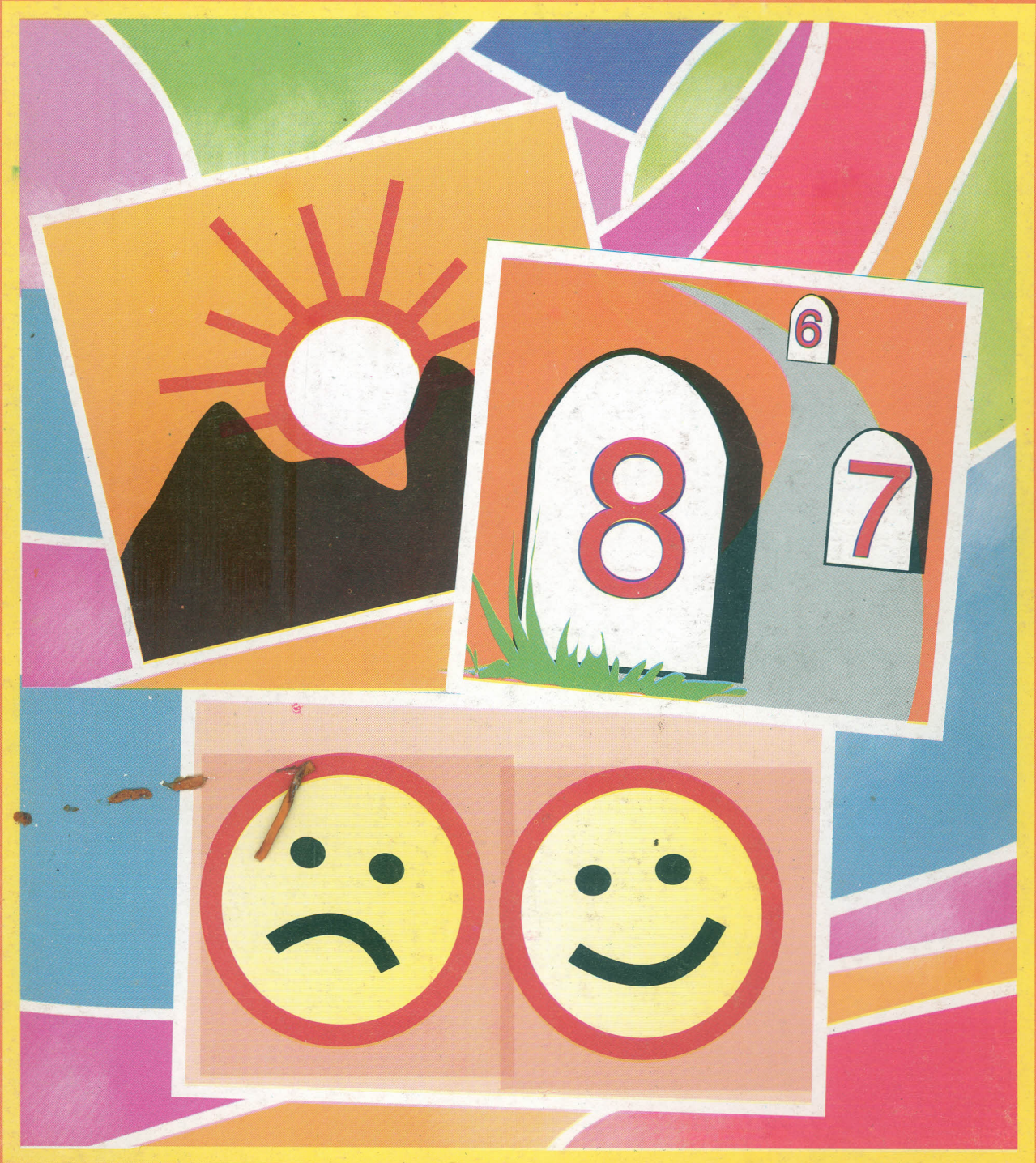


MCFT-003
Counselling and Family Therapy:
Basic Concepts and
Theoretical Perspectives



“Education is a liberating force, and in our age it is also a democratizing force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances.”

— Indira Gandhi

“शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्तगत विषमताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।”

- इन्दिरा गांधी



Indira Gandhi National Open University
National Centre for Disability Studies

MCFT-003
Counselling and Family
Therapy: Basic Concepts
and Theoretical
Perspectives

Block

2

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BLOCK 2 SCHOOLS OF COUNSELLING AND PSYCHOTHERAPY

The Block 2 of Course MCFT-003 is named as "Schools of Counselling and Psychotherapy". As the name suggests we will study various approaches to counselling in this Block. This Block broadly includes counselling approaches like psychodynamic approaches, cognitive behavioural approaches, person-centered approaches, group counselling and other counselling approaches. The Block consists of four Units.

Unit 5 is "Psychodynamic Approaches". The Unit begins with the discussion on historical roots of psychodynamic therapy. The Unit also defines psychodynamic psychotherapy including the assumptions of psychodynamic approaches and differences between psychoanalysis and psychodynamic. The processes in psychodynamic psychotherapy are also explained in this Unit, which includes indications and contraindication for psychodynamic psychotherapy and phases of psychodynamic psychotherapy like initiation phase, middle phase and termination phase. The Unit also highlights the evolution of short-term psychodynamic psychotherapies and types of short-term psychodynamic psychotherapy. The differences between long-term psychodynamic psychotherapy and short-term psychodynamic psychotherapy are also described in detail. At the end, the Unit acquaints you with knowledge on efficacy and effectiveness of psychodynamic psychotherapy.

Unit 6 is on "Cognitive Behavioural Approaches". The Unit begins with the history of cognitive behavioural therapy. Further, the Unit explains the concept of cognitive behavioural therapy which includes Rational Emotive Behaviour Therapy (REBT) by Ellis and its application to family therapy. Cognitive Therapy by Aaron Beck is also discussed in detail, in this Unit. It includes basic principles of cognitive therapy, genesis of the problem, homework/assignment and the importance of structure. The Unit also acquaints you with the knowledge of Donald Meichenbaum's Cognitive Behaviour Modification (CBM). The constructivist perspective is described in this approach. Therapist's function and role are also explained in this Unit. All these approaches has some differences and similarities which are discussed in detail, further the differences of CBT from other therapies are also explained. After studying this Unit you will know that what types of problems can be addressed by this approach. Further, cognitive behavioural approached are critically analysed with the merits and limitations of CBT. To make the CBT more understandable the case illustration of A-B-C-D is explained in the end of this Unit.

Unit 7 entitled "Person-centered Counselling". The Unit begins with the introduction and assumptions in person-centered counselling. Further, it acquaints you with the evolution of person-centered approach in various stages like stage 1: nondirective (1940 – 1950), stage 2: client-centered (1950 - 1961), and stage 3: person-centered(1961 - present). Major concepts of person-centered approach are also discussed in this Unit such as actualizing tendency, self-concept, organismic valuing process and need for positive regard. The unit further explained the goals and conditions for person-centered counselling. Core conditions for growth like congruence, empathic understanding, and unconditional positive regard are also discussed

in detail. The Unit also acquaints you with knowledge of strategies for providing the care. At the end of the Unit, limitations and criticism of person-centered counselling is explained.

Unit 8 is on "Group Counselling and Other Counselling Approaches". The Unit begins with the introduction of group counselling which includes meaning of groups, types of groups, multi-cultural context, ethical issues, characteristics for a group leadership, skills in group leader, formation of a group. Transactional analysis is explained in detail in this Unit. Basic assumptions, key concepts and goals of transactional analysis are discussed in detail. The therapeutic procedure, implementation of therapy, therapeutic operations, and re-decisional approach of the Gouldings are explained in this Unit. Further, the existential approach to counselling is described with the key concepts and its application. The Unit also acquaints you with the eclectic approach to counselling.

UNIT 5 PSYCHODYNAMIC APPROACHES

Structure

- 5.1 Introduction
- 5.2 Historical Roots of Psychodynamic Therapy
- 5.3 What is Psychodynamic Psychotherapy?
 - 5.3.1 Assumptions of Psychodynamic Approaches
 - 5.3.2 Differences between Psychoanalysis and Psychodynamic Psychotherapy
- 5.4 Processes in Psychodynamic Psychotherapy
 - 5.4.1 Indications and Contraindications for Psychodynamic Psychotherapy
 - 5.4.2 Phases of Psychodynamic Psychotherapy
- 5.5 The Development of Short-Term Psychodynamic Psychotherapy
 - 5.5.1 Types of Short-Term Psychodynamic Psychotherapy
 - 5.5.2 Differences between Long-Term Psychodynamic Psychotherapy and Short-Term Psychodynamic Psychotherapy
- 5.6 Efficacy and Effectiveness of Psychodynamic Psychotherapy
- 5.7 Let Us Sum Up
- 5.8 Glossary
- 5.9 Answers to Check Your Progress Exercises
- 5.10 Unit End Questions
- 5.11 Further Readings and References

5.1 INTRODUCTION

Psychodynamic psychotherapy is a method of verbal communication used to help a person find relief from emotional pain. Any therapy involving the gradual exploration of conflicts not previously accessible to the conscious mind can be considered a dynamic psychotherapy. Psychodynamic treatments and approaches assume that each of us has an inner life that is important in understanding our outer life, and that both are the product of our personal histories.

The theoretical basis for dynamic therapies is '*neurotic conflicts*', that are unconscious conflicts resulting in anxiety and, can lead to psychopathology. The individual's previous experiences and relationships that are relevant to these conflicts and the powerful associated emotions will emerge during therapy. Awareness of these unconscious conflicts, as well as associated desires and symbolic meanings, can bring understanding of the emotional state of a patient, as well as relief from symptoms. Psychodynamic psychotherapy has similarities with detective work. It seeks out motives and tries to read between the lines of human behaviour, focusing on what the patients do not know and do not want to know. It looks for repetitive patterns of behaviour; uses present relationships to shed light on the past and pays attention to the irrational things and unspoken words. The Unit focuses on psychodynamic approaches to therapeutic interventions.

Objectives

After studying this Unit, you will be able to:

- Describe the major psychoanalytic schools that have influenced the development of psychodynamic approaches;
- Define the primary assumptions of psychodynamic psychotherapy and explain how it differs from psychoanalysis;
- Illustrate the indications and contraindications for psychodynamic psychotherapy;
- Elaborate on the therapeutic processes and techniques during the initial, middle and termination stages of psychodynamic psychotherapy;
- Trace the historical development of models of short-term psychodynamic therapy;
- Describe the differences between short-term and long-term psychodynamic approaches; and
- Summarise the research evidence on the effectiveness of psychodynamic psychotherapy.

5.2 HISTORICAL ROOTS OF PSYCHODYNAMIC THERAPY

The theory supporting psychodynamic therapy originated in and is informed by psychoanalytic theory. There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are Freudian psychology, ego psychology, object relations psychology and self psychology.

1. Freudian Psychology

Freudian psychology is based on the theories first formulated by Sigmund Freud in the early part of twentieth century and is sometimes referred to as the *drive* or *structural model*. The essence of Freud's theory is that sexual and aggressive energies originating in the *id* (or unconscious) are modulated by the *ego*, which is a set of functions that moderates between the *id* that seeks immediate gratification of these instinctual drives and the *superego* which represents the moral and ethical demands of external social reality. *Defense mechanisms* are constructions of the *ego* that unconsciously operate to protect against conscious awareness of anxiety-provoking memories, wishes, fears or needs. The major defense mechanism is *repression*, which induces "forgetting" of harsh realities. The *psychoanalytical model* also states that many of the unconscious conflicts develop in early childhood and may account for strong feelings, conflicts and symptoms later in life. This psychosexual theory postulated the oral, anal, phallic, latency and genital stages of development. Psychoanalysis emphasises the concept of *psychic determinism*, which states that people behave in specific ways for specific reasons, even if these remain out of conscious awareness.

2. Ego Psychology

Ego psychology derives from Freudian psychology and its proponents include Heinz Hartmann, Anna Freud, Erik Erikson, Paul Gray and Fred Busch. Ego psychology broadened the scope of psychoanalytic concerns, from psychopathology to general human development and an increased focus on normal and pathological ego functions and adaptation to the demands of reality. Ego psychology stresses the individual's capacity for defense adaptation and reality testing.

3. Object Relations Psychology

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

4. Self Psychology

Self psychology was founded by Heinz Kohut, in Chicago during the 1950s. Kohut observed that the self refers to a person's perception of her or his experience of self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). Disturbances in "*self-object*" internalisations from parents are associated with later difficulties.

Although these theoretical schools differ in many ways, they are united by the emphasis on unconscious elements and their influence on mental health. These psychoanalytical theories have formed the basic elements of contemporary psychodynamic psychotherapy.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Name the four main schools of psychoanalytic thought and their proponents, which have influenced the development of psychodynamic therapy.

.....

.....

.....

5.3 WHAT IS PSYCHODYNAMIC PSYCHOTHERAPY?

Psychodynamic approaches are characterised by certain underlying assumptions and intervention methods. These set psychodynamic approaches apart from other therapeutic modalities.

5.3.1 Assumptions of Psychodynamic Approaches

Psychodynamic approaches are based on certain assumptions; these are as follows:

- 1) what people say and do has meaning, although it may be outside of conscious awareness;
- 2) there are patterns to one's behaviour;
- 3) these repetitive patterns can be discerned from the individual's life narrative, and observed in the therapeutic relationship; and
- 4) although these behaviours become fixed, they can change with insight and understanding.

Psychodynamic psychotherapy utilises seven types of interventions or techniques that differentiate it from other types of therapy (Blagys and Hilsenroth, 2000). These are given below:

- 1) A focus on affect and expression of the patient's emotions;
- 2) Exploration of the patient's attempts to avoid topics or engage in activities that hinder the progress of therapy (avoidance, resistance);
- 3) Identification of patterns in the patient's actions, thoughts, feelings, experiences, and relationships;
- 4) An emphasis on past relationships;
- 5) A focus on interpersonal experiences;
- 6) An emphasis on the therapeutic relationship; and
- 7) An exploration of wishes, fantasies and dreams.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Mark 'True' or 'False':

- | | |
|--|------------|
| i) Psychodynamic psychotherapy focuses on thoughts, feelings and behaviours that have unconscious roots. | True/False |
| ii) Psychodynamic psychotherapy avoids exploration of past childhood experiences and relationships. | True/False |
| iii) Identification of negative automatic thoughts is the hallmark of psychodynamic psychotherapy. | True/False |
| iv) One of the primary goals of psychodynamic psychotherapy is insight. | True/False |

5.3.2 Differences between Psychoanalysis and Psychodynamic Psychotherapy

Psychodynamic psychotherapy has derived from psychoanalysis and has many similarities with psychoanalysis. It may be useful to conceptualise the two that is psychoanalysis and psychodynamic psychotherapy as lying on a therapeutic continuum without many rigid differences. The differences between the two are given as follows:

- The *frequency* of sessions in psychodynamic psychotherapy is lower (1 to 3 sessions per week) than in psychoanalysis (4 to 5 sessions per week).
- The *use of the couch* for patient to lie on during sessions, with the patient out of the therapist's visual range, is characteristic of psychoanalysis whereas patient and therapist sit face to face in psychodynamic psychotherapy.
- The *goals* of therapy tend to be more modest in psychodynamic psychotherapy, when compared with psychoanalysis. This may include symptom relief, only partial personality reorganisation and partial reconstruction of the past. The aim is a more select and focused understanding of problems and some conflict areas may be intentionally overlooked.
- Psychodynamic psychotherapy focuses more on *current* dynamic conflicts and problems than on *past* issues.
- There are some differences related to the *therapeutic relationship*. The adherence to therapeutic neutrality is less rigid in psychodynamic psychotherapy than in psychoanalysis. *Neutrality* means that the analyst does not take sides in the patient's conflicts, express feelings about the patient, or talk about her or his own life. Therapist neutrality is intended to help the patient stay focused on issues rather than be concerned with the therapist's reactions. Psychodynamic psychotherapy also acknowledges the real personality and attitudes of the therapist. There is often more therapist activity in psychodynamic psychotherapy.
- Although psychodynamic psychotherapy stresses the importance of *transference* within the treatment relationship, it does not promote the depth and intensity of the transference to the same extent as in psychoanalysis. Transference refers to patients' repetition of thoughts and feelings connected with siblings, parents or other past figures, in the relationship with therapist. Psychodynamic psychotherapy places greater emphasis on the 'here and now' in terms of the patient's interpersonal relationships and experiences outside of the therapy. Positive transference may not be explored, unless it interferes with progress in therapy. In psychoanalysis, there is much greater emphasis on the experiences within the analysis and the relationship between the therapist and patient. The transference neurosis may be fostered and then analysed.
- In terms of *techniques*, psychodynamic psychotherapy may integrate certain supportive and more directive techniques apart from the techniques like free association, clarification and interpretation derived from psychoanalysis. These include reassuring and affirming the patient and giving of relevant advice, along with emphasis on more here-and-now and partial interpretation. Free association, where the patient talks about whatever comes into mind, without censoring or editing the flow of ideas or memories, is used extensively in psychoanalysis. Free association allows the patient to return to earlier or more childlike emotional states ("regress").

- While psychodynamic psychotherapy may not always vary in *length* from psychoanalysis, there are short-term variants of psychodynamic psychotherapy, upto about 20 sessions, which address focal conflicts. Psychoanalysis is by definition, a long-term treatment lasting from three to five years or more.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Fill in the blanks:

- i) Therapeutic neutrality is strictly adhered to in _____.
- ii) _____ has a relatively greater focus on current conflicts than on past dynamic issues and problems.
- iii) The use of the couch is characteristic of sessions in _____.
- iv) _____ emphasises partial interpretation of unconscious conflicts.
- v) The frequency of therapy sessions ranges from one to three sessions per week in _____.

5.4 PROCESSES IN PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy might not be the treatment of choice for all patients. In this Section, we look at the important indications and contraindications for psychodynamic psychotherapy. The phases of psychodynamic psychotherapy are described with their distinct foci and goals, therapeutic techniques and therapeutic processes.

5.4.1 Indications and Contraindications for Psychodynamic Psychotherapy

There are a number of factors that guide the selection of patients for psychodynamic psychotherapy. These include:

- **Psychological-mindedness** : *Psychological-mindedness* refers to the capacity for insight and to understand problems in psychological terms. Patients with this capacity can think abstractly and symbolically about meanings of behaviour and tend to look inwards for explanations of things that happen to them, rather than externalising responsibility.
- **Motivation for insight and change** : Psychodynamic psychotherapy requires adequate motivation for introspection and change.
- **Average to above average intelligence.**
- **Verbal capacity**: Patients need to have a well-developed ability to verbalise internal experiences.

- **Adequate ego strength** : Adequate ego strength includes the ability to sustain feelings and fantasies without impulsively acting upon them, being overwhelmed by anxiety, or losing the capacity to continue the dialogue. The individual with good ego strength is better able to maintain a therapeutic alliance.
- **Relatively mature superego development** : Patients who commit criminal acts or have inadequate superego development are rarely suitable.
- **Ability to tolerate change and a degree of frustration, sadness and other painful emotion.**
- **The capacity to distinguish between reality and fantasy.**
- **Ability to form and sustain relationships** : The capacity to relate well enough to form an effective working relationship with the analyst. Where there is inability to enter into trusting relationships (for example, in paranoid personality disorder), or where there is significant inability to maintain relationship boundaries (for example, in borderline personality disorder), psychodynamic psychotherapy is not indicated.

People considered best suited to psychodynamic psychotherapy include those with depression, certain personality disorders, anxiety, sexual difficulties, neurotic conflicts and chronic relationship problems. Common problems including difficulties with intimacy, lack of assertiveness, self-defeating behaviour and problems with authority, unresolved grief or problems related to separation or rejection are also treated through this form of psychotherapy.

