson, 1991) and reduce harmful drinking (Connors & Walitzer, 2001) and drug use (Horan & Williams, 1982; Williams, Hadden, & Marcavage, 1983). Assertiveness training can be helpful for clients, particularly those who tend to communicate in an overly passive or aggressive manner.

16.5. SUMMARY

Alcoholism is a social problem that also affects the health of the individual. It encompasses a variety of behaviour patterns that have physiological and psychological needs characterized lack of control over drinking and subjective craving for alcohol.

Intervention programs involved in counselling alcohol dependence are: motivational enhancement therapy skills training and relapse prevention. By themselves each of the three models are not self-sufficient. A multi-modal approach combining several treatment modalities has the advantage of being more comprehensive than any one model of treatment.

Most drugs provide the kind of experience similar to emotional and psychotic reactions. A number of socio-cultural and psychological factors are involved in drug abuse. Drug addicts show the traits of impulsiveness, rebelliousness and dependency.

It is beneficial for counsellors working in medical settings to have sometraining in addictions and substance Interventions may involve medical, psychological and sociological procedures. Medical procedures include drug therapy that helps in alleviating psychotic and neurotic symptoms it however does not resolve inner conflicts or personality change

16.6. TECHNICAL TERMS

Craving: An interrelated set of psychological, physiological, behavioural and biochemical response seen in alcoholics

Curriculum integration: It is a substance abuse prevention approach that school counsellors can employ.

Multi-model approach: This is a comprehensive approach to alcohol abuse that includes several treatment modalities and treats biological and environmental factors

alike.

16.7. SELF ASSESSMENT QUESTIONS

1. Examine the interventions involved in alcoholic de-addiction
2. What are the different drugs abused and explain their treatment modalities

16.8. REFERENCE BOOKS

1. Locke, D.C., Myers, J.E & Herr .E.L (2001). The Handbook of Counselling. California: Sage Publications.
2. Narayana Rao, S. (1997). Counselling and Guidance. New Delhi: Tata McGraw-Hill.

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303SW21

ACHARYA NAGARJUNA UNIVERSITY
CENTER FOR DISTANCE EDUCATION
SEMESTER-III
SOCIAL WORK

Paper-3: COUNSELLING THEORY AND PRACTICE

Time: Three house **Maximum: 70 Marks**

Answer any Five Questions
All Questions carry Equal Marks

1. Explain the concept, definition and meaning of counselling?
2. Discuss the behavioral theory of counselling?
3. Trace the theoretical Beginnings of Behavioral counselling?
4. Describe the factors influencing counselling process?
5. Explain in detail the Directive and Non-Directive Counselling Techniques?
6. Define Empathy, its uses and scale to measure Empathy?
7. Briefly explain the interventions included for treating children with mentally retardation?
8. What is premarital counselling? Discuss the significance of premarital preparation and counselling?
9. Briefly explain cognitive techniques of counselling for depression?
10. What are the different drugs abused and explain their treatment modalities?