Assessment of suitability for psychodynamic psychotherapy should also include some external life situations. Patients in midst of major life crisis, for example, loss of job or divorce, serious physical illness or inadequate financial resources may not be suitable for initiating psychodynamic psychotherapy.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Mark 'True' or 'False'

The following patient characteristics are considered as indications for patient selection is psychodynamic psychotherapy:

- | | |
|--------------------------------------|------------|
| i) Good verbal capacity | True/False |
| ii) Use of mature defence mechanisms | True/False |
| iii) Psychological-mindedness | True/False |
| iv) Adequate ego strength | True/False |

5.4.2 Phases of Psychodynamic Psychotherapy

Sessions of psychodynamic psychotherapy may be scheduled from one to three days per week, with greater frequency allowing for more in-depth treatment. The duration of individual sessions varies, but typically lasts for 45 to 50 minutes. The length of treatment may vary from several sessions to months or years.

Initiation Phase

Psychodynamic psychotherapy begins with a period of evaluation in the initial sessions, with a focus on three major tasks. This phase of interviewing and learning may take place in one session or over a series of sessions.

Firstly, the patient's strengths, emotional problems and reasons for seeking treatment are discussed. This process gives the therapist the opportunity to learn about the person, to develop an understanding of her or his troubles, and to formulate ideas about how treatment should proceed. What the therapist focuses on is how the patient reveals herself or himself, patterns of relating to others, feelings and sources of anxiety, initial defenses and resistances to treatment and situations that influence behaviour. Early transference responses by the patient are also noted and stored for future use in the treatment when a better understanding of the patient's past experiences will shed light on the present response.

An important component of the psychodynamic approach is the psychodynamic formulation. This is a statement of the patient's central issues and conflicts. It attempts to explain their role in the present situation and predict how they will affect treatment and the therapeutic relationship. The psychodynamic formulation begins by addressing the question of "*Why this particular patient presents with this diagnosis and these particular problems at this particular time?*" (Perry, Cooper & Michels, 1987). The psychodynamic formulation serves as a kind of blueprint or game plan, and can be modified over time as one gets additional information and circumstances change. When the patient's behaviour in therapy is seen as a manifestation of their individual dynamics, and as characteristic problems can be predicted and understood, the therapist can be more objective, non-judgemental and empathic.

Secondly, this phase involves "getting to know the patient" and forming a sense of trust and safety in the therapeutic relationship.

Thirdly, factors as the frequency and length of sessions, responsibilities of both patient and therapist and the policy for payment are also discussed.

The Middle Phase

The middle phase is devoted to exploring, analysing, working through, and resolving patients' intrapsychic, interpersonal problems and interpreting defenses. In this stage, the transference responses and the resistance to treatment, which only began budding earlier, become more pronounced and become a vital part of the treatment itself. Each individual patient brings her or his own history, problems and ways of relating which makes the practice of doing psychodynamic psychotherapy an art as well as a science.

The term *resistance* is one that is ubiquitous in psychodynamic psychotherapy. It means that the patient is avoiding full awareness of unconscious drives, conflict and fantasies. First, resistance is unconscious, the patient does not know what she or he is avoiding and uses all kind of defenses to avoid that realisation. Second, resistance reflects a search for gratification of a forbidden wish. Third, it also speaks of the fear of change that we all experience in many situations; to try a new pattern of relating is scary. But in order to develop and mature, these resistances need of be explored and understood before new patterns can be tried, a new self-awareness achieved, realities accepted and age-appropriate needs satisfied.

Table 5.1: Some common defense mechanisms

Defence mechanism	Definition
Repression	Relegation of threatening wishes, needs or impulses into unawareness.
Projection	Attribution of conflicted thoughts or feelings to another person/s.
Denial	Refusal to accept information about oneself or others.
Regression	A partial return to childlike levels of adaptation to avoid conflict.
Splitting	Experiencing others as all good or all bad.
Reaction formation	Transformation of an unwanted thought or feeling into its opposite.
Isolation	Divorcing a feeling from its unpleasant idea.
Rationalisation	Using seemingly logical explanations to make untenable feelings or thoughts more acceptable.
Displacement	Redirection of unpleasant feelings or thoughts onto another person.
Dissociation	Splitting off of thought or feeling from its original source.
Conversion	Transformation of unacceptable wishes or thoughts into bodily sensation.
Sublimation	A mature mechanism whereby unacceptable thoughts and feelings are channelled into socially acceptable ones.

One of the major resistances used by any patient is that of *transference*. Transference, in which the individual relates to the therapist based on past experiences with parents or significant others, and the here-and-now collaboration between therapist and patient, together make up the therapeutic alliance. This constitutes one of the most effective tools towards change. The therapist attempts to create a safe environment by being consistent, non-judgemental and supportive.

Countertransference is the phenomenon in which the therapist is affected by and responds to the patient in some unconscious way. This is often viewed as a reaction to the patient's transference. For example, the therapist 'forgets' the appointment of an emotionally demanding patient or the therapist prolongs the treatment sessions of a patient who expresses feeling 'unloved' by her or his mother. Initially, countertransference was considered to be an impediment to psychotherapy but it is now considered to be a potentially very helpful phenomenon in understanding the patient. Therapists need to be self-reflective and recognise countertransference early.

Confrontation highlights aspects of behaviour and feelings that the patient is trying to minimise or avoid. For example, the therapist might say, in a gentle and sensitive manner, "I am not sure if you have noticed, but whenever I ask you to tell me more about your mother, you change the subject".

Clarification is another important intervention wherein the therapist attempts to summarise various things expressed by the patient and even help the patient articulate what they might have difficulty putting in words.

Interpretations may involve explanatory statements that link behaviours, thoughts, fantasies, feelings or symptoms to their unconscious meanings or origins. For example, the therapeutic interpretation might state, "It may be that you cannot confront your colleague at work because he reminds you about your father".

Interpretation of the transference is carried out by linking the experiences in the therapeutic relationship to current or past relationships. These unconscious drives, defenses, attitudes or feelings could be a wish for satisfaction (for example, to depend on someone or to idealise someone or to be taken care of), or need for punishment, or sexual or aggressive fantasies. The therapist becomes the person that the patient struggled with in her or his childhood. These struggles are played out again in the present, but this time with the therapist's help to look at the conflicts. With insight into the way she or he misreads or misperceives other people in the present, new patterns of behaviour and experience could result.

Working through occupies most of the work in psychoanalytic treatment after the transference has been formed and the patient has begun to acquire insights into her or his problems. Working through is a process in which the new awareness is repeatedly tested and "tried on for size" in other areas of the patient's life. It allows the patient to understand the influence of the past on her or his present situation, to accept it emotionally as well as intellectually, and to use the new understanding to make changes in present life. Working through thus helps the patient to gain some measure of control over inner conflicts and to resolve them or minimize their power. This leads the patient to experience wider choices in life, since past distortions no longer cloud present decision making.

The Termination Phase

The final part of the treatment phase is the period in which changes are consolidated and new behaviours are solidified. Old patterns are understood in the context of one's past and old memories are available where previously they have been repressed. Conflicts resulting in maladaptive behaviour in the outside world, which were relived in the therapeutic situation with the therapist, are resolved. Treatment continues until the troubling symptoms have been reduced or alleviated and the person is consistently making use of more adaptive methods of coping with greater insight.

A major issue at the time of termination is to be able to explore issues related to separation, loss and change for both the patient and the therapist. It is an extremely important phase for the patient because it helps the patient review the experience, both emotionally and intellectually, and to be able to separate from a parent-like figure. The therapist also needs to become aware of possible countertransference responses of anger, thoughts about breaking boundaries or failure to terminate when indicated. The length of time allotted to the termination phase varies with the type of treatment and with the needs of the individual.

After this point, the sessions will become less like an interview; the person is asked to say whatever is on her or his mind. It is the therapist's job to listen and to help identify patterns of thinking, feeling and interacting that may be contributing to the patient's current struggles. Consequently, the person becomes more aware of her or his thoughts and feelings; learns how some present ways of coping are no longer adaptive even though they may have been necessary in childhood; and discovers

that she or he as an adult has a greatly expanded repertoire of resources and can use far more effective ways of dealing with problems. Deeper awareness and new insights stimulate psychological growth and change.

Psychodynamic psychotherapy places great importance on the therapeutic dyad, which is a medical term for the relationship between the therapist and the patient. It is within the context of the therapeutic dyad that positive changes in the patient's outlook and behaviours are able to unfold. This relationship is unique because the therapist maintains a uniform, neutral and accepting stance. Unlike other well-intentioned people in the person's life, the therapist has been trained to listen objectively and without criticism. This therapeutic attitude makes it easier for the person seeking treatment to speak freely and to therefore provide as much information for the therapist to work with as is possible.

Check Your Progress Exercise 5

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Choose the correct answer:

- i) In psychodynamic psychotherapy, the analysis of _____ is the process by which the therapist interprets the feelings expressed by the client toward the therapist as being indicative of the feelings typically expressed by the client toward important people in her or his personal life.
 - a) free association b) resistances c) dreams d) transference
- ii) The tentative statement of the patients' individual dynamics and conflicts is called _____.
 - a) psychodynamic formulation b) clarification c) insight d) reaction formation
- iii) All of the following are components of psychodynamic therapy except for:
 - a) interpretation b) working through c) socratic questioning d) clarification
- iv) Issues related to separation, loss and change are prominent in the _____ stage of psychodynamic psychotherapy.
 - a) middle b) termination c) initial d) follow-up
- v) In psychodynamic psychotherapy, _____ is the process by which new insights are acquired and these are used to make changes in current life situations and functioning.
 - a) analysis of defences b) analysis of transference c) working through d) interpretation
- vi) The defense mechanism in which an unacceptable thought or feeling is transformed into its opposite is:
 - a) displacement b) sublimation c) reaction formation d) denial

5.5 THE DEVELOPMENT OF SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY

Current trends highlight the evolution of short-term dynamic therapies. The healing and change process envisioned in long-term psychodynamic therapy typically requires at least two years of sessions. This is because the goal of therapy is often to change an aspect of one's identity or personality or to integrate key developmental learning missed while the client was stuck at an earlier stage of emotional development. Practitioners of brief psychodynamic therapy believe that some changes can happen through a more rapid process or that an initial short intervention will start an ongoing process of change that does not need the constant involvement of the therapist. A central concept in brief therapy is that there should be one major focus for the therapy rather than the more traditional psychoanalytic practice of allowing the client to associate freely and discuss unconnected issues. In brief therapy, the central focus is developed during the initial evaluation process, occurring during the first session or two. This focus must be agreed on by the client and therapist. The central focus singles out the most important issues and thus creates a structure and identifies a goal for the treatment. In brief therapy, the therapist is expected to be fairly active in keeping the session focused on the main issue. Having a clear focus makes it possible to do interpretive work in a relatively short time because the therapist only addresses the circumscribed problem area.

5.5.1 Types of Short-Term Psychodynamic Psychotherapy

Major influences on the development of short-term psychodynamic approaches include Ferenczi, Rank, Reich and Alexander. Franz Alexander challenged the psychoanalytic emphasis on frequent, long-term treatment that could foster dependency. He emphasised the need to identify a "focal conflict", need for an adequate dynamic formulation and the central role of the "corrective emotional experience". Alexander and French (1946) asserted that the principal curative power of treatment occurs as the patient gains the emotional perception that she or he is no longer a child and no longer subject to the unconscious behaviour patterns put in place at that time. Alexander offers the example of a patient's early expressions of aggression having been intimidated by a father who required complete submissiveness from his son. As a result the patient has become inhibited in all situations in which she or he faces a person of authority. The patient makes that shift when she or he can express her or his aggressiveness and her or his vulnerability with the therapist without being punished, and can assert herself or himself without being censured. This type of corrective emotional experience allows an individual to experience a difference between the way things were in the past and the present emotional experience.

As one of the early pioneers in the field, Malan (1963, 1976) introduced the use of videotaped sessions and scientific research on *Focal Psychotherapy*. This included the development of inclusion criteria for patient selection, identification of focal issues, emphasis on intense affect experienced by the patient, analysis of transference linked with childhood and the importance of working through "loss" of therapist during termination.

A parallel development was Mann's 12-session *Time-limited Therapy* (Mann, 1973), that focused on separation-individuation issues that were stimulated by the quick, planned termination of therapy. This therapeutic approach elicited four universal conflicts; which are as follows:

1. Independence *versus* dependence,
2. Activity *versus* passivity,
3. Adequate self-esteem *versus* diminished self-esteem, and
4. Unresolved or delayed grief.

Short-term anxiety provoking therapy developed by Sifneos (1973, 1987), selected patients having conflicts related to the oedipal stage. Techniques provoked anxiety by early and repeated focus on transference patterns and the interpretation of defenses and resistance. Potential candidates who met the stringent selection criteria were limited to those with the less severe neurotic disorders.

Intensive short-term dynamic psychotherapy developed by Davanloo (1979), even included a single-session treatment. Unlike the earlier models of short term dynamic psychotherapy, Davanloo's approach could be used with a range of patients with neurotic disorders along with highly resistant personality disorders. Interestingly, he used the initial interview as a "trial therapy" to judge patients' potential suitability and therapy response.

Two important concepts included the *triangle of conflict* (Fig. 9.1b) and the *triangle of person* (Fig 9.1 a). The triangle of conflict is the interplay between defense, anxiety and impulse-feeling. The triangle of person refers to the transference (T), current life figures (C), and significant past figures (P). The primary therapeutic technique is the extensive use of transference. The therapist makes T-C-P links, clarifying and confronting the defenses against intimacy and closeness which tend to sabotage relationships. This "unlocking of the unconscious" makes the patient aware of transference patterns rooted in the past and also involves expression of grief and guilt feelings over past losses.

Figure 9.1a: Triangle of Person

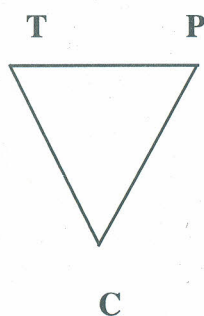
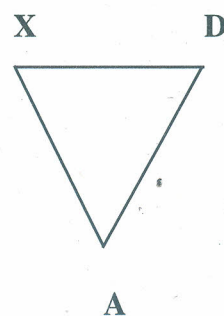


Figure 9.1b: Triangle of Conflict



T Transference (relationship to therapist)

X Impulse (hidden feelings)

C Current relationship difficulties

D Defence

P Relationship with past figures

A Anxiety

Contemporary versions of short-term psychodynamic psychotherapy include *Time-Limited Psychotherapy* (TLP; Strupp & Binder, 1984) and *Short-term Supportive-Expressive Psychoanalytic Psychotherapy* (Luborsky, 1984). These models include training and supervision using treatment manuals and an emphasis on research of treatment processes and outcomes.

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Match the following:

- | | |
|--------------------|---------------------------------------|
| i) Franz Alexander | a) Oedipal conflict |
| ii) Malan | b) Corrective emotional experience |
| iii) Davanloo | c) Separation-individuation conflicts |
| iv) Mann | d) Triangle of person |
| v) Sifneos | e) Focal psychotherapy |

5.5.2 Differences between Long-term Psychodynamic Psychotherapy and Short-term Psychodynamic Psychotherapy

It is useful to distinguish more classical or traditional psychodynamic psychotherapy from short-term psychodynamic psychotherapy.

The open-ended and long-term intervention has certain defining characteristics. The sessions are usually 1 to 3 times a week and could extend over a few years. The therapist is less directive, allowing the patient to bring up whatever seems important or meaningful to them. In fact, the underlying issues or reasons for seeking treatment may not become apparent until well into therapy. The focus is more on the whole person and their character, defenses and values, etc. The presenting complaint or initial diagnosis receives relatively less attention. Transferences are analysed as the relationship between patient and therapist goes through a number of changes and permutations. Therapy goals include insight and personality reorganisation.

Short-term psychodynamic psychotherapy, on the other hand, is usually time-limited, consisting of 16 to 30 sessions, conducted on once or twice-weekly basis. The therapist is relatively active, and fosters the development of a therapeutic alliance and positive transference. There is focus on specific conflicts or themes that are formulated early in therapy. The psychodynamic formulation is conceptualised most simply in terms of a formative or critical life event and the coping skills or defenses used to deal with it or as a pattern of relationship conflicts. Attention is paid to the setting of achievable goals, adhering to the tasks at hand, and on issues involving termination. The use of manual-based treatments and systematic research is more common in short-term psychodynamic psychotherapy.

Check Your Progress Exercise 7

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Briefly describe the differences between short-term and long-term psychodynamic psychotherapy in terms of frequency and duration of therapy, herapeutic goals and the levels of therapist directiveness.

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5.6 EFFICACY AND EFFECTIVENESS OF PSYCHODYNAMIC PSYCHOTHERAPY

There is increasing research evidence suggesting that psychodynamic psychotherapy is an effective psychological treatment for individuals experiencing mental health problems.

An initial review (Roth & Fonagy, 1996) concluded that there was a lack of confirming evidence for short-term psychodynamic psychotherapy. More recently positive outcomes have been reported for short-term psychodynamic psychotherapy, equivalent to already established treatments (for example, cognitive-behavioural therapy) in specific psychiatric disorders (Leichsenring & Leibing, 2007). Notably, the effects proved stable and even tended to increase with follow-up. Emerging data supports its role as a treatment for depression, generalised anxiety disorder, panic disorder and some personality disorders. There remains limited evidence for the use of this treatment for patients with anxiety disorders that relate more to stress. Limited and inconclusive evidence currently exists to support short-term supportive psychotherapy as a treatment for bipolar disorder, eating disorders and drug dependency (Lewis, Dennerstein & Gibbs, 2008).

As one might expect, there are few studies of the effectiveness of long-term psychodynamic psychotherapy. The Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPP) followed up patients over a three year period while the German Psychoanalytic Association Study looked at therapy changes seven years post treatment. Both studies pointed to the value of intensive long-term treatment.

There is little research that guides us regarding a choice between long-term and short-term psychodynamic approaches. A recent study (Knekt *et al.* 2008) reported that short-term therapies produced benefits more quickly than long-term psychodynamic psychotherapy but long-term psychodynamic psychotherapy is superior to short-term therapies at the end of three years.

Some clinicians criticise dynamic therapies because they have arisen primarily from theory and clinical observations instead of evidence-based research studies. Further, research is needed on specific psychiatric disorders, effectiveness of different models of psychodynamic psychotherapy, usefulness of therapy manual and differences

related to therapist factors. Evaluation of therapeutic progress must go beyond symptom reduction and should include important changes in personality organisation and structure like decreased vulnerability to stress, improved coping strategies and defenses.

5.7 LET US SUM UP

In this Unit, we have learnt about psychodynamic approaches in therapeutic intervention. The Unit focused on tracing the historical contributors to the development of psychodynamic approaches. The Unit outlined the basic assumptions of psychodynamic psychotherapy. We have learnt the differences between psychodynamic psychotherapy and psychoanalysis. Further, the Unit listed the indications and contraindications for psychodynamic psychotherapy. The Unit also described the therapeutic processes and techniques in the initial, middle and termination phases of psychodynamic psychotherapy. The Unit described the different models of short-term psychodynamic approaches. It clarified the differences between short-term and long-term psychodynamic approaches. In the end, the Unit summarised the research evidence on the effectiveness of psychodynamic approaches.

5.8 GLOSSARY

- Clarification** : Clarification is the technique by which the therapist elucidates and separates details of a phenomenon from other thoughts that the patient is having. For example: "You have mentioned feeling anxious in sessions recently, but it now seems clear that this started right after you mentioned to me that you were having difficulty with your wife".
- Confrontation** : Confrontation is the process of drawing the patient's attention to a particular phenomenon and getting him to recognise something that he has been avoiding and that will have to be further understood. For example: "I notice that each time your boss praises your work, you become disinterested in your job and think about quitting".
- Countertransference** : The therapist's feelings, attitudes and reactions to the patient's transference.
- Defense mechanisms** : Unconscious mental operations that operate to protect against conscious awareness of anxiety-provoking memories, wishes, fears or needs.
- Free association** : Technique in which the patient verbalises her or his thoughts and feeling without reservation or censorship, even though such thoughts may be embarrassing, sexual, humiliating, and/or aggressive, and even though such thoughts may be about the therapist. Free association is extremely useful for elucidating unconscious processes.

- Interpretation** : Interpretation refers to the therapist making connections between the patient's current behaviour (including thoughts, feelings, fantasies and dreams) and the patient's past history (including childhood experiences, wishes and fears) to highlight its unconscious meanings. For example: "Despite your wish to remain close to your husband, you are pushing him away just as you felt that your mother pushed you away".
- Regression** : An unconscious defensive process by which the patient reverts to a previous level of functioning, usually to a certain infantile or juvenile stage.
- Resistance** : All forces which oppose the treatment in an attempt to defend the status quo of the patient's neurosis. Resistance is usually motivated by anxiety and the unconscious avoidance of painful affects, ideas, wishes and fears.
- Transference** : The experience of feelings, thoughts, attitudes, fantasies and defences toward a person in the present that are inappropriate to that person and are a repetition or a displacement of reactions originating towards significant persons of early childhood (for example, parents). Transference may be positive or negative.
- Working through** : Working through refers to the complex and extended process of gradual change reflecting the efforts of insight and practising and recognising new behaviours.

5.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Following are the four main schools of psychoanalytic thought and their proponents, which have influenced the development of psychodynamic therapy:
 - i) Freudian psychology by Sigmund Freud;
 - ii) Ego psychology by Heinz Hartmann, Anna Freud, Erik Erikson, Paul Gray and Fred Busch;
 - iii) Object relations psychology by Melanie Klein, W.R.D. Fairbairn, D.W. Winnicott, and Harry Guntrip; and
 - iv) Self psychology by Heinz Kohut.

Check Your Progress Exercise 2

1.
 - i) True
 - ii) False

- iii) False
- iv) True

Check Your Progress Exercise 3

1. i) psychoanalysis
ii) Psychodynamic psychotherapy
iii) psychoanalysis
iv) Psychodynamic psychotherapy
v) psychodynamic psychotherapy

Check Your Progress Exercise 4

1. i) True
ii) False
iii) True
iv) True

Check Your Progress Exercise 5

1. i) d) transference
ii) a) psychodynamic formulation
iii) c) socratic questioning
iv) b) termination
v) c) working through
vi) c) reaction formation

Check Your Progress Exercise 6

1. i)-b, ii)-e, iii)-d, iv)-c, v)-a

Check Your Progress Exercise 7

Following are the differences between short-term and long-term psychodynamic psychotherapy:

- 1) Frequency and duration of therapy: Short-term psychodynamic psychotherapy is usually time-limited, consisting of 16 to 30 sessions, conducted on once or twice-weekly basis. In long-term psychodynamic psychotherapy, sessions are usually 1 to 3 times a week and could extend over a few years.

Therapeutic goals: In long-term psychodynamic psychotherapy, the therapy goals include insight and personality reorganisation. In short-term psychodynamic approaches, the goals are more limited, focusing on specific conflicts and what might be achievable in the time available.

Levels of therapist directiveness: The therapist level of directiveness is relatively higher in short-term psychodynamic psychotherapy than in long-term psychodynamic psychotherapy.

5.10 UNIT END QUESTIONS

1. Discuss the differences between psychoanalysis and psychodynamic psychotherapy.
2. Enumerate the indications and contraindications for patient selection in psychodynamic psychotherapy.
3. What are defense mechanisms? Describe some important defense mechanisms and their significance in psychodynamic psychotherapy.
4. Describe the therapeutic techniques used predominantly in the middle phase of psychodynamic psychotherapy.
5. What is the importance of the termination phase in psychodynamic psychotherapy?
6. Briefly discuss the important models of short-term psychodynamic psychotherapy.

5.11 FURTHER READINGS AND REFERENCES

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UNIT 6 COGNITIVE BEHAVIOURAL APPROACHES

Structure

- 6.1 Introduction
- 6.2 History of Cognitive Behavioural Therapy
- 6.3 Concept of Cognitive Behavioural Therapy
 - 6.3.1 Rational Emotive Behaviour Therapy by Ellis
 - 6.3.2 Application to Family Therapy
- 6.4 Cognitive Therapy by Aaron Beck
 - 6.4.1 Basic Principles of Cognitive Therapy
 - 6.4.2 Genesis of the Problem
 - 6.4.3 Homework/Assignment
 - 6.4.4 The Importance of Structure
- 6.5 Donald Meichenbaum's Cognitive Behaviour Modification
- 6.6 Therapist's Functions and Role
- 6.7 Differences and Similarities Between REBT, CT and CBM
- 6.8 What Types of Problems can be Addressed by this Approach?
- 6.9 Critique of Cognitive Behavioural Therapy
 - 6.9.1 Merits of Cognitive Behavioural Therapy
 - 6.9.2 Limitations of Cognitive Behavioural Therapy
 - 6.9.3 How Does CBT Work in Learning Coping Skills?
- 6.10 Case Illustration of A-B-C-D-E Analysis
- 6.11 Let Us Sum Up
- 6.12 Glossary
- 6.13 Answers to Check Your Progress Exercises
- 6.14 Unit End Questions
- 6.15 Further Readings and References

6.1 INTRODUCTION

This Unit focuses on cognitive behavioural therapy (CBT). Cognitive behavioural therapy (CBT) describes a number of therapies with similar approach to solve problems. Cognitive behavioural therapy was originated by clinical psychologists who originally worked as psychoanalysts. In this Unit, you will learn about the historical background of cognitive behavioural therapy, and the concept of cognitive behavioural therapy? After going through this Unit you able to answers such questions like: What are the types of cognitive behavioural therapy?; What is the process involved in cognitive behavioural therapy?; What types of problems can be addressed by this approach?; What are the skills required

in CBT? The Unit further discusses the merits and limitations of CBT and how it is different from other therapeutic approaches. You will learn about the nature of relationship between the client and the counsellor. You will also learn how this therapy is applied in some of the case illustrations.

Objectives

After studying this Unit, you will be able to:

- Understand the historical background of CBT;
- Explain the concept of different types of CBT;
- Describe the conditions when CBT can be used; and
- Use CBT when faced with the problems of clients.

6.2 HISTORY OF COGNITIVE BEHAVIOURAL THERAPY

Cognitive behavioural approaches include therapies that make use of cognition in solving of problems, including Rational Emotive Behaviour Therapy (REBT), Cognitive Therapy (CT), and Cognitive Behavioural Modification (CBM) propounded by the pioneering experts. In 1955, (REBT) was originated by Albert Ellis, a New York clinical psychologist who originally worked as a psychoanalyst. He became dissatisfied with it because he felt it took a long time and did not produce very effective results. It was preceded by earlier schools of thought in Greece, especially the Stoic philosopher Epictetus, who said, in the first century A.D, "People are disturbed not by things, but by the view which they take of them".

Even Adler writes that our emotional reactions and lifestyle are associated with our basic beliefs and are, therefore, cognitively created. In the 1960s, Aaron T. Beck, an American psychiatrist and psychotherapist observed an 'internal dialogue' going on in the minds of his patients during his analytical sessions. But they reported only a fraction of this 'internal dialogue' to him. For example, in a therapy session the client might attribute various reasons for no apparent intervention by the therapist. Their thoughts lead to certain feelings which in turn evoked certain behaviour. Beck realised that the link between thoughts and feelings was very important. He coined the term 'automatic thoughts' to describe emotion-filled or 'hot' thoughts that might pop up in the mind. According to Beck, identifying these thoughts was crucial for understanding the client and overcoming her or his difficulties.

Beck called it cognitive therapy because thinking was considered important. It's now called Cognitive Behavioural Therapy (CBT) because the therapy employs behavioural techniques as well. Since then CBT has undergone scientific trials in many places by different teams, and has been applied successfully to a wide variety of problems.

Another major alternative to rational emotive behaviour therapy is Donald Meichenbaum's cognitive behaviour modification (CBM), which focuses on changing the client's self-verbalisations (Meichenbaum, 1977).

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill in the blanks:

i) Cognitive behavioural approaches include therapies that make use of in solving of problems and techniques as well.

ii) The pioneers of CBT are,, and

2. State whether 'True' or 'False'

i) Beck gave the concept of interpersonal dialogue. T/F

ii) CBT is based on the link between thoughts, feelings and behaviour. T/F

6.3 CONCEPT OF COGNITIVE BEHAVIOURAL THERAPY

Let us first understand the meaning of the term 'Cognitive behavioural therapy'. *Cognitive behavioural therapy (CBT)* is an active type of psychotherapy in which the client and the counsellor talk, act and work together to achieve goals that are mutually agreed. In between the sessions assignments are given to the client that may include behavioural exercises and/or reading. CBT is a combination of psychotherapy and behavioural therapy. Psychotherapy emphasises the importance of the personal meaning we place on things and how thinking patterns begin in childhood. Behavioural therapy pays close attention to the relationship between our problems, our behaviour and our thoughts.

Cognitive behavioural therapy assumes that it is our belief system, interpretations and perceptions of life events that determine our feelings, moods and our actions. Therefore, CBT enables people to identify, understand and modify their belief systems and also their self-defeating behaviours so that they can function more effectively. Cognitive behavioural therapy (CBT) includes a number of therapies with similar approach to solving problems. These include:

- Rational Emotive Behaviour Therapy (REBT) by Ellis
- Cognitive Therapy (CT) by Aaron Beck
- Cognitive Behaviour Modification (CBM) by Donald Meichenbaum

The therapies focus on the thoughts, images, beliefs and attitudes that we hold (our cognitive processes) and also on how these cognitive processes affect the way we behave. CBT works by changing people's attitudes and their behaviour.

Rational Emotive Behaviour Therapy (REBT) by Ellis is based on the assumption that we contribute to our own problems and specific symptoms as our emotions emerge mainly from our beliefs, evaluations, own attitudes, views, perceptions, interpretations, thoughts about ourselves, and our reactions to life situations, and the world. It assumes that reorganisation of one's self statements will result in a corresponding reorganisation of one's behaviour. Inappropriate emotions are caused by self-defeating thoughts, while appropriate emotions result from rational thinking. If we learn to alter our beliefs that are not functional, we can improve our ability to deal with everyday problems, and live more emotionally satisfying and productive lives.

This approach is based on the assumption that cognition, emotions and behaviours interact significantly and have a reciprocal cause and effect relationship. REBT has consistently emphasised all three of these modalities and their interaction, thus qualifying it as a multimodal and integrative approach.

REBT is a system of psychotherapy, which shows individuals how their belief systems largely determine how they feel about and act towards events in their lives. The way we feel depends on the beliefs we hold about the specific event. This can be understood through an example given below:

*Three students in the class are punished by the teacher. One student is angry because she believes she should not have been punished. On the contrary she should have been appreciated; the second student is depressed because she believes that she is worthless; and the third person is happy because she always found the classes boring and was happy to be out of them. The important lesson to learn from this story is that although, the scolding in the class contributes to a series of emotional reactions, it does not cause them: **how each individual perceives being scolded is the key factor in determining these emotional reactions.***

REBT helps people change self-defeating or unhealthy thinking patterns and behaviours to more positive ones. It is also used to treat many kinds of problems and/or to improve skills.

REBT helps people achieve specific changes or goals in a brief period of time, and usually focuses on current situations rather than past ones.

REBT relies heavily on thinking, disputing, debating, challenging, interpreting, explaining, and teaching. Some of the techniques are explained below:

1. ABC Theory of Personality

The ABC theory of personality is central to REBT theory and practice. A is the existence of an event, or the behaviour or attitude of an individual. B is the belief of the person about A. C is the emotional and behavioural consequence or reaction of the individual; the reaction can be either healthy or unhealthy. A (the activating event) does not cause C (the emotional consequence). Instead, B, which is the person's belief about A, largely causes C, the emotional reaction.

A (activating event) B (belief) — C (emotional and behavioural consequence)

D (disputing intervention) – E (effect) – F (new feeling)

If a person experiences depression after a failure, for example, it is not the failure itself that causes depressive reaction but the person's beliefs about being a failure and apprehension about ridicule by others. The beliefs about the failure and ridicule (B) are what mainly cause the depression (C) – not the actual event of the failure (at point A). Thus, human beings are largely responsible for creating their own emotional reactions and disturbances. The therapist shows the clients how they can change the irrational beliefs that directly "cause" their disturbed emotional consequences, the client may blame himself such as "I am totally to blame for the failure", "I am a miserable failure, and everything I did was wrong," "I am a worthless person".

After A, B and C comes D (disputing) which is the application of the scientific method to help clients challenge their irrational beliefs. The principles of logic can be used to destroy any unrealistic, unverifiable hypothesis. There are three components of this disputing process; detecting, debating, and discriminating. First, clients learn how to detect their irrational beliefs, particularly their absolutistic "shoulds" and "I musts" that are exaggerated beyond proportion. Then clients debate their dysfunctional beliefs by learning how to logically and scientifically question them and to vigorously argue themselves out of believing them. Finally, clients learn to discriminate irrational (self-defeating) beliefs from rational (self-helping) beliefs.

Eventually clients arrive at E, an effective philosophy, which has a practical side. A new and effective rational philosophy consists of replacing unhealthy thoughts with healthy ones.

Disputing Irrational Beliefs

REBT usually involves actively disputing the clients' irrational beliefs and teaching them how to do this challenging on their own. Clients are given practice in challenging their irrational beliefs like "must", "should", or "ought" until they no longer hold them, or at least until it is reduced to a great extent, for example, clients may learn to tell themselves: "Why *must* everyone treat me respectfully?" "If I don't get what I want, it may be disappointing, but it is not the end of the world". "If life doesn't always go the way I would like it to, it isn't awful, though it may be inconvenient".

Activity 1 : Identify some of your beliefs that have been bothering you. Write down the dialogue that you visualize for disputing them.

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The clients can be asked to make lists of their problems, identify their absolute beliefs, and dispute these beliefs. In homework assignments the clients track down the absolute beliefs such as “shoulds” and “musts” that reveal their internalized self-messages. Clients are then asked to apply the A-B-C theory to some of their problems. Through such exercises and modeling by the therapist, the client learns how to think differently.

Activity 2: Identify some of your beliefs that have been bothering you. Also analyze the A, B, C, D, E, and F. How has it changed your thinking, in case it has.

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Changing One’s Language: In REBT inappropriate language is considered one of the causes of distorted thinking processes, that are beliefs or “musts”, “oughts”, and “shoulds”, can be replaced by preferences, for example, instead of saying, “It would be absolutely awful if...”, client can learn to say “it would be inconvenient or uncomfortable if...”. Thus, clients can learn to use milder forms of self-statements instead of self-reprimand or projection of self as helpless.

Activity 3: List some of your beliefs that you would like to change. Do you think your feeling would change if you change the language? Give two examples and your reactions.

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Using Humour: Emotional disturbances occur as we tend to take things too seriously. In the process, we lose our sense of perspective and humour over the events of life. Hence, the therapist employs humour to counterattack the over serious side of individuals and to assist the client in disputing their present philosophy of life that is causing tension in them.

Activity 4: Think of situations when you were too tense about achieving your goal. How could you have used human to lessen the tension.

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2. Emotive Techniques

These are used in REBT and include unconditional acceptance, rational-emotive role playing, modeling, rational-emotive imagery, and shame-attacking exercises.

Rational-emotive imagery is a form of intense mental practice for establishing new emotional patterns. Clients imagine themselves thinking, feeling, and behaving exactly the way they would like to think, feel and behave in real life. They can also practice imagining one of the worst things that could happen to them, how to feel inappropriately upset about this situation, how to experience their feelings intensely, and then how to change the experience to an appropriate feeling. Once clients are able to change their feelings to appropriate ones, they stand a better chance of changing their behaviour in the situation. Practising rational-emotive imagery several times a week for a few weeks can desensitize a client and she or he does not feel upset over such events any more.

Activity 5: Practice imagining one of the worst things that could happen to you.

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Do you feel upset about this situation?

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Are these feelings in proportion to the situation?

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How can you experience these feelings intensely?

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How can you change the experience to an appropriate feeling?

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Role Playing

The therapist often interrupts to show clients what they are telling themselves to create their disturbances and what they can do to change their inappropriate feelings to appropriate ones. Clients can rehearse certain behaviours to bring out what they feel in a situation. The focus is on working through the underlying irrational beliefs that are related to unpleasant feelings.

Activity 6: Enact a role play session and note down the appropriate and inappropriate feelings.

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Shame-Attacking Exercises

These can be given to help people reduce shame over behaving in certain ways that seem irrational to others around. We have to tell ourselves not to feel ashamed by telling ourselves that it is not catastrophic if someone thinks we are foolish. The main point of these exercises is that clients work to feel unashamed even when others clearly disapprove of them. This procedure typically involves both emotive and behavioural components. Clients may accept a homework assignment to take the risk of doing something that others are likely to disapprove of.

Activity 7: Give example of one situation that you would use to help people reduce shame over behaving in certain ways that seems irrational to others around.

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Force and Vigour

These can be used as a way to help clients go from intellectual to emotional insight. Clients are also shown how to conduct forceful dialogues with themselves in which they express their irrational beliefs and then powerfully dispute them. The therapist can also engage in reverse role playing by strongly clinging to the client's self-defeating philosophy; the client is asked to vigorously debate with the therapist in an attempt to persuade him or her to give up these dysfunctional ideas.

Activity 8: Conduct forceful dialogues with yourselves in which you express your irrational beliefs and then powerfully dispute them.

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3. Behavioural Techniques

These make use of behaviour therapy procedures, especially operant conditioning, self-management principles, systematic desensitization, relaxation techniques and modeling.

Behavioural homework assignments to be carried out in real-life situations are done systematically and are recorded and analyzed on a form. Many involve desensitization, skill training, and assertiveness training. To desensitize gradually REBT clients are encouraged to perform the things they are afraid of doing. For example, a person with a fear of lifts may decrease her or his fears by going up and down in a lift several times in a day. Clients actually do new and difficult things, and in this way they put their insights to use in the form of concrete action. By acting differently, they also tend to incorporate functional beliefs that they can undertake a task successfully.

Although REBT uses many other cognitive, emotive and behavioural methods to help clients minimize their irrational beliefs, it stresses this process of disputing both during the sessions and in everyday life. Eventually clients arrive at an effective philosophy, E, which has a practical side. The new and effective rational philosophy consists of replacing unhealthy thoughts with healthy ones. This further leads to a new set of feelings, F. Thus, instead of berating oneself and punishing oneself with depression over the failure, one would reach a rational and empirically based conclusion and may tell oneself. "Well, I'm genuinely sorry for what happened but that does not mean..... Although I wish I could have worked things out in a better way but it isn't the end of the world. I am not wholly responsible for the failure or disaster". According to REBT theory, the ultimate effect is minimizing feelings of depression and self condemnation.

Thus philosophical restructuring to make our beliefs functional would involve following steps : (1) fully acknowledging that we are largely responsible for creating our own emotional problems; (2) accepting the notion we have the ability to change

these disturbances significantly; (3) recognizing that our emotional problems largely stem from irrational beliefs; (4) clearly perceiving these beliefs; (5) seeing the value of disputing such self-defeating beliefs; (6) accepting the fact that if we expect to change we had better work hard in emotive and behavioural ways to counteract our beliefs and the dysfunctional feelings and actions that follow; and (7) practising REBT methods of uprooting or changing disturbed consequences for the rest of our life.

6.3.2 Application to Family Therapy

The cognitive behavioural approach focuses on family interaction patterns, and family relationships, cognitions, emotions, and behaviour are viewed as exerting a mutual influence on one another. A cognitive inference can evoke emotion and behaviour, and emotion and behaviour can likewise influence cognition in a reciprocal process that sometimes serves to maintain the dysfunction of the family unit.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. State whether 'True' or 'False':

- | | |
|--|-----|
| i) Appropriate and inappropriate emotions are a result of our thoughts. | T/F |
| ii) Modifying our beliefs about things and events can help us deal effectively with everyday problems. | T/F |
| iii) REBT focuses on past events rather than current situations. | T/F |
| iv) REBT can help people to change their thoughts and behaviour. | T/F |

6.4 COGNITIVE THERAPY BY AARON BECK

Cognitive Therapy (CT) works by changing people's attitudes and their behaviour. The CT 'model' or theory believes that it is not events themselves that upset us, but the meanings we attach to them. Our thoughts come in the way of our seeing things that don't fit in our framework or with what we believe to be true. Thus, we continue to hold on to the same old beliefs and fail to perceive anything new. These irrational beliefs that have been acquired and self-constructed are maintained and self-indoctrinated. The client is taught the skills that give them the tools to identify and dispute these irrational beliefs. In this process of counselling, the client learns to replace ineffective ways of thinking with effective and rational cognitions. As a consequence of this, they change their emotional reactions to situations. This is learnt by them as that they can apply to many other problems in life or future problems that they may encounter later in life.

For example, a depressed woman may think, 'I can't face going into work today: I can't do it. Nothing will go right. I'll feel awful'. As a result of having these thoughts – and of believing them – she may well ring in sick. By behaving like this, she won't have the chance to find out that her prediction was wrong. She might have found some things she could do, and at least some things that were

okay. But, instead, she stays at home, brooding about her failure to go in and ends up thinking: 'I have let everyone down. They will be angry with me. Why can't I do what everyone else does? I am so weak and useless'. So, that woman probably ends up feeling worse, and has even more difficulty going in to work the next day. Thinking, behaving and feeling like this may start a downward spiral. This vicious circle can apply to many different kinds of problems.

6.4.1 Basic Principles of Cognitive Therapy

Beck contends that people with emotional difficulties tend to commit characteristic "logical errors" that tilt objective reality in the direction of self-deprecation. Cognitive therapy perceives psychological problems as stemming from commonplace processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality. Let's examine some of the systematic errors in reasoning that lead to faulty assumptions and misconceptions, which are termed *cognitive distortions*:

- *Arbitrary inferences* in which we make conclusions without supporting and relevant evidence. This includes "catastrophizing," or thinking of the absolute worst scenario and outcomes for most situations e.g. you may have the conviction that you will not be liked or valued by others.
- *Selective abstraction* in which we form conclusions based on an isolated detail of an event. In this process, other information is ignored, and the significance of the total context is missed. The assumption is that the events that matter are those dealing with failure and deprivation. As a professional, you might assess your worth by one mistake and not by your successes.
- *Overgeneralization* which is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to events or settings that are not common to the one from which it is being generalized. If you have difficulty working with one adolescent, for example, you might conclude that you will not be good at working in any situation.
- *Magnification* consists of perceiving a case or situation in a greater light than it truly deserves, for example, assuming that even minor mistakes in your profession as a teacher could easily create a crisis for the individual and might result in psychological damage. Such a type of behaviour on your part would make a cognitive error.
- *Personalization* is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection. If a person does not give an appointment to you for a second time, you may be convinced that this 'evasive' behaviour on his part is due to your terrible performance during your first visit. You might tell yourself, "This situation proves that my work will not be done".
- *Labeling and mislabeling* involve portraying one's identity on the basis of imperfections and mistakes made in the past and allowing them to define one's true identity. For example a child with physical challenges may not create an image where people would have expectations from him and the child may tell himself, "I am totally worthless and cannot achieve anything in life".

- *Polarized thinking* involves thinking and interpreting in all-or-nothing terms, or categorizing experiences in either-or extremes. With such dichotomous thinking, events are labeled in black or white terms. You might give yourself no latitude for being an imperfect person. You might view yourself as either being the perfectly competent person who has to outshine in every activity or as a total flop if you are not fully competent (which means there is no room for any mistakes).

Beck (1976) wrote that, in the broadest sense, “cognitive therapy consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals”. For him the most direct way to change dysfunctional emotions and behaviours is to modify inaccurate and dysfunctional thinking. The cognitive therapist teaches clients how to identify these distorted and dysfunctional cognitions through a process of evaluation. Through a collaborative effort, clients learn to discriminate between their own thoughts and events that occur in reality. They learn the influence that cognition has on their feelings and behaviours and even on environmental events. Clients are taught to recognize, observe, and monitor their own thoughts and assumptions, especially their negative automatic thoughts.

6.4.2 Genesis of the Problem

Beck suggested that thinking patterns are set up in childhood, and become automatic and relatively fixed. So, a child who didn't get much unconditional affection from the parents but was praised for school work, might come to think, “I have to do well all the time. If I don't, people will reject me”. Such a rule for living (known as a *dysfunctional assumption*) may help them to work hard. But if something happens that's beyond their control and they experience failure, then the dysfunctional thought pattern may be triggered. The person may then begin to have *automatic* thoughts like, “I have completely failed. No one will like me. I can't face them”.

CT acts to help the person understand that this is what's going on. It helps her or him to step outside their automatic thoughts and test them out. CT would help the client with a problem to examine real-life experiences to see what happens to them, or to others, in similar situations. Then, in the light of a more realistic perspective, they may be able to take the chance of testing out what other people think by discussing their difficulties.

Clearly, negative things can and do happen. But when we are in a disturbed state of mind, we may base our predictions and interpretations on a biased view of the situation. This makes the difficulty that we face appear much worse. CT helps people to correct these misinterpretations.

6.4.3 Homework/Assignment

Working on homework assignments between sessions is a vital part of the process. Assignments can be of varied nature. For example, at the start of the therapy, the therapist might ask the client to keep a diary of any incidents that provoke feelings of anxiety or depression, so that they can examine thoughts surrounding the incident. Later on in the therapy, another assignment might consist of exercises to cope with problem situations of a particular kind.

6.4.4 The Importance of Structure

The reason for having structure is that it helps to use the counselling time most efficiently. It also makes sure that important information isn't missed out and that

both, therapist and client, think about new assignments that naturally follow from the session. Initially, the therapist takes an active part in structuring the sessions.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List the basic principles of cognitive therapy.

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6.5 DONALD MEICHENBAUM'S COGNITIVE BEHAVIOUR MODIFICATION

This approach shares with REBT and Beck's cognitive therapy the assumption that distressing emotions are typically the result of maladaptive thoughts.

Donald Meichenbaum's cognitive behaviour modification (CBM) focuses on changing the client's self-verbalisation. According to Meichenbaum (1977), self-statements affect a person's behaviour in much the same way as statements made by another person. A basic premise of CBM is that clients, as a prerequisite to behaviour change, must notice how they think, feel and behave and the impact they have on others. For change to occur, clients need to interrupt the scripted nature of their behaviour so that they can evaluate their behaviour in various situations.

Cognitive restructuring plays a central role in Meichenbaum's approach. He describes cognitive structure as the organizing aspect of thinking, which seems to monitor and direct the choice of thoughts.

Cognitive structures, and behaviours and their resultant outcomes; Meichenbaum describes a three-phase process of change in which these three aspects are interwoven:

Phase 1: Self-observation: The beginning step consists of clients learning how to observe their own behaviour. Initially, their internal dialogue is characterized by negative self-statements and imagery. This process involves an increased sensitivity to their thoughts, feeling, actions, physiological reactions, and ways of reacting to others.

Phase 2: Starting a new internal dialogue: As a result of the early contacts with the therapist, clients learn to notice their maladaptive behaviours, and see opportunities for adaptive behavioural alternatives, and change their internal dialogue through therapy. Their new internal dialogue serves as a guide to new behaviour.

Phase 3: Learning new skills: The third phase of the modification process consists of teaching clients more effective coping skills, which are practised in real-life situations. At the same time, clients continue to focus on telling themselves new sentences and observing and assessing the outcomes. The stability of what they learn is greatly influenced by what they say to themselves about their newly acquired behaviour and its consequences.

Stress management training has potentially useful applications for a wide variety of problems and clients, both for remediation and prevention. Some of these applications include anger control, anxiety management, assertion training, improving creative thinking, treating depression, and dealing with health problems.

The Constructivist Perspective

The constructivist perspective focuses on the capacity of human beings for creative and imaginative thoughts. At the core of constructivist theory is a view of people as active agents who are able to derive meaning out of their experiential world. Thus, the process of change can be facilitated, but not directed by a therapist. Constructivism stresses the client's reality without disputing whether it is accurate or rational.

Meichenbaum operates on the assumption that there are multiple realities and one of the therapeutic tasks is to help clients appreciate how they construct their realities and how they write their own stories.

Meichenbaum states that the constructivist approach to cognitive behaviour therapy is less structured and more discovery-oriented than standard cognitive therapy. The constructivist approach gives more emphasis to past development, tends to target deeper core beliefs, and explores the behavioural impact and emotional toll a client pays for clinging to certain root metaphors. REBT challenges the irrationality of client's thoughts and beliefs, whereas constructivist therapists are concerned with helping clients explore how they create their realities and the consequences that follow from such constructions.

Check Your Progress Exercise 4

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill in the blanks:

- i) CBM shares with REBT and Beck's cognitive therapy the assumption the _____ are typically the result of maladaptive thoughts.
- ii) CBM focuses on changing the client's _____.
- iii) Self-statements affect a person's _____ in much the same way as statements made by another person.
- iv) A basic premise of CBM is that clients, as a prerequisite to _____, must notice how they think, feel and behave and the impact they have on others.

- v) Meichenbaum's approach describes cognitive structure as _____, which seems to monitor and direct the choice of thoughts.
- vi) The constructivist perspective focuses on _____ for creative and imaginative thoughts.
- vii) Constructivist approach to cognitive behaviour therapy is less _____ and _____ discovery-oriented than standard cognitive therapy.
- viii) Meichenbaum operates on the assumption that there are _____ and one of the therapeutic tasks is to help clients appreciate how they construct their realities.
2. Order the following steps of the process of change during a CBM session as they occur:
- i) Starting to change self-verbalization. _____
- ii) Learning new coping effective skills. _____
- iii) Observation of self thoughts to recognise thoughts and feelings.

6.6 THERAPIST'S FUNCTIONS AND ROLE

Following are the major functions and role of therapist:

- Encourages clients to discover a few basic irrational ideas that motivate much disturbed behaviour,
- Challenges clients to validate their ideas,
- Demonstrates to clients the illogical nature of their thinking,
- Uses humour to confront the irrationality of clients' thinking,
- Uses a logical analysis to minimize these irrational beliefs,

- Shows how these beliefs are inoperative and how they will lead to future emotional and behaviour disturbances,
- Explains how these ideas can be replaced with more rational ideas that are empirically grounded,
- Teaches clients how to apply the scientific approach to thinking so that they can observe and minimize present or future irrational ideas and illogical deductions that foster self-destructive ways of feeling and behaving, and

- Uses several cognitive, emotive, and behavioural methods to help clients work directly on their feelings and to act against their disturbances.

6.7 DIFFERENCES AND SIMILARITIES BETWEEN REBT, CT AND CBM

In both Beck's cognitive therapy and REBT, reality testing is highly organized. Clients come to realize that they have interpreted situations in different way and that their beliefs are not realistic. Yet, there are some important differences between REBT, CT, and CBM, especially with respect to therapeutic methods and style.

REBT Ellis	CT Beck	CBM Meichenbaum
Highly directive, persuasive and confrontive. Focuses on teaching role of therapist.	Uses a Socratic dialogue by posing open-ended questions to clients. Gets clients to focus on personal issues and arrive at their own conclusions.	More direct and confrontational in uncovering and disputing irrational thoughts.
The therapist works through a process of rational disputation to persuade clients that certain of their beliefs are irrational.	Therapist places more emphasis on helping clients discover their misconceptions for themselves and generally applies more structure than REBT.	Self instructional therapy focuses more on helping clients become aware of their self-dialogue.
	Does not agree with REBT's concept of irrational beliefs as such a message to the client can be detrimental because clients believe they are rational and realistic.	The therapeutic process consists of training clients to modify the instructions they give to themselves so that they can cope.

Check Your Progress Exercise 5

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. State whether the statement is "True" or "False":

- i) REBT is often highly directive, persuasive, and confrontive and focuses on the teaching role of the therapist. _____

- ii) Beck uses a Socratic dialogue by posing open-ended questions to clients with the aim of getting clients to reflect on personal issues and arrive at their own conclusions. _____
- iii) The REBT therapist works through a process of rational disputation to persuade clients that certain of their beliefs are irrational. _____
- iv) CT therapists view dysfunctional beliefs as being problematic because they interfere with normal cognitive processing, not because they are irrational. _____
- v) REBT is different from CBM as it is more direct and confrontational in uncovering and disputing irrational thoughts; Meichenbaum's self instructional therapy focuses more on helping clients become aware of their self-dialogue. _____
- vi) The therapeutic in CBM process consists of training clients to modify the instructions they give to themselves so that they can cope more effectively with the problems they encounter. _____

6.7.1 Difference From Other Therapies

CBT also differs from other therapies in the nature of the relationship that the therapist will try to establish. Some therapies encourage the client to be dependent on the therapist, as part of the treatment process. The client can then easily come to see the therapist as all-knowing and all-powerful. The relationship is different with CBT.

CBT favours '*collaborative empiricism*' that is client and therapist work together to test out how the ideas behind CBT might apply to the client's individual life. It is a more equal relationship that is more business-like, being problem-focused and practical. The therapist frequently asks the client for feedback and for views about what is going-on in therapy.

People who describe having particular problems are often the most suitable for CBT. It's likely to be more helpful for anyone who can relate to CBT's ideas, its problem-solving approach and the need for practical self-assignments. People tend to prefer CBT if they want a more practical treatment, where gaining insight is not the main aim.

6.8 WHAT TYPES OF PROBLEMS CAN BE ADDRESSED BY THIS APPROACH?

Some of the situations or problems where CBT has been successful are:

- Anger management,
- Anxiety and panic attacks,
- Child and adolescent problems,
- Depression,
- Drug or alcohol problems,
- Eating problems,

- General health problems,
- Habits, such as facial tics,
- Mood swings,
- Obsessive-compulsive disorder,
- Phobias,
- Post-traumatic stress disorder,
- Sexual and relationship problems,
- Sleep problems,
- Sleeping difficulties,
- Relationship problems, and
- Drug and alcohol abuse.

CBT cannot cure all of the above problems. For example, it cannot cure chronic pain or disorders such as chronic fatigue syndrome. However, it might help people with arthritis or chronic fatigue syndrome, to find new ways of coping while living with the disorders.

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. State the types of problems where you can use CBT.

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6.9 CRITIQUE OF COGNITIVE BEHAVIOURAL THERAPY

6.9.1 Merits of Cognitive Behavioural Therapy

An important advantage of CBT is that it tends to be short. It may take only three to six months for most emotional problems if sessions are held once a week, each session lasting about 50 minutes to an hour. During this time, the client and therapist work together to understand what the problems are and to develop a new strategy for tackling them. CBT orients the clients to a set of principles that they can apply whenever they need throughout their lives.

6.9.2 Limitations of Cognitive Behavioural Therapy

Everybody can not benefit, at least not to full recovery, in a short span of time. Sometimes, therapy may have to go on longer to do justice to the number of problems and to the length of time the problems have existed.

6.9.3 How Does CBT Work in Learning Coping Skills

CBT tries to teach people skills for dealing with their problems. A new strategy for coping can lead to more lasting changes to basic attitudes and ways of behaving. The anxious client may learn to avoid avoiding things! She or he may also find that anxiety is not as dangerous as they assumed it to be. She or he may learn to change beliefs and behaviours.

One-to-one CBT can bring the client into a kind of relationship they may not have had before. The 'collaborative' style means that they are actively involved in changing. The methods of CBT may be useful in solving life problems that may have been long-standing and stuck.

Case Illustration of A-B-C-D-E Analysis

The Case of Yvonne (Source Sherilyn Cormier L. & Harold Hackney, The professional counsellor: A process guide to helping. Boston : Allyn and Bacon. Pp. 145-147)

This case illustrates the use of the A-B-C-D-E analysis that one counsellor used with an individual client over a period of time. The client was seen weekly for approximately twenty sessions.

Yvonne is a thirty-year-old woman who presents for counselling because of "mood swings" and "depression." Assessment reveals that Yvonne's depression began about three years ago, following her divorce from her husband. During the last three years, Yvonne reports periodic bouts of depression that seem to stem largely from thoughts of failure and guilt. Specifically, Yvonne blames herself and feels like a failure because of the divorce. She states that she cannot get rid of thoughts that she is a failure and that she is to blame for the breakup of the marriage.

History and intake: Yvonne is of above-average intelligence and possesses a masters degree in business. She is currently employed as a marketing analyst for a large chain of fast food restaurants. She dates some men from time to time but has not been involved in a serious or steady relationship since her divorce three years ago. She apparently is in excellent health.

After intake and assessment sessions, the counsellor proposes the use of the A-B-C-D-E analysis to Yvonne. The counsellor speculates that Yvonne is a good candidate for this technique because her depression seems to be largely the result of errors in cognitive thinking, she processes information dealing with internal dialogue or self-talk easily, she is above-average in intelligence. She is moderately distressed, and she seems willing and able to think logically and to carry out systematic assignments as part of her counselling programme.

The counsellor first gives Yvonne an overview of the strategy and tells her how it may be helpful, stressing the fact that her continued thoughts of failure and self-

blame, not her divorce *per se*, are largely responsible for creating her moodiness and down feelings. The counsellor uses examples and analogies to emphasize how the strategy will help Yvonne acquire more realistic thinking, give up self-defeating ways of thinking, and achieve a state of less emotional distress. As soon as Yvonne indicates that it is plausible to her that thoughts cause feelings, the counsellor can begin A-B-C-D-E work with her.

First, the counsellor helps Yvonne identify any situations which she feels are responsible for her emotional distress. Yvonne indicates that the primary one is her divorce. She states, "If I were still happily married, I wouldn't feel this way." At this point, the counsellor helps Yvonne to explore and determine whether this situation is something she has the control to change or not. When Yvonne indicates she does not, the counsellor points out that her thoughts and feelings about the situation can change, even though the external event will not. The counsellor also has Yvonne try on the following sentence, "Just because my marriage did not work out does not mean I have to feel terribly upset and depressed".

Next, the counsellor helps Yvonne identify more specifically the emotional consequences or feelings she is having about the divorce. Yvonne's primary feelings seem to be frustration and depression. These are supported by her non-verbal behaviours like: she frequently looks down at the floor, speaks slowly in a low, soft voice, and appears listless or lethargic. The counsellor emphasizes that Yvonne can decide whether she wants to keep or change these feelings so that they do not keep producing so much distress for her. The counsellor also helps Yvonne explore ways in which these feelings are debilitating to her everyday life situations; for example, to what extent have they been keeping her from getting more involved with other men?

At this point, the counsellor and Yvonne are ready to spend some time working with the Bs—her beliefs, thoughts, or internal "self-talk". The counsellor reiterates that some beliefs can cause unnecessary levels of emotional distress, particularly those that are self-defeating or cannot be supported by data, facts, or external evidence. The counsellor gives some examples of these and contrasts them to more rational or self-enhancing beliefs. Thoughts such as, "I'm a failure", "It's my fault the marriage didn't work out", are presented to Yvonne as examples of self-defeating thoughts. Thoughts such as, "The marriage failed — I didn't", or "The marriage didn't work out—I'm still intact", are presented as examples of self-enhancing thoughts. The counsellor encourages Yvonne to close her eyes, imagine or recreate the situation surrounding the divorce, and note what she is thinking about or what is going through her mind at this point. Yvonne indicates again that her primary thoughts are:

- "I'm a failure because my marriage didn't work out".
- "I was the wife, and I should have kept the marriage together. It's up to the wife to do that. It's my fault we couldn't work things out".
- "It's terrible to be thirty years old and divorced".

Yvonne's Bs share common characteristics that are typically associated with depression:

1. Belief in one's inadequacy.

2. Horror of not having what you need.
3. Awfulness of the way things are.

In addition, Bs of depressed clients are usually full of self-blame and self-pity.

Next, the counsellor is ready to start helping Yvonne learn how to dispute the emotional beliefs. Because the effects of disputation are usually more long-lasting if a variety of methods are used, the counsellor starts with *cognitive* disputation, followed by *imaginal* and *behavioural* disputation.

For cognitive disputation, the counsellor uses a series of questions to help Yvonne examine and dispute the Bs on a sentence-by-sentence basis. For example, the counsellor takes the first B on Yvonne's list ("I'm a failure because my marriage didn't work out") and asks Yvonne to challenge this statement using the following kinds of questions:

- Can you prove that?
- How do you know that?
- Where is that written?
- Where will this assumption get you?
- As long as you believe that, how will you feel?

This same process then occurs with all the other Bs identified by Yvonne and the counsellor.

6.11 LET US SUM UP

In this Unit, we have studied cognitive behavioural approaches to family therapy. The Unit begins with the history of cognitive behavioural therapy which includes approaches like REBT, CT and CBM propounded by the pioneering experts. The Unit discusses the concept of cognitive behavioural therapy which includes rational emotive behavioural therapy by Ellis and its applications to family therapy. Further, we studied about the cognitive therapy by Aaron Beck which includes basic principles of cognitive therapy, genesis of the problem and the importance of structure. The Unit also described Donald Meichenbaum's cognitive behaviour modification approach. The focus was given on the construction perspective. The role and functions of the therapist in cognitive behavioural therapy were also discussed. Further, the Unit differentiated between REBT, CT and CBM. The Unit highlighted the types of problems that can be addressed by this approach. At the end of the Unit, merits and limitations of cognitive behavioural therapy were discussed.

6.12 GLOSSARY

CBM	:	Cognitive Behaviour Modification.
CBT	:	Cognitive Behavioural Therapy.
Cognitive behaviour therapy	:	An active type of psychotherapy in which the client and the counsellor talk, act and work together to achieve goals that are mutually agreed.

Magnification

: Perceiving a case or situation in a greater light than it truly deserves.

Personalization

: A tendency for individuals to relate external events to themselves.

REBT

: Rational Emotive Behaviour Therapy.

6.13 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1.
 - i) cognition, behavioural
 - ii) Albert Ellis, Aaron T. Beck and Donald Meichenbeum
2.
 - i) False
 - ii) True

Check Your Progress Exercise 2

1.
 - i) True
 - ii) True
 - iii) False
 - iv) True

Check Your Progress Exercise 3

1. Following are the basic principles of cognitive therapy :
 - i) Arbitrary inferences,
 - ii) Selective abstraction,
 - iii) Overgeneralization,
 - iv) Magnification and minimization,
 - v) Personalization,
 - vi) Labeling and mislabeling, and
 - vii) Polarized thinking.

Check Your Progress Exercise 4

- i) distressing emotions
- ii) self-verbalisation
- iii) behaviour
- iv) behaviour change

- v) the organizing aspect of thinking
 - vi) the capacity of human beings
 - vii) structured, more
 - viii) multiple realities
2. i) - 2, ii) - 3, iii) - 1.

Check Your Progress Exercise 5

1. i) True
- ii) True
- iii) True
- iv) True
- v) True
- vi) True

Check Your Progress Exercise 6

1. Following are the types of problems where one can use CBT:
- i) Anger management,
 - ii) Anxiety and panic attacks,
 - iii) Child and adolescent problems,
 - iv) Depression,
 - v) Drug or alcohol problems,
 - vi) Eating problems,
 - vii) General health problems,
 - viii) Habits, such as facial tics,
 - ix) Mood swings,
 - x) Obsessive-compulsive disorder,
 - xi) Phobia,
 - xii) Post-traumatic stress disorder,
 - xiii) Sexual and relationship problems,
 - xiv) Sleep problems,
 - xv) Sleep difficulties,
 - xvi) Relationship problem, and
 - xvii) Drug and alcohol abuse.

6.14 UNIT END QUESTIONS

1. List the cognitive behavioural approaches.
2. How would you go about desensitization of a client who has phobia of darkness?
3. How would you provide assertive training to a client of yours who cannot talk to her parents about her problems?

6.15 FUTURE READINGS AND REFERENCES

1. Burns D. D. (1990). *The feeling good handbook*. New Delhi: Penguin.
2. Sherilyn, C. L. & Harold, H. *The professional counsellor: A process guide to helping*. Boston: Allyn and Bacon. (pp. 145-147)

UNIT 7 PERSON-CENTERED COUNSELLING

Structure

- 7.1 Introduction
- 7.2 Assumptions
- 7.3 Evolution of Person-Centered Approach
- 7.4 Major Concepts
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7.1 INTRODUCTION

“It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behaviour — and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided”.

These words of Carl R. Rogers best describe the philosophy behind the Person-centered approach to counselling and family therapy. Rooted in the Humanistic-Existential family of therapies, person-centered approach has created the most momentous wave in the area of counselling and family therapy. Rogers is also known as “Father of Counselling Psychology”.

Rogers firmly believed in the self-actualizing potential of each individual. He followed a *non-directive* therapeutic system, which ensured that the therapeutic setting provided the vital conditions for nurturing the growth of the individual. Person-centered approach is not only a psychotherapy system, it is a “point of view, a philosophy, an approach to life, a way of being, which fits any situation in which growth – of a person, a group or a community – is part of the goal”. (Rogers, 1980)

“The central truth for Rogers was that the person knows best. It is the person who knows what hurts and where the pain lies and it is that person who will discover the way forward. The task of the counsellor is to be the kind of companion who can relate to the person in such a way that she or he can access own wisdom and recover self direction”. (Mearns, 2007)

Objectives:

After studying this Unit, you will be able to:

- Describe the philosophical assumptions of the person-centered approach to counselling;
- Discuss the person-centered understanding of major theoretical constructs of person-centered counselling;
- Summarize the necessary conditions under which psychological growth and/or behaviour changes occur according to this counselling approach;
- Explain the etiology of maladaptive behaviour based on person-centered counselling.
- Describe the skills required for providing the core conditions in the therapeutic relationship;
- Demonstrate the specific procedures and techniques that facilitate constructive client change in person-centered counselling;
- Discuss the similarities and differences of person-centered and other approaches to counselling; and
- Evaluate the limitations and contributions of the person-centered approach to counselling.

7.2 ASSUMPTIONS

Person-centered approach is a way of being with people based on a theory of helping relationships which, in turn, rests on a deep respect for and trust in the individual’s capacity for growth, development and creativity. It is a democratic, non-authoritarian and non-directive approach to people that emphasises constructive human relationships as the key to the change process.

Person-centered approach challenged the prevalent belief of human behaviour being driven by negative impulses. Rogers supported the belief that humans were basically good and could be trusted to direct their own lives. Unlike the psychodynamic viewpoint, the person-centered counselling is rooted in the here and now and not in the childhood events.

Rogers was able to bring about an attitudinal shift by making a pivotal change to the way an individual was addressed and looked upon in the therapeutic system. He objected to the term '*patient*' and replaced it with '*client*' (who comes actively and voluntarily to gain help for the problem and is not a helpless being).

Rogers therapeutic intervention involves the counsellor's entry into the person's unique world. Rogers maintained that we behave as we do because of the way we perceive our situation. "As no one else can know how we perceive, we are the best experts on ourselves" (Gross, 1992). Rogers postulated that persons possess resources of self-knowledge and self-healing, and that personality change and development are possible if a definable climate of facilitative conditions is present (Rogers, 1980). This implies that certain persons and environments foster growth and development in human beings, and some undermine and inhibit growth.

This tenet formed the foundation for the revolutionary treatment approach that is based on the personal characteristics of the counsellor than on any techniques. Rogers challenged the psychotherapy community by formally articulating the belief that the "facilitative conditions" of empathy, positive regard, and genuineness on the part of the counsellor were the necessary and sufficient conditions for therapy (Rogers, 1957). The therapeutic relationship is the essence of person-centered therapy.

Rogers' theory emphasises the counsellor's creation of a permissive and non-interventionist climate in which the client is free to move at her or his own pace and in her or his own direction. Rogers actively promotes that the attitude, personal characteristics and qualities of the counsellor are the prime determinants of the successful outcomes of the therapeutic process.

Central to Rogers' theory is the notion of self or self concept. This is defined as, "the organized, consistent set of perceptions and beliefs about oneself". It consists of all the ideas and values that characterize 'I' and 'me' and includes perception of 'what I am' and 'what I can do'. Consequently, the self-concept is a central component of an individual's total experience and influences both his or her perception of the world and perception of oneself. For instance, a child who perceives herself or himself as strong may behave with confidence and come to see her or his actions as actions performed by someone who is confident.

According to Rogers, individuals want to feel, experience and behave in ways which are consistent with their self-image and which reflect what they would like to be like, their ideal-self. The closer the self-image and ideal-self are to each other, the more consistent or congruent they are and the higher is the sense of self-worth.

Maladjustment

The self-concept does not necessarily always fit with reality, though, and the way we see ourselves may differ greatly from how others see us. For example,

a person might be very interesting to others and yet consider herself or himself to be boring. The person judges and evaluates this image, that she or he has of herself or himself as a bore and this valuing will be reflected in her or his self-esteem.

A person is said to be in a state of incongruence if some of the totality of their experience is unacceptable to them and is denied or distorted in the self-image. *Incongruence* is “a discrepancy between the actual experience of the organism and the self-picture of the individual insofar as it represents that experience” (Rogers 1957). Such a state of incongruence often leads to confusion and tension and thus maladjustment. As we prefer to see ourselves in ways that are consistent with our self-image, we may use defense mechanisms like denial or repression in order to feel less threatened by some of what we consider to be our undesirable feelings. A person whose self-concept is incongruent with her or his real feelings and experiences will defend because the truth hurts.

Here is an example from Rogers (1957).

“An instance would be the mother who develops vague illnesses whenever her only son makes plans to leave home. The actual desire is to hold on to her only source of satisfaction. To perceive this in awareness would be inconsistent with the picture she holds of herself as a good mother. Illness, however is consistent with her self-concept, and the experience is symbolized in this distorted fashion. Thus...there is a basic incongruence between the self as perceived (in this case as an ill mother needing attention) and the actual experience (in this case a desire to hold onto her son)”.

Distortion between an individual’s actual experience and self concept make the person vulnerable and leads to maladjustment. Thus, person-centered counselling aims to address the incongruence that the individual develops.

7.3 EVOLUTION OF PERSON-CENTERED APPROACH

Rogers constantly worked and improvised on his theories. Three main phases in the development of person-centered counselling have been identified:

- **Stage 1 Nondirective (1940 - 1950):** This phase emphasised acceptance of the client and establishment of a non-judgmental atmosphere in which the emphasis was on the skills of the counsellor to promote the counselling process.
- **Stage 2 Client-centered (1950 - 1961):** This phase emphasised the counsellor’s attitudes rather than skills, and on reflecting the client’s feelings. Theoretical ideas of resolving discrepancies between the client’s ‘real’ and ‘ideal’ self became incorporated, and the idea of the counsellor as a person involved subjectively in the counselling relationship began to take shape.
- **Stage 3 Person-centered (1961 - present):** This phase put emphasis not only on the counsellor’s attitudes and values but additionally on the relationship qualities. The counsellor’s role is seen even less as skilled performance and more as an expression of the counsellor being responsively engaged with the client. More stress is laid on relational issues.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Define incongruence.

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2. List the three phases in the development of person-centered counselling.

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7.4 MAJOR CONCEPTS

Person-centered counselling rests on several important concepts. These theoretical constructs have been abridged from See (1986).

7.4.1 Actualizing Tendency

According to Rogers, humans have an instinctive need to grow and develop in a positive direction. However, for this natural tendency to bloom, it must be supported by a loving and permissive environment. If the environment is nurturing, then the individual will reach its full potential. The growth process of self-actualization is characterized by increasing congruence and autonomy.

7.4.2 Self-Concept

According to Rogers, the central personality construct is the image that individuals have of themselves. It is the sum total of all of the thoughts, feelings, and values held and their relationships to things and people within the world. The self-concept determines to a large extent how individuals behave.

7.4.3 Organismic Valuing Process

In order to satisfy the actualising tendency, we need to know what is of value to that growth. This ability to weigh up and to value experiences positively or negatively is the 'organismic valuing process'. If we listen to our 'organismic valuing process' we will know what will help us move towards our potential.

7.4.4 Need for Positive Regard

During the early stages of development, there is an inherent need for love, or positive regard, from others. When significant others provide unconditional love,

infants are free to develop according to the actualizing tendency and will learn of their potential by directly experiencing the world. Because human beings are instinctively good and act in ways that enhance the organism, this self-directed search for identity can be trusted to result in a well-developed and congruent personality. However the environment's provisional love based on an individual's behaviour can significantly limit the growth. Conditional love cripples development because it requires that individuals listen to others rather than to themselves. When individuals conform in order to obtain love, they are living according to values of others, or what Rogers calls the "conditions of worth". Thus, for facilitating the actualizing tendency of an individual, providing 'unconditional positive regard' is a requisite.

7.5 COUNSELLING PROCESS

7.5.1 Goals of Person-Centered Counselling

Person-centered approach believes that psychological difficulties are caused primarily by obstacles in the actualising tendency. The goal of therapy is not only to alleviate the person's problem but to assist the process of growth. Thus the counselling process facilitates release of the individual from any constraints or restrictions. The client is enabled to achieve congruence and to explore their inner experiences that were denied or distorted.

The entire journey of counselling would be led by the individual who has the route map for her or his growth and terminate at the destination, which is becoming "fully functioning". Once the person has reached here, there is absolute acceptance of self for what they really are, irrespective of others' opinions. As per Rogers, the fully functioning individual has:

- i. Basic trust in self,
- ii. Openness to experiences,
- iii. Willingness to continuous growth, and
- iv. Internal source of evaluation.

In brief, person-centered approach aims to develop the above characteristics in the individual.

7.5.2 Conditions for Person-Centered Counselling

For person-centered counselling to work Rogers said that counselling needed to take place under the following conditions:

- Two persons are in psychological contact.
- The first, whom we shall term the client, is in a state of incongruence, being vulnerable and anxious.
- The second person, whom we shall term the therapist or counsellor, is congruent or integrated in the relationship.

- The counsellor experiences unconditional positive regard for the client.
- The counsellor experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.
- The communication to the client of the counsellor's empathic understanding and unconditional positive regard is to a minimal degree achieved.

We shall now understand the various dimensions of the therapeutic process.

1. The Client

People who enter counselling usually are in a vulnerable and anxious state. They may have had experiences that resulted in immense misery for them. However during the course of counselling, these individuals undergo a journey and go through the following stages:

- **Stage One:** The client is very defensive, and extremely resistant to change. She or he is apprehensive about the counselling itself, the counsellor and their decision.
- **Stage Two:** Client becomes slightly less rigid, and will talk about external events or other people. Also the client begins to recognize and express previously denied feelings and moves towards more open and honest communication.
- **Stage Three:** Client talks about herself or himself, but as an object. Avoids discussion of present events. She or he gradually gains awareness of the inner experiences and is able to accept those experiences.
- **Stage Four:** Client begins to talk about deep feelings and develops a relationship with the counsellor. Now she or he changes the locus of evaluation outside themselves to an internal state.

The next three stages represent substantial growth in the person's journey of self-actualization.

- **Stage Five:** Client can express present emotions, and are beginning to rely more on their own decision making abilities and increasingly accept more responsibility for their actions. A decline in negativity, anxiety, self-doubt and blaming seen in the client.
- **Stage Six:** The client shows rapid growth toward congruence, and begins to develop unconditional positive regard for others. This stage signals the end for the need for formal therapy.
- **Stage Seven:** The client is a fully functioning, self actualized individual who is empathic and shows unconditional positive regard for others. This individual can relate their previous therapy to present day real-life situations.

A stage seven person can be fully involved in existential living, that is living in the moment. Although stage seven's fully functioning individual is the goal of Rogerian counselling, studies indicate that Stage four or five is much more commonly reached.

2. The Counsellor

The person-centered approach claims that the personal qualities of the counsellor are more important than training. The counsellor invariably must realise that she or he can trust her or his own experiencing and the validity of own perceptions.

In this framework, Rogers describes the counsellor's role as follows:

- The counsellor's attitude towards the client is one of respect as an equal,
- The counsellor provides an atmosphere of acceptance where the client is able to become more aware of self and is able to explore her or his experiences and relationships with others,
- The counsellor attempts to understand the client and is genuine and open to her or his own experience in the counselling relationship,
- The counsellor offers the client unconditional acceptance and empathetic understanding, and
- The counsellor does not offer advice.

The counsellor is meant to address the entire person, listening to and responding empathically to the client's experiences. She or he doesn't set goals for the client, but for self. The counsellor attempts to understand the client's frame of reference and its dynamics. The counsellor actively stays engaged with the world of her or his client, without judgement but with respect and authenticity. She or he is an alert companion and, simultaneously, an empathic and non-judgemental observer (Merry, 2002).

7.6 CORE CONDITIONS FOR GROWTH

Counsellor attitudes are considered to be of paramount importance in facilitating the relationship. Throughout her or his professional life, Rogers maintained that there are three counsellor attributes which create a growth-promoting climate in which individuals could move forward and become what they are capable of becoming. These are congruence, empathic understanding and unconditional positive regard.

7.6.1 Congruence

Congruence means that the counsellor's outward responses match their inner awareness and feelings; that they are genuine, real, open, authentic and transparent. Rogers stressed that congruence is not a question of the counsellor blurting out feelings; rather it is a state of being. Feelings are to be expressed only when they are persistent and of great strength and when communication of them assists the therapeutic process.

As Rogers states, "*When I can accept the fact that I have deficiencies, many faults, make lots of mistakes, am often ignorant when I should be knowledgeable, often prejudiced when I should be open-minded, often have feelings which are not justified by circumstances, then I can be much more real*".

Endeavouring to be so open the counsellor acts as a role model sending the message that it's okay to feel and communicate feelings. In order to develop and maintain congruence counsellors need to constantly work at being aware of their underlying feelings. The extent to which the counsellor is deeply in touch with her or his own feelings and attitudes and expresses them in deeply felt ways to the client is the extent to which therapy will be facilitated (Rogers, 1977).

7.6.2 Empathic Understanding

Empathy is the process of understanding another person 'as if you were that person but without ever losing the 'as if' quality'. Rogers described it as a way of 'laying aside our own views and values in order to enter another's world without prejudice, *A Way of Being* (Rogers, 1943). If the 'as if' quality is lost then the process can become one of identification whereby the counsellor is no longer understanding the event from the client's frame of reference but rather from their own experience of a similar event. Rogers eloquently described this condition:

"The way of being with another person which is termed empathic has several facets. It means entering the private, perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in the other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living his/her life, moving about in it delicately without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening" (Rogers, 1980).

Research has shown clearly that when clients' experience their counsellors as deeply empathic they are helped to explore their inner selves more profoundly and change is more likely to occur; alienated clients also feel more connected and less isolated.

7.6.3 Unconditional Positive Regard

Unconditional positive regard on the part of the counsellor means that the counsellor offers the person respect, acceptance (it does not have to be approval), caring and appreciation regardless of the client's attitude or behaviour. Rogers often used the word 'prizing' to convey the meaning of this condition.

Unconditional positive regard involves accepting the client's own personal constructs/personal values/valuing system. It would be possible to imagine conflict between the valuing systems of counsellor and client. The person-centered counsellor allows herself or himself to accept the valuing systems of clients which are far removed from her or his own. This does not mean that the counsellor must share the client's values, or pretend that she or he shares the client's values. She or he is required to accept in full that the client's values are the client's values, that the client is entitled to hold those values for as long as the client wishes, that the client's values are not deficient (however much they may appear to be deficient from the standpoint of the counsellor's values), and that the client's values may never change.

This condition is important because it undermines the clients' beliefs that they are only valued if they behave as required by significant others. There is no longer any need for the client to shy away from aspects of her or his inner self which may be painful or shameful because she or he learns that it is possible to be truly herself or himself and still be accepted.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the major concepts of person-centered counselling.

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2. What are the qualities of fully functioning individual?

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3. Define the following terms:

i) Congruence

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.....

ii) Empathy

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.....

iii) Unconditional positive regard

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7.7 STRATEGIES FOR PROVIDING THE CORE CONDITIONS

Rogers has emphasized on the therapeutic relationship and the environment being critical to the process of growth of the client. So there are certain strategies that can be deployed in order to make sure the core conditions are provided in the therapeutic environment. However these strategies are the way of being for the counsellor in the relation.

7.7.1 Communicating Empathic Understanding

As discussed earlier, *empathic understanding* means perceiving the world from the client's perspective. However, in order to facilitate the relationship with the

client, the counsellor must also be able to communicate empathy. Some strategies that allow the counsellor facilitate empathic understanding are verbal and non-verbal communication of empathy.

1. **Attending: Communicating Empathy Non-verbally**

To understand the client's inner world, the counsellor must attend to the client. Attending is giving all of your physical and psychological attention to the client. By attending the counsellor communicates to the client that "I am interested in what you have to say, I totally accept you and what you are saying", however, a lack of good attending communicates that "I really don't care about what you have to say".

The counsellor's body and facial expressions tell the client if the counsellor is attending. This is done through positioning the parts of the body so that they invite and hold an interpersonal relation. A relaxed alertness expressed by body posture seems best suited for fostering good communication.

Bolton offers these suggestions to establish a posture of involvement:

- **Lean toward the speaker:** This posture will communicate energy and attentiveness. This will also communicate the counsellor's interest and active involvement in the relationship.
- **Face the other squarely:** It means your right shoulder to the speaker's left. This posture communicates your involvement. It is especially important for you to position yourself so that you are at the eye-level with the client. This will circumnavigate feelings of threat and can greatly aid in forming an interpersonal relationship.
- **Maintaining an open posture :** It is also important for fostering interpersonal relatedness. A closed posture (that is crossed arms and or legs) often communicates coldness and defensiveness.
- **Proximity to the client:** You also need to be aware of your proximity to the client. We all have a concept of "personal space." When those boundaries are crossed it puts the other on the defensive and makes them feel uncomfortable. However, too much distance communicates aloofness and disconnectedness.
- **Gestures:** Gestures also are used to show attention. The purpose of gesturing when you are listening is to encourage the client to continue speaking. This can most easily be done with a periodic head nod.
- **Effective eye contact:** It says that you are visually attuned to what the speaker is saying. Good eye contact involves focusing on the speaker's face and occasionally shifting the focus to other parts of the body. The key is that the other is aware that they have your attention because your eyes are "on them". Good eye contact should seem natural to the other person. Whatever you do, don't "stare them down". This makes them anxious and sometimes critical.

The environment where the communication takes place is also an important factor in whether an interpersonal relationship can be formed. It is not always possible to move the conversation into a private room or office, but every attempt should be made to reduce the number of distractions that are present.

In his book, 'The Skilled Helper (1998)', Gerad Egan offers what he has labelled the 'Micro Skills of Attending'. He has developed the following acronym.

S - face the client Squarely

O- have an Open posture

L- Lean into the conversation

E- Eye contact

R- be Relaxed

2. Reflections: Communicating Empathy Verbally

Understanding the client's world means understanding the client's affective and cognitive messages and then communicating to her or him the same. One way to communicate these messages verbally to the client are using reflections.

One way that the counsellor can do this is through paraphrasing. A *paraphrase* is a concise response to the client that restates the essence of the communication in the counsellor's own words. The paraphrase deals with facts or ideas and not the emotions. In this respect it focuses on the content of the client's message.

In order to paraphrase the following steps can be followed:

- I. The counsellor can use the key words and construct systems used by the client. The idea is to use the main ideas of the client and some of her or his exact words.
- II. The counsellor can also paraphrase by stating the essence of what the client has said in her or his own words.

Let's look at a case vignette. The client is narrating his life events after a recent split from his wife.

Case Vignette

Client: *"So many things are going on right now. Another hectic semester has started, my health is poor, and my mom is ill too. I find myself running around trying to take care of everything. I am not sure I can take it anymore"*.

Counsellor: *"You're not sure if you can handle all the challenging situations around you – the hectic semester, your own health concerns, mom's illness"*.

Another aspect of reflecting is the *mirroring back emotions* of the client as they make their statements. It is important to tune into the client's feelings. If we, as counsellors, miss the feeling content we have missed a major part of the client's reaction and experience. Reflecting feelings also give the client an opportunity to evaluate how she or he is responding to a problem situation.

In reflecting the client's feelings, the counsellor could say :

Counsellor: *"You appear to be feeling quite overwhelmed by all the things that are going on around you. I also sense helplessness"*.

Not only should the listener reflect feeling, she or he also needs to *reflect meaning*.
Content + feeling = meaning.

Reflecting meaning allows the counsellor to be sure that they are “getting” what the client is saying. Reflecting feeling and content are the baby steps to reflecting meaning.

In order to reflect on the meaning of the client, the counsellor could say:

Counsellor: *“Looks like you’re unable to handle all these single handed. You’re missing the support system around you”*.

Reflections help the counsellor communicate to the client that they are understood completely.

3. Silence

At many instances during counselling, ‘Silence is Golden’. Silence gives that time to both the client and the counsellor in being in the state, which is the essence of the person-centered counselling. It helps both to process feelings and meanings. The silence communicates to the client that *“I sense that we need time to deal with this”*.

These periods of silence are not uncomfortable to the client. Also, it sends a message to the client that she or he can take more time to reflect.

7.7.2 Communicating Congruence

Congruence in a relationship implies a measure of equivalence. It is the degree to which we are able to relate to people in an honest, sincere, and transparent manner. In person-centered counselling, skills and techniques play a much less important role than engaging and relating with the client authentically. To be able to demonstrate congruence in a therapeutic relationship, an awareness of self and an acknowledgement of our own beliefs, prejudices and values are important. Effective counselling depends wholly on the degree to which the counsellor is integrated, open, genuine and self-aware of potential blind spots.

Since counsellors are asking people to take an honest look at themselves and to make choices concerning how they want to change, it is critical that counsellors themselves be open to the same kind of personal scrutiny. Genuineness encourages client’s self-disclosure, although, it is imperative to note that a congruent counsellor should not feel under any compulsion to disclose; either about at every feeling aroused within the counselling relationship. Counsellors should be able to keep client’s agenda in focus, by recognising and accepting aspects of the client’s behaviour that may possibly be conflicting with their own personal values.

According to Egan (1975), in order to communicate congruence, the counsellor must keep the following aspects in perspective:

1. **Spontaneity:** A spontaneous person can communicate freely, without constantly weighing what to say. Spontaneous counsellors behave freely without being technique or rule bound, without having to hide behind the professional role.
2. **Non-defensiveness:** A congruent counsellor is non-defensive. They are well aware about their strong and weak areas. They are open to negative client expressions without feeling attacked.

3. **Consistency:** Congruent individuals have few discrepancies between what they think, how they feel and the way they behave. So congruent counsellors would not think one way about the client, express something else to them and act in a different way.
4. **Sharing of self:** Congruent individuals are open to sharing about themselves. A congruent counsellor would self-disclose when appropriate in order to allow clients to know them as well.

Being congruent would help the counsellor focus on the client and facilitate the growth.

7.7.3 Communicating Unconditional Positive Regard

It is one of the three characteristics or attitudes that form an integral part of every successful therapeutic relationship. This condition exists when the counsellor develops a warm caring for the client. A caring which is not possessive and demands no personal gratification. It involves feelings of acceptance of the client's negative, despondent and painful emotions as well as their positive, good, mature and sociable feelings.

A counsellor shows acceptance when she or he adopts a non-judgemental stance in a way that conveys respect, warmth and genuineness. This communicates to the client a feeling of self-worth and value, and this facilitates a process of self-acceptance and growth.

In showing acceptance, the client's behaviour is not ignored but rather seen as reaction to the underlying problem they are presenting. The counsellor's role is to help in ways which respect the client's values, personal resources and capacity for self-determination. Counsellors do not automatically jump in to smooth away unhappiness or try to cheer clients up. Instead, they encourage clients to express their feelings fully and to come to terms with things as they are at the present.

In person-centered communication, Hanka Grobler *et al.* explain the importance of self-acceptance, "when an individual is able to symbolise most of her or his experiences and integrate them into a total self concept, such individual will display greater understanding of themselves...". When clients experience acceptance from a counsellor, they begin to accept themselves, which increases their self-esteem. Low self-esteem is at the root of many problems because it erodes our confidence in our ability to manage our lives.

The person-centered counsellor can engage in following behaviours to communicate positive regard to the client:

1. Giving quality attention to the client's concerns and feelings.
2. Communicating a non-evaluative attitude towards client as a person worthy of genuine care.
3. Responding to the client with empathy and understanding client's frame of reference.
4. Reflecting to the client her or his potential and capabilities.

The relationship between client and counsellor is itself the vehicle for therapeutic change. Genuine empathy, essential congruence and real acceptance will quite often provide the means for clients to overcome encrusted habits, pain, divisive disordered

thoughts and dysfunctional behaviours. Clients who experience their counsellors' empathy and understanding, develop an increased self-acceptance and self-empathy, which are powerful sources of personal growth in their own right. When clients accept responsibility for their behaviour and emotions, they recognise that even in the most difficult of circumstances, they have the ability to choose how they respond.

One of the principles underlying counselling is the desire to empower clients to take responsibility for themselves and to identify, develop and use resources that will make them more effective agents of change in the counselling sessions as well as in their everyday lives. This is central to the reciprocal relationship that lies at the heart of effective and reflective practice, and counsellors have the task of paying attention to the client's expressed needs.

7.8 LIMITATIONS AND CRITICISM

Critiques of Rogers' person-centered counselling begin with his basic conception of human nature as tending toward the good and the healthy. Another limitation of the counselling is that the counsellors tend to be very supportive of clients without being challenging.

Furthermore, critics of Rogers' theories maintain serious doubts that counsellors can, or should, establish a relationship of unconditional positive regard in the case of dangerously violent persons. They also fail to understand how parents might put into practice her or his ideas when raising children whose behaviour may sometimes be difficult to countenance with wholehearted approval. At best, Rogers' detractors claim, his ideas may be applied only among a limited range of clients, specifically those suffering from the milder forms of neurosis. Despite such criticisms, Rogers' theory of personality and his therapeutic methodology continue to gain adherents and have become among the most widely influential trends in the history of psychology.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. State 'True' or 'False':

- i) Empathic understanding means perceiving the world; from the client's perspective. _____
- ii) Gestures are not used to show attention. _____
- iii) A paraphrase is concise response to the essence of the communication in the counsellor's own words. _____
- iv) A congruent counsellor is non-defensive. _____

7.9 LET US SUM UP

In this Unit, we studied that:

- A basic tenet of person-centered counselling is that people have worth and dignity in their own right; therefore, they deserve respect.

- According to person-centered beliefs, people have the potential for constructive change and self-actualization.
- Person-centered counselling is considered a nondirective counselling because of the counsellor's encouraging and listening role.
- The person-centered counsellor exhibits genuineness, unconditional positive regard and empathy in dealings with clients.
- The predominant technique of the person-centered approach is communicating empathy.
- The ultimate goal of person-centered counselling is to help a person realize her or his potential for being a fully functioning human being.

7.10 GLOSSARY

- Carl Rogers** : The father of person-centered counselling. Rogers viewed people as good, rational, and forward-moving beings.
- Congruence** : A person-centered attitude of genuineness. Rogers described this as being authentic or "all in one piece".
- Empathy** : The person-centered attitude that holds counselling together. Empathy is the counsellor's ability to genuinely understand the feelings and emotions of the client.
- Reflection** : The process of letting the client know that the counsellor truly hears and understands what she or he is saying and feeling. This can be accomplished through careful listening to the client's core message and responding in such ways as paraphrasing and repeating the client's feelings, thoughts, and concerns.
- Nondirective counselling** : The first name for person-centered counselling based on the counsellor's listening and encouraging role.
- Unconditional positive regard** : A person-centered attitude of respect for the client that is free of judgement.

7.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Incongruence is a discrepancy between the actual experience of the organism and the self-picture of the individual insofar as it represents that experience.
2. Following are the three main phases in the development of person-centered counselling:

- i) Stage 1: Nondirective (1940-1950),
- ii) Stage 2: Client-centered (1950-1961), and
- iii) Stage 3: Person-centered (1961-present).

Check Your Progress Exercise 2

1. Following are the major concepts of person-centered counselling:
 - i) Actualizing tendency,
 - ii) Self-concept,
 - iii) Organismic valuing process, and
 - iv) Need for positive regard.
2. According to Rogers, the fully functioning individual has following qualities:
 - i) Basic trust in self,
 - ii) Openness to experiences,
 - iii) Willingness to continuous growth, and
 - iv) Internal source of evaluation.
3.
 - i) Congruence: Congruence means that the counsellors outward responses match their inner awareness and feeling; that they are genuine, real, open, authentic and transparent.
 - ii) Empathy : It is process of understanding another person as if you were that person but without ever losing the 'as if' quality.
 - iii) Unconditional positive regard: Unconditional positive regard on the part of the counsellor means that the counsellor offers the person respect, acceptance (it does not need to be approved), caring and appreciation regardless of the client's attitude or behaviour.

Check Your Progress Exercise 3

1.
 - i) True
 - ii) False
 - iii) True
 - iv) True

7.12 UNIT END QUESTIONS

1. What did Rogers see as the reason for negative and antisocial emotions?
2. What did Rogers say are the six conditions for personality change?
3. What are the three main attitudes or traits possessed by person-centered counsellors?
4. What are the basic assumptions of Rogers' person-centered counselling? Discuss.

5. Describe the nonverbal ways of communicating empathy.
6. Describe the stages of Rogerian counselling.
7. While watching a TV show, pay attention to the dialogue. Record several conversational phrases and write empathic responses to as many statements as possible.
8. Rogers believed that all humans move toward self-actualization. Consider your own life. Do you feel you are moving toward self-actualization? If so, how? If not, why not? Do you want to change this? Discuss with a partner.

7.13 FURTHER READINGS AND REFERENCES

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UNIT 8 GROUP COUNSELLING AND OTHER COUNSELLING APPROACHES

Structure

- 8.1 Introduction
- 8.2 Group Counselling
 - 8.2.1 Meaning of Groups
 - 8.2.2 Types of Groups
 - 8.2.3 Multi-Cultural Context
 - 8.2.4 Ethical Issues
 - 8.2.5 Characteristics for Group Leadership
 - 8.2.6 Skills in a Group Leader
 - 8.2.7 Formation of a Group
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 - 8.3.1 Basic Assumptions
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 - 8.3.3 Goals of Therapy
 - 8.3.4 The Therapeutic Procedure
 - 8.3.5 Implementation of Therapy
 - 8.3.6 Therapeutic Operations
 - 8.3.7 Redecisional Approach
- 8.4 The Existential Approach to Counselling
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 - 8.4.2 Application
- 8.5 Indian Psychotherapy and Counselling
- 8.6 Eclectic Approach to Counselling
- 8.7 Let Us Sum Up
- 8.8 Glossary
- 8.9 Answers to Check Your Progress Exercises
- 8.10 Unit End Questions
- 8.11 Further Readings and References

8.1 INTRODUCTION

We all are born in 'family' and become an integral part of 'our extended family, community and society' upon birth. All these are forms of social groups in which we are at times passive and at times active members. With the passage of time children form groups to play with, peer groups are formed during adolescence,

also, we are always an active member in some kind of 'group' like neighbourhood, tuition group, dance, sing, work, theatre group, etc.

In this Unit, we are talking about groups formed for counselling and therapeutic purposes which are mostly formed intentionally. Group counselling is an effective method especially for counselling of parents of young school children, children with disabilities, alcoholic groups etc. Groups counselling helps to learn that others are also having similar problems, say in child rearing practice, problems associated with children with disabilities and the knowledge that they are not the only one's with this kind of situation or problem helps to develop internal resilience in people to face different situations.

In this Unit, we will study in detail about group counselling, its principles and applications, psychodrama, play therapy, transactional analysis, existential psychotherapy and eclectic psychotherapy approach to counselling.

For this Unit, we have basically drawn from Corey's work on Theory and Practice of Group Counselling and Patterson's work on Theories of Counselling and Psychotherapy.

Objectives

After studying the Unit, you will be able to:

- Delineate the general principles in group counselling;
- Understand the use of structured groups for therapeutic purposes;
- Develop in-depth knowledge and skills for group counselling and other counselling approaches; and
- Apply the themes and concepts learnt about group counselling and other counselling approaches in practical situations.

8.2 GROUP COUNSELLING

Groups that help make people change their feelings, thoughts, behaviour, construct emotions affectively are the groups which have a therapeutic base and also at times develop coping skills among its members.

Groups counselling is used in a variety of settings for therapeutic interventions. For most of the theoretical approaches to counselling, groups counselling method could also be used.

8.2.1 Meaning of Groups

Groups could be social in nature like family, school, peer, kin, etc. Groups can be therapeutic in nature like people form a group intentionally to solve a problem. The concept of 'Group' in psychotherapy was also used by Freud (1921) in his book on 'Group counselling and the analysis of ego'. James Strachey (1949) translated this work of Sigmund Freud. According to Freud, Group Psychology is concerned with 'the individual man as a member of a race, of a nation, of a caste, of a profession, of an institution, or as a component part of a crowd of people who have been organized into a group at some particular time for some definite purpose' (p-3). Freud draws from Le Bon's famous work *Psychologies*

des foules. Le Bon's work discussed here has been described in the translation. 'The Crowd: A study of the popular mind' by Fisher Unwin (1920). According to Le Bon, the most striking peculiarity presented by a psychological group is that whoever be the individuals that compose it, however like or unlike be their mode of life, their occupations, their character, or their intelligence, the fact that they have been transformed into a group puts them in possession of a sort of collective mind which makes them feel, think and act in a manner quite different from that in which each individual of them would feel, think and act were he or she in a state of isolation. There are certain ideas and feelings which do not come into being, or which do not transform themselves into acts except in the case of individuals forming a group.

According to Le Bon, psychological group is a coalition of heterogeneous individuals which are combined for a cause or purpose to work as a whole unified unit for a given reason or cause.

Le Bon continues to explore the unity of an individual mind into the 'group' collective mind and later discuss the role and function of a group leader. He believed that morals of the groups are higher than that of individuals and 'that only collectivities are capable of a high degree of unselfishness and devotion' (p.24).

McDougall (1920) in his work on 'The Group Mind' says, that 'group' possesses no organization at all and describes a group as a 'crowd' (p. 26). But McDougall believes that when human beings come together and the crowd fulfills the following conditions, the disadvantage of group formation are removed. According to McDougall, these conditions are:

- 1) The first and fundamental condition is that, there should be some degree of continuity of existence in the group. This may be by the same individuals remaining in the group for some time or in a group, a system of fixed positions which are occupied by a succession of individuals is present.
- 2) The second condition is that, in the individual member of the group some definite idea should be formed of the nature, composition, functions and capacities of the group, so that the individual develops emotional relation to the group as a whole.
- 3) The third condition is that, the group should be brought into interaction (perhaps in the form of rivalry) with other groups similar to it but differing from it in many respects.
- 4) The fourth condition is that the group should possess traditions, customs and habits, especially those that determine the relations of its member to one another.
- 5) The fifth and the last condition is that, the group should have a definite structure, expressed in the specialization and differentiation of the functions of its constituents (p. 30-31, Strachey).

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Write the meaning of psychological group according to Le Bon in your own words.

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2. Who described a group as 'crowd' a that fulfills certain conditions?

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8.2.2 Types of Groups

Groups are groupings of individuals who come together for a given purpose or cause. There could be various types of groups; some of which are:

- Religious group: Individuals belonging a particular sect or religion or prophet/saint may form such groups
- Region group: Individuals from a particular race/region may form groups
- Caste group formed on these criteria
- Kin group
- Extended family group
- School tour group
- Tuition group
- Dance group
- Singing group
- Parent – Teacher group
- Training groups: Group formed for vocational training, personality development, motivation training, say-No or assertion training etc.

- Alcoholics group,
- Tobacco cessation group,
- Drug deaddiction group,
- Children of drug abuse/alcoholics group,
- Groups of parents of children with disabilities – such as mental retardation, autism, learning disability, cerebral palsy etc.

Corey (1990) delineates the following types of groups to deal with problems specific to that particular group:

- i) Counselling groups for children:** For reasons like emotional problems, behaviour problems, educational remedial reasons; group counselling at schools is provided.
- ii) Counselling for adolescents:** This could be provided for reasons like the same as above and also for peer pressures, identity crisis, dependence/independence struggles, acceptance/rejection conflicts, etc. According to Corey, group counselling provides adolescents a place to express conflicting feelings, communication with other and self, explore self doubts and realization that they share similar concerns as their peers and, thereby, they can help one another towards self-understanding and self-acceptance.
- iii) Counselling groups for college students:** These could be for the college goers experiencing developmental crisis related to career decisions, heterosexual relationship, identity problems, educational plans, isolation feelings etc.
- iv) Counselling groups for the elderly:** According to Corey, these groups are as useful as for the adolescents. These groups would assist in strengthening the elderly population and help them to live a meaningful life.
- v) Group psychotherapy:** These are the groups formed to help the individuals through therapy. According to Corey, in group counselling emphasis is on growth, development, enhancement, prevention, self-awareness and releasing blocks to growth, while group therapy has emphasis on remediation, treatment and personality reconstruction. He defines group psychotherapy as 'a process of re-education that includes both conscious and unconscious awareness and both the present and past'.

Both group counselling and group psychotherapy is based on one of the theories or therapeutic models. Any of the Units studied earlier in this Block can be used in group counselling. In this Unit, an attempt would be made to understand other theoretical /therapeutic perspectives which have not been discussed earlier.

Remember that simply reading any therapeutic model does not qualify you to start counselling in that direction. You should read a lot of literature regarding the same. A list of suggested readings has been provided for the same reason. Then you should carry out the initial counselling/therapy sessions under supervision of the experienced professionals in this field. For this, supervised practicum has been provided which needs to be undertaken seriously.

- vi) **Structured groups:** Structured groups are the groups that have some central or specific theme and are concerned with specific age group. For example, Rose (1987) promoted the social competence of children in middle childhood years through a time bound, structured small group.
- vii) **Self help groups:** These are the groups of people with a common interest to create a support system for themselves to protect them from psychological stress and strain. Such groups help to modify people's life. You must be aware of the women self help group who have formed a big business in India – 'Lizzat papad'. Like this, self help groups are formed among say drug abusers, alcoholics, tobacco users, parents of children with mental retardation or autism, etc.

Both, self help groups and therapy groups emphasize expressing and sharing emotions (Lakin, 1985). This is based on the presumption that people suffer because of unexpressed emotions, feelings, thoughts, attitudes, behaviours, etc. Further, self help group's and therapy groups encourage, support, lead to behavioural change, and lay emphasis on group's identity. Even though these groups seem similar but Riordan and Beggs (1988) pointed out critical differences among the two groups, such as in self help groups only a single topic is central issue like addiction, cancer or obesity, whereas in therapy groups improving general mental health or one's interpersonal functioning is the central theme (Riordan & Beggs, 1987). Lakin (1985) pointed out that self help groups emphasise inspiration, persuasion and support while therapy groups use self-understanding, behavioural reinforcement and member feedback. Also, the leadership used in both the groups is different. Self help groups emphasise common identity or common life situation of group members; here members accept and support each other. While therapy group is like a real social environment of group members, a social microcosm which acts as a catalyst for change in real social world (Corey, 1990). Both self help group and therapy group are used in real life situations but the reason to employ them are different and should be decided on the need of the person or client.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List down the groups you are aware of in your locality. Don't mention the one's listed above.

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8.2.3 Multi-cultural Context

Group counselling in multi-cultural context should take the cultural background of the group members and the group leader into consideration. Pedersen (1988) defined multicultural counselling as two or more persons with different ways of perceiving their social environment attempt to work together in a helping relationship. He defined 'race' as shared genetic history or physical characteristics; 'ethnicity' as shared socio-cultural heritage of a religion, history or common ancestry; and 'minority' as a group that has received differential and unequal treatment because of collective discrimination. Further, he believed that culture always influences person as well as counselling. It is important to remember that different cultures may attach different or same importance to a specific behaviour. The importance of a specific behaviour or attitude has to be understood from the patient or client's perspective giving emphasis and importance to what is perceived in their culture rather than the belief in the counsellor's society or culture. In group settings you should be able to deal with the entire group as a whole and meet each individual member's unique needs and differences. Therapist should not impose her or his ideas on the group members nor consider one's own culture superior to others or the group members. Corey emphasized that counsellor's genuine respect of the difference among members of group and openness to learn from them will go a long way in building the trust that is necessary for bridging differences between the counsellor and the group.

Essential characteristics in group counsellor in multi-cultural context are discussed below.

Characteristics to become a culturally effective group counsellor, according to Sue (1978, 1981) are:

1. To recognize their own values and assumptions in contrast with alternative assumptions,
2. To be aware of basic characteristics of counselling that cut across classes and cultures,
3. To understand the socio-political forces that influence the attitudes of minorities or oppressed groups,
4. To have the capacity to share a client's world view without criticism or judgement,
5. To develop their own eclectic or integrated approach to counselling so that they are able to utilize various intervention models from various theoretical orientations, and
6. To possess a range of beliefs, attitudes, ideas, and skills so as to develop therapeutic relationship with diverse clients.

Check Your Progress Exercise 3

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What do you understand by the term multi-cultural context?

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8.2.4 Ethical Issues

Group counselling or group therapy has to take into consideration the ethical issues like in other counselling or psychotherapy or family therapy process. The details of this have been discussed in detail in Course IV. Here, we will focus on ethical issues and professional issues only in the light of group counselling.

Group members have a right to know the nature and purpose of the group before joining it. Confidentiality of matters related to group members has to be observed. The rules of the group and the procedure that would be employed in group counselling has to be clearly outlined to the group members. Rights and responsibilities of the group members have to be decided and the members clearly told when they can break the confidentiality clause. Group leader (the counsellor) needs to tell about oneself to the group and one's rights and responsibilities. The responsibility of group members includes being regular, divulging personal information to the group and giving their opinion or feedback to group members. The members have the freedom to leave the group, give their opinion or feedback to group counselling any time they wish. No group member or leader should impose their values on other group members and be given equal respect irrespective of social-cultural backgrounds.

8.2.5 Characteristics for Group Leadership

When assuming the role of group counselling one becomes the group leader. Our own personality influences our role as group leader. Corey identified the following characteristics that influence group leadership:

1. **Emotional presence:** Group leader should be emotionally present in the group should be moved by the joy and pain of the group members. It means "to be their" or "being their" with the group members and it involves genuine caring and willingness to enter their psychological world.
2. **Personal power:** Personal power involves self-confidence and an awareness of one's influence on others. It means not to dominate or bully but to be able to influence others to use their unused power. This can be done by those leaders who feel they possess the power in their own lives.
3. **Courage:** They have to exhibit courage in their interactions with the group and not sit in the role of counsellor. It means to be able to be 'real' person, that is, be able to admit mistakes, be vulnerable at times, act by intuition and beliefs.
4. **Willingness to confront oneself:** Self confrontation with questions like why I am a group leader, why do I behave as I do in groups, what needs of mine are being served by being a group leader, etc. is important. These questions have no simple answers but confronting these questions would help to make you honest about your motivations for being a group leader.
5. **Sincerity and authenticity:** Group leader should have sincere interest in the wellbeing and growth of others. She or he has to be honest and direct in telling the group members to look into parts of their life which they are denying. Sincere group leader is mostly authentic. She or he does not hide behind facades but has the determination to stand firm and share feelings with the group and of the group.

- 6. **Sense of identity:** She or he should have a clear sense of identity; then only they would be able to help group members discover themselves.
- 7. **Belief in group process and enthusiasm:** She or he should have firm belief in the group process to make the group a success. Also, she or he should be enthusiastic to be a group leader firm conviction to bring about change.
- 8. **Inventiveness and creativity:** Spontaneous creativity and approaching the group with new ideas is a great potential of a good group leader.

Do remember that a group counsellor initially may have some anxiety to face the group and make the group a great success. They may be anxious regarding how much self-disclosure should be done by them and interjections allowed when the disclosure is made. In a group some members may resist you or other members in the group. Group counsellor is expected to deal with such situations effectively by telling them rules of acceptance, dignity and equal respect for all members. There could be some members who are unwilling to disclose or share or express themselves. In such cases, they should be given freedom to join in when they want.

Check Your Progress Exercise 4

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

- 1. List down the characteristics of a good group leader.

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Now, we need to understand the skills required for being a group leader.

8.2.6 Skills in a Group Leader

Like any skill, leadership skills also have to be learnt. Corey enumerated the following group leadership skills:

- 1. **Active listening:** It means giving total attention to the speaker and being sensitive to what is being communicated at both verbal and non-verbal levels. It also involves understanding unsaid messages.
- 2. **Restating:** It means repeating what the speaker said in different words so that meaning is clear to both speaker and the group. It is to clarify what has been said.
- 3. **Clarifying:** It means clarifying confusing and unclear thoughts and aspects of statements in a message by focussing on underlying issues and helping the person sort out conflicting feelings. This helps to sort out thoughts.

4. **Summarizing:** It means putting together important elements of a group session. It helps in moving from one topic to another and linking the two topics.
5. **Questioning:** It means using appropriate questions to ask or involve group members in a session. Closed questions having answers of 'yes' or 'no' should be avoided as far as possible.
6. **Interpreting:** It means interpretation of participant's behaviour, feelings, thoughts, emotions or experiences. It helps to give perspective, alternative, and insight to the individuals.
7. **Confronting:** It means challenging the members to take an honest look at themselves. It helps involve even the reluctant group members.
8. **Reflecting feelings:** It is a skill of responding to the essence of what a person has communicated. This informs the members that they have been heard and understood.
9. **Supporting:** It means giving members encouragement, reinforcement, and support especially when they are disclosing personal information or personal experiences.
10. **Empathizing:** It means that the group leader is able to have empathy or sensitivity towards the group experiences and at the same time is able to maintain her or his separateness or individuality.
11. **Facilitating:** It means to enhance group experience and help them reach their goals.
12. **Initiating:** It means to bring the group's attention to the central theme or issue to be discussed.
13. **Goal setting:** It means helping the members to set their goals and re-set the same with the passage of time.
14. **Evaluating:** It means assessment of the group process, group members and also individual members; meaning evaluating the group as a whole as well as the individuals comprising it.
15. **Giving feedback:** It means to give honest and clear feedback to the group members and also obtaining clear and honest feedback from the group.
16. **Suggesting:** It helps the participants to develop an alternative way of thinking or doing.
17. **Protecting:** It means to protect the members from psychological and/or physical risk associated with being members of a group. Individual members' psychological needs have to be taken care of.
18. **Disclosing oneself:** It means that the leader reveals personal information about oneself to the group. She or he has to decide how much to disclose, what to tell and when to tell.
19. **Modeling:** It means being a role model to the group. To foster qualities in the group, the leader has to demonstrate the same first to the group.

- 20. **Linking:** It means to develop linkages or communications at member-to-member level and among all members to foster more connectedness and to bring about change.
- 21. **Blocking:** It means to stop counterproductive behaviours within the group. Group pressure, gossiping, making fun of one member, etc. needs to be stopped.
- 22. **Terminating:** It means leaders should know how to terminate or close the group. They should give suggestions to the group to effectively use the knowledge gained in the group in their practical daily life.

Check Your Progress Exercise 5

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Write short notes on the following:

a) Modeling:

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b) Evaluating:

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c) Interpreting:

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8.2.7 Formation of a Group

When a group is formed it should be made clear to the group members what the objectives of the group are. Expectations of each group member should be clear. All should have a freedom to express their thoughts and feelings, Members during the group meetings should be frequently asked if they are facing any problems in the group meetings or in doing the homework assignments. If there are any doubts or misconceptions, those should be clarified. All group meetings should close after inquiring if the members have any doubts or want to ask or clarify anything. And, when the group has to terminate it should sum up all the sessions and suggestions to implement the ideas learnt in the group in real life settings should be provided. Screening of group members for a particular group needs to take into consideration the expectation of the member and purpose of the

group. Individual interview of the member at times helps to decide whether she or he should participate in the group. Fees charged has to be told at the start of the group formation. Preferably time limit of a sessions, total number of sessions, frequency and duration, time, day and dates should be clarified at the outset of the group formation. If you have a co-leader in the group then you should have a clear idea about each person's role and both share equal responsibility in the group. Both of you should be attuned with each other, share a deeper understanding to make the group work a success.

Corey gave the following stages in the development of a group:

Stage 1: Initial Stage – Orientation and Exploration

During initial stage one has to orient towards the goal of the group and explore the expectations of the group members. Now, goals have to be defined, initial personal anxiety and concerns have to be converted into open expression in group meetings. Members have to identify with the group and 'be one' or included in the group. It takes some time on part of the members to be integrated within the group.

Stage 2: Transition Stage – Dealing with Resistance

During transition stage, the group leader helps the members to identify and deal with their anxiety, resistance and conflict. It leads to openness and trust in the group members and revelations on the part of the members. Conflicts and negative feelings also occur now. These need to be dealt with. Remaining aloof or quitting or being afraid of being observed would not help group members. Criticism also may happen at times and may lead to challenging the group leader. Her or his feelings may at times be hurt. There could be resistance or avoidance on other or self exploring personal issues which hurt. For the group to be effective, creating a supportive environment is important.

Stage 3: Working Stage – Cohesion and Productivity

During this stage exploration of significant problems is done. Now, the group senses a closeness or cohesion among its members; they identify with each other's problems and a sense of belongingness, inclusion and solidarity emerges. All members feel being part of the group. They develop trust in each other and accept each other as they are, which leads to sharing their inner self-thoughts and feelings with the group members. Understanding each others' feelings and emotions leads to both having empathy and caring for the other person. Hope emerges in the members. The confidence and motivation to do group work and commitment towards the goals of the group acts as a therapeutic act in itself. Members have now the freedom to experiment and decide what and which behaviour they want to change. They have to then have commitment to change in the group first and later when the group terminates. Intimacy develops among the group members as they find others similar to themselves and identify with each other. Emotional release or catharsis takes place. People find a vent to their feelings when sharing it with others at an interpersonal level. And, this helps in accepting and giving a new meaning to the experience. This leads to cognitive restructuring of the existent beliefs or issues or situations. New meaning is added in the light of catharsis. Self-disclosure helps in open communication within the group. It leads to interaction and discussion in the group. Here, sometimes confrontation of the group members is done. It may help to provide an insight or accurate understanding of a given problem or issue. Feedback is given to the members, exchanged

between members and received from the members. It helps the members to feel confident that they can change if they want to.

Stage 4: Final Stage – Consolidation and Termination

During this stage, all the issues or topics discussed during the meetings are consolidated. Members should be aware of the termination of the group from the beginning of the group. Integrating and interpreting of the group experience is now done by the group members and then summarized by the group leader. Before the last session comes near, the leader should inform the group that it would be terminated in a few sessions time. This helps preparing the group for the end of the group meetings. The use of the learnt group experiences in the real life settings should be emphasized.

Follow-up and Evaluation

After the group has been terminated, a follow up session should be planned with the group by deciding the day, date and timing with the group. This would give the members a chance to come together again. The leader can assess the impact of the therapy on the members and also all could have a realistic picture of the impact of these sessions on themselves and their group members. Corey advises that individual follow-up sessions should also be organised to understand the changes in the member and to show the member the personal concern of the leader.

A word of caution is important in this context. Expertise in individual counselling and psychotherapy does not automatically make you an expert in group counselling and psychotherapy also. One has to have thorough knowledge and understanding to apply the principles of group counselling in practice. Initially, one should work under supervision. After practice start independent group counselling.

Check Your Progress Exercise 6

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What are the four stages of group formation?

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8.3 TRANSACTIONAL ANALYSIS

Transactional analysis was developed by Eric Lennard Berne (1910-1970). Berne was a psychiatrist and also trained as psychoanalyst. He deviated from psychoanalysis as it took a long time to cure the patients. His work is more on groups though he used this approach for individual therapy also. In this section, we would try to understand the basic concepts and principles of this approach to counselling.

8.3.1 Basic Assumptions

There are a few basic assumptions of Transactional Analysis (TA). According to this approach, propounded by Berne, each individual has the capacity to develop to her or his potential to the best advantage of herself or himself and society, to enjoy herself or himself and to be able to work productively and creatively, and to be free of psychological disabilities. One of the basic assumptions in transactional analysis is that awareness leads to change in our thinking or behaving. Another assumption is that each of us is responsible for our thoughts, actions and feelings. Individuals or clients need to take charge or responsibility for changing themselves. They should not blame others for their misgivings in life; instead, should take responsibility on self and thereby be able to change the circumstances. They need to understand their past actions and decisions and its impact on the present and be able to change their present to improve their future.

8.3.2 Key Concepts

Let us now discuss in detail the key concepts of Berne's theory. Transactional analysis is basically based on the belief that the decisions we take in present are rooted in our past survival needs which may no longer be relevant in the present times.

1. The Ego States or the Personality Structure

Berne formulated three ego states which constitutes our personality structure. These three ego states are: the Parent, the Adult and the Child ego state. It is presumed in this theory that the person shifts among these three ego states.

The Parent Ego State

The *parent ego state* (P) consists of the attitudes and behaviour incorporated from external sources, primarily one's parents (Corey) or those whom the person considered parent substitutes. This parental influence on the person is direct which has an impact on the attitudes, behaviours, gestures, postures, communication patterns, etc. of the person. Its one aspect is also Freud's superego. Parent ego state is not present in only abstract forms; it is more direct; for example, it can be said that one behaves like one's father. It is derived from *exteropsyche*, involving identification activities.

The parent ego state has the role of being nurturant, give encouragement, prohibit, command, be critical, etc. It contains the rules of living and following our parents' footsteps in the same situations. Parent ego state also takes decisions as parents would take for their child.

The Adult Ego State

The *adult ego state* (A) is the part which can process information and take decisions in a realistic way. It also acts as mediator between the parent ego state and the child ego state.

The Child Ego State

The *child ego state* (C) is mainly the emotions, feelings and impulse desires. Here, the child ego is not equal to Freud's id, though id can influence the child ego. According to Berne, the child could be a natural child who is

impulsive, spontaneous, open, alive, charming but untrained; an adapted child who has adapted or whose behaviour has been modified or inhibited by the parents; or the rebellious child who rebels or resists the parental authority.

Parent	(P)	ethical guide
Adult	(A)	realistic
Child	(C)	archaic tendency

Fig. 8.1: Diagrammatic representation of ego states

Fig. 8.1 is a diagrammatic representation of the parent, adult and child ego states — all have equal space and respect in an individual's life. These three ego states form the personality structure in Berne's theory of transactional analysis.

Personality Function

The parent ego state has a role to enforce standards or norms of the society. The adult ego state processes and stores the information received. The child ego state contains impulses and desires. When a stimuli is present, all these ego states perceives it, and interact among themselves to react to it. Psychic energy or cathaxis flows from one ego state to another and the state that is cathected at a particular time has executive power, which determines the individual's behaviour at that time. The active state is cathected with unbound energy; the inactive state is said to be cathected with bound energy and the energy which moves freely from one ego state to another is free cathaxis and the feeling of 'Self' resides in the ego state in which free cathaxis is present. The executive ego state generally has both the unbound energy and free cathaxis (Patterson, 1986).

These ego states have boundaries and they don't overlap each other but in various situations or problems their placement may be changed. For example, in an alcoholic the parent ego state is the weakest while child ego state is strongest and they replace each other's position (Patterson).

2. Strokes

Transactional analysis theory presumes that individuals need both physical and psychological strokes to live happily in the society. These strokes lead to formulation of trust in the world and acceptance of their worth and loving themselves. Steiner (1974) said that strokes are as necessary to human life as are other primary biological needs such as food, water and shelter needs which if not satisfied will lead to death. Strokes can be positive or negative and both these have an impact on the psychological well being of an individual. Positive strokes have a positive impact on the psyche. Positive strokes are warmth, affection, appreciation, acceptance, etc. These may be expressed verbally or non-verbally — like through facial expressions, smile, eye contact, touch, gesture etc. Negative strokes have a negative influence on one's psyche. These are considered to be preferred than no stroke at all. For example, attention

seeking behaviour of a child who prefers being scolded by the parent rather than being ignored.

Positive strokes are either given unconditionally or conditionally. Unconditional positive stroke leads to the feeling of being important just because one exists, it has no role with the individual's behaviour or role. On the other hand, conditional positive stroke is given when one does the activity or role as one is expected to do. In transactional analysis, group members are taught to recognize strokes that motivate them, they are sensitive to and also change the perception of the strokes received by the individuals.

3. Injunctions and Counterinjunctions

Injunctions are parental messages that arise from the parent's child ego state. These messages are primarily "Don'ts" – expressed by disappointment, frustration, anxiety, unhappiness, etc. These "don'ts" are learnt during childhood.

"Don't", "Don't be", "Don't be close", "Don't be separate from me", "Don't want", "Don't need", "Don't succeed", "Don't be you", "Don't be same", "Don't be well", "Don't belong", etc. (M. Goulding, 1987; M. Goulding & R. Goulding, 1979).

M. Goulding (1987) states that children decide whether to accept these parental messages or to fight against them. And, if they decide to accept them, they would further decide precisely how they will accept them. Acceptance of some injunctions leads to decisions made by children which further defines their permanent character.

Counterinjunctions are the counterpart of injunctions. These are the parental messages that come from the parent's parent ego state. These contain messages that should be done primarily. These consists of 'dos', 'shoulds', 'oughts', of parental expectations – like, 'Be tough', 'Be perfect', 'Work up to your potential', 'Do what I expect of you', 'Hurry up', 'Try hard', 'Please me', 'Be careful', 'Be polite', etc. (Corey). These counterinjunctions cannot be achieved in totality. Hence it leads to unsatisfaction and frustration of not having done to their maximum expectation. Transactional analysis helps people to evaluate their internalized 'dos' and 'don'ts' and later help them critically examine whether they want to continue living with them or not.

4. Decisions and Redecisions

As discussed above, injunctions and counterinjunctions received from the parents largely determine the individual's present decisions. Transactional analysis provides an understanding based on cognitive, rational and/or behavioural aspects to become aware of our decisions and the capacity to take rededitions new decisions which lead to and better psychological well being. Berne (1964, 1972) said that people are victims of their injunctions and of the decisions based on them. He said that how people are scripted by their parents in the long run determines their life plans. Though Goulding and Goulding (1976) do not agree on this with Berne, they believe that each child makes decisions in response to real or

imagined injunctions and thereby scripts herself or himself. The Gouldings said that many injunctions children live under are not issued by parents but instead are from the children's own fantasy and misinterpretations. They also say that both injunctions and counterinjunctions represent parental authority, but the child has to accept them to have any impact on self.

Here, the client is made to relive the decisions taken during childhood. And, later the client would add fantasy to it and in some way reject the old decision and take a redecision. Here the clients discard their child decisions, critical parent and develop their own self-nurturing which leads to their being more happy and psychologically healthy individuals and develop a new entity or self for themselves in the world.

5. Social Intercourse

Transaction is the primary unit of social intercourse. A transactional stimulus is initiated by the person who initiates the transaction and when the other person responds a transactional response occurs.

Transaction occurs in series which could be through material programming, social programming and individual programming. Material programming is through activities or procedures that deal with material external reality. Social programming is through activities during social interaction, rituals, pastimes and games. Rituals are socially prescribed forms of behaviour in standard social situations, like greeting on meeting others; 'Hello/ Goodbye'. These are generally stereotyped and predictable. Pastimes are less restricted. They begin and end with rituals but facilitate more social interaction with others and give the person a role to play.

6. Games

Games are more serious than both rituals and pastimes. Games play a number of functions and fill or occupy most of the individual's social life. While pastimes could be boring, games are exciting and provide strokes or social reinforcement. Repetition of game leads to collection of a particular feeling or of 'trading stamps'. Dynamic function of games is to preserve psychic equilibrium of a person. Frustration during a game leads to rage or despair. Feelings of guilt, inadequacy, hurt, fear, resentment, anger, worthlessness, unhappiness may at times be resultant of games. These are the trading stamps. Self indulgence in these negative feelings is called *racket*. Berne believed that procedures, rituals, pastimes are directly taught by parents while games are taught indirectly and are learnt through imitation. In games one person has bad or negative feelings in the end. Games prevent intimacy and lead to social withdrawal.

7. Intimacy

Intimacy is a part of individual programming. It is the ideal human living and should provide safety and happiness. To develop intimacy, the person has to let go games, rituals and procedures learnt and negative influence of family and parents.

8. Life Positions

During early childhood period, one takes a decision about oneself, the world and relate to others. Such decisions have been called life positions and they develop into life scripts. Once a life position has been decided upon by the individual, individuals do not change unless intervention or therapy is provided to change. According to transactional analysis, there are four basic life positions based on childhood experiences, which help to know how the person relates to themselves and to the outside world or others. These life positions are:

- 1) I am OK – You are OK.
- 2) I am OK – You are not OK.
- 3) I am not OK – You are OK.
- 4) I am not OK – You are not OK.

'I' and 'You' (others) and 'OK' and not 'OK' are two polars in these statements. 'I' may at times be 'We' and 'You' be 'They'. 'OK' may be good traits and 'not OK' any bad traits in others or groups.

I am OK – You are OK : It is characterized by trust, openness, acceptance of others as they are. It is game free.

I am OK – You are not OK : It is characterized by a sense of superiority complex in self. Here one may feel disgust, anger, criticism, etc. at others.

I am not OK – You are OK : It is characterized by inferiority feeling. They feel powerless, marginalized, victimized, do only for others.

I am not OK – You are not OK : It is characterized among those who have lost all hope and interest from life. They may be withdrawn, self destructive.

9. Life Scripts

Berne said that during childhood interactions with parents and others based on the strokes received by them which may be supporting strokes or disparaging strokes, one forms life scripts. The earliest transaction in script is called the *protocol* and derives from experiences with and the influence of parents. It is later influenced by the myths and fairy tales heard by the child. In later years it is repressed but reappears in the preconscious as the *script proper*. The script proper is modified as a compromise with reality and becomes the *adaptation*. All these three together – protocol, script proper and adaptation – constitute the term *script* (Patterson). Script decides how a person would live, role play in real life. Script refers to the childhood decisions taken by individuals and at times needs to be changed.

One of the major function during transaction analysis is the script analysis, so as to know how these scripts were formed during the life course. It also helps them to change their life positions and develop the ideal life position — I am OK – You are OK.

Check Your Progress Exercise 7

Note: a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Give diagrammatic presentation of the personality structure according to Berne.

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2. What do you understand by the term 'strokes'.

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8.3.3 Goals of Therapy

The goal of transactional analysis therapy is to do structural readjustment and reintegration of self. It believes in total transformation of an individual.

8.3.4 The Therapeutic Procedure

Contracts

The transactional analysis is preceded by an agreement or a contract by the participants or patients, where in, it is explicitly written what one desires or wants from the therapy and therapist also writes what she or he can offer. The contract is amended as the therapy proceeds. Contract is a practical tool to bring out change and also assess how much change is happening.

Structural Analysis

Structural analysis involves understanding the three ego states. Here redefining the ego boundaries and the adult takes place. The clients are first helped to identify their own ego states and later change the ego state that is causing problem. Berne (1961) described two types of problems that need to be considered in structural analysis: exclusion and contamination. *Exclusion* is excluding one ego state completely by another ego state; it consists of rigid ego state boundaries which do not permit free movements. There are three forms of exclusion: *the Constant Parent*, *the Constant Adult* and *the Constant Child*, signifying that the person relates primarily to the parent, adult or child, respectively. The constant parent would exclude adult and child ego states; and similarly the constant adult would

exclude parent and child ego states while the constant child would exclude the parent and adult ego states. The constant parent persons are found to be duty bound or work alcoholics. The constant adult type are found to be very objective, concerned with only facts. The constant child type persons are the ones who do not face the reality or refuse to grow up.

Contamination is overlapping of one ego state on another leading to intermixing of two states. Adult can be intermixed by the parent or child ego states and then behaviour is influenced accordingly.

Transactional Analysis

Even though the theory is named as transactional analysis one of the major therapeutic process is also called *transactional analysis*. It involves the description of what people do and say to one another. According to Berne there are three types of transactions, these are: complementary transactions, crossed transactions and ulterior transactions. *Complementary transactions* are those in which specific state of one person gets predicted response from the specific ego state of another person. *Crossed transactions* are unexpected response received from the ego state of another person. *Ulterior transactions* are more complex and involve more than two ego states and a disguised message during the interaction of two persons. Group is important for transactional analysis.

Analysis of Pastimes and Games

Analysis of pastimes is part of the initial phase of group therapy. Games are evaluated in the therapy process. Berne stressed the importance of learning to understand why and how games take place and how people are kept apart because of these games. The individual games are evaluated in terms of primary gains (external and internal), secondary gains, social gains and biological gains (the removal of isolation by stimulation). The game analysis provides freedom from games in intimate relationships and in society (Patterson).

Life Script Analysis

Life script analysis involves identifying the life pattern on which the person bases the life script. This aims to help individuals to change their lives by redefining actions. It portrays the actions and strategies employed by the individuals. They replay their childhood memories and now as adults understand the injunctions and counterinjunctions learnt during the childhood period. Various techniques are employed to understand the family. It could be through giving group members a role to play in the family play. It could be through didactic procedures like Karpman Drama Triangle in which members identify scripts and games. The triangle has a 'Persecutor', a 'Rescuer', and a 'Victim'. It is based on Karpman's (1968) work. Persecutor criticizes other (victim), rescuer saves the victim and victim is helpless and passive member. Steiner (1967) developed a life-script questionnaire to help group members explore their life positions, roles and games. This is another method of script analysis.

Analysis of Relationships

This is done in marital relationships or other intimate relationships. It should be done with a lot of care and caution as patients would take it as personal influence on their decisions.

8.3.5 Implementation of Therapy

Patterson (1986) writes that Berne has three injunctions for the therapist and these are:

1. The therapist should do no harm. Intervention should be made when necessary and to the extent necessary.
2. All organisms have built-in drive to normal health and the therapist's role is to remove the blocks to natural healing and growth.
3. The therapist treats the patient but God does cure the patient. It is therapist's who gives the best possible treatment but it is the nature or God who does the healing.

Further, Berne gave some hints for the beginning therapist Patterson enumerate them as follows:

1. First learn to differentiate the adult from the child, the parent ego state would become clear later.
2. You should wait until the patient has provided at least three examples or diagnostic illustrations before introducing the system's concept that is applicable to him/her.
3. Later diagnosis of the parent or the child ego state must be confirmed by actual historical material provided by the patient.
4. Realize that the three ego states are to be taken literally, as though the patient were three people. The therapist must also recognize her or his own three ego states and their influence on the therapy.
5. Every patient is assumed to have an adult ego state; the problem arises in cathecting it.
6. The child ego state is not childish but child like and possesses potentially valuable qualities.
7. The person must recall its experience of the child ego state. It is not simply recalling its experiences (regression analysis) but also experiencing the pain and anxiety of those memories.
8. Pastimes and games are not habits, attitudes or occasional occurrences; they constitute most of the patient's activities.
9. "The ideal intervention is the 'bull's eye', one which is meaningful and acceptable to all three aspects of the patient's personality, since all three overhear what is said". It is recognized by all three ego states.
10. The beginner is likely to experience a negative reaction towards the terminology, but this is an expected part of learning a new system of therapy.

Therapist should be a keen observer and should use all her or his senses.

8.3.6 Therapeutic Operations

Berne considers eight categories of basic techniques of transactional analysis, which is a group treatment. These are as follows:

- Interrogation** : Interrogation should be done when therapist is sure that the patient's adult will respond and only the information required should be asked.
- Specification** : Specification means reiterating to the patient by the therapist regarding what has been elicited by the patient.
- Confrontation** : The therapist during confrontation would use previously obtained information from the patient and say it at a point of inconsistency in the patient's thought. Its purpose is to cathect the uncontaminated part of the patient's adult.
- Explanation** : Explanation is done to strengthen the patient's adult. Explanations should be concise and should be used if the patient is not facing the facts by self.
- Illustration** : Illustration is usually followed after confrontation to lessen the impact of undesirable effects of confrontation. It is used when both adult and child are listening.
- Confirmation** : Confirmation is to be used only if previous confrontation and illustration were successful and the patient's adult has become strong.
- Interpretation** : If the above techniques have been useful in successfully cathecting and decontaminating the patient's adult, and the adult is now strong, and can understand self and be ready for of the therapy termination can take place.
- Crystallization** : Transactional analysis is completed by crystallization even if interpretation is not done. It happens when the adult of therapist is able to interact with the adult of patient. To cure the patients, therapist may at times also use its parent or child ego states, but remember, therapist does not play roles.
- Regression analysis** : Regression analysis is used in addition to the eight techniques mentioned above. It means the child ego state has to be heard in the presence of both adult and parent ego states and later the analysis is done with the patient.

8.3.7 Redecisional Approach

The Gouldings gave a redecisional approach to therapy which has some contrast with the classical Berne transactional analysis approach. According to them, the client has to make redecisions while they are in the child ego state. This can happen when the client enters into the child ego state and takes a decision to change; understanding of the problem from adult ego state does not help.

The Initial Stage of the Group

In this approach, establishment of good rapport with the leader and members is important. The members initially may not bring forth their main concerns and would avoid important issues. Trust has to be established and later inquiry of their problems would lead to accurate answers. The client has to take action by responding and then contract has to be formulated.

The Working Stage of the Group

After contract has been formulated, racket is explored — of bad intentions and feelings while games are played, actions used to justify wrong acts and decisions taken for the same. The person is taken from the present feelings to the past childhood days from where the decisions were taken. Then games are analysed and challenges placed if the client is not taking responsibility. Then the client can take redecisions when they learn and understand that they had taken early decisions and so they can now change or take redecisions. This kind of therapy according to the Gouldings will not take a long time in analysis.

The Final Stages of the Group

Once redecision in the child ego state is made then change in the body, voice, gestures are explicit to all group members. Reinforcement of this decision by the client and other group members is important.

Group members have to tell new story to replace old story and now group members would receive both verbal and non-verbal strokes for their decisions. The ways in which members would devise support systems outside the group would be found. They need to fantasize the change, new problems and new successes during the final stage and before termination. This would help the client to settle down in later life more effectively.

Check Your Progress Exercise 8

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What is the difference between Gouldings' and Berne's perspective in transactional analysis?

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8.4 THE EXISTENTIAL APPROACH TO COUNSELLING

The existential approach to counselling is based on the “third force” or philosophical approach. For existential psychotherapy the main concerns are: freedom, isolation, death and meaninglessness – the roots of human existence (Yalom, 1980).

Existentialism tries to understand client’s subjective view of the world. This approach peeps into the lives of the clients as well as therapist as perceived and experienced by the client. This approach helps the client to understand that they are not living a full meaningful life as they would have desired to live and to bring about the desired changes in the selves – take the right choices that will help them to live a life they are capable of being. The key existential writers were Heidegger and Sartre, who did not write from therapy view point directly but tried to understand the human experiences deeply. Existential therapy may also be used in group situations.

8.4.1 Key Concepts

The key concepts of this approach are: self awareness, self-determination, responsibility, existential anxiety, death and non-being, the search for meaning, the search for authenticity, aloneness/relatedness. Let us briefly discuss each of these key concepts.

Self-awareness

Self-awareness helps to differentiate between other organisms and develop an understanding of our freedom to choose and to act upon. This freedom to choose helps us to understand that whether we have to be passive or active in determining a route for ourselves. Self-awareness gives direction or meaning to our existence—whether we decide for ourselves or others will decide for us. Either we develop an identity for ourselves or let it be lost to conformity to others. Whether we want to do our maximum potential or do little of our capacity. Whether we are prepared for the anxiety to take self decisions or we want to depend on others. To find a meaning of our life or lead an empty and meaningless existence. To accept the inevitability of our eventual death or escape from this reality as it makes you anxious. These are some of the options that self-awareness leads one to recognize (Corey).

Self-Determination and Personal Responsibility

Existential approach believes that we are free to choose, determine among which alternative to choose, direct our life and shape our destiny. Sarte (1971) points out that we are free to choose but we have to constantly choose the kind of person we want to be and with time, the choices needs to be changed. Russell (1978) further said that each time we act, we choose and create ourselves as we want to be and this process never ends and it impacts all the deeds one does. Frankl (1963) said that, “Life ultimately means taking responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual”. According to Frankl, clients should accept their role in creating their distress and after acceptance only they can change. The others or the environment does not change, one has to change.

Existential Anxiety

According to this approach, anxiety is the main characteristic of human life. It also acts as a motivation to do something. Anxiety is a result of our choices without knowing the outcome. Kierkegaard said "existential anxiety is the dizziness of freedom". Anxiety results because we have to leave our familiar ways and choose the unknown new ways to do things. May (1983) said that "anxiety is the experience of the threat of imminent nonbeing". Existential anxiety is the result of 'change' or 'want' to become what we are capable of. It helps us to take action for growth. If we remove or blunt existential anxiety, then we have constricted our lives and limited our choices (Corey).

Death and Non-being

According to the existentialist, life has meaning because it will end, death gives purpose to life and gives significance to the present hour and the present hour is what we really have to live. The reality that one day I would die is the most important thing and this realization brings anxiety. Frankl said it is not important how long we live, but how we live determines the quality and meaningfulness of our life.

The Search of Meaning

The search of meaning refers to search of answers to questions like – 'Who am I?', 'Why am I here?', 'Where am I going?', 'Why am I going?', 'What is the purpose of life?', 'Why am I living?'. These questions become essential to existentialist viewpoints. It is 'I' who has to give meaning to life and to create it through a positive reasoning. Frankl said that we can create meaning through various ways like – work, love, doing things to alleviate other's suffering. He said that the therapist should not tell the client what is the meaning of life for her or him but encourage them to find it for themselves. He further stated that our suffering, pain, despair can be turned into achievement by the stand we take in the face of it.

The Search for Authenticity

Authenticity is the 'courage to be' (Paul Tillich, 1952) to live from inside. Discovering, creating and maintaining the core deep within our being is a difficult and never-ending struggle (Corey). Keen (1970) said that authentic being is born of anxiety, the anxiety of never knowing if are making the right choices and having the courage to do so. Frankl says that it is the therapist's role to challenge the clients to become their full and authentic selves and make life commitments. Inauthenticity leads to existential guilt, which means a sense of incompleteness and the realization that we are not utilizing our full potentials (Corey). Authenticity or leading a life to our maximum ability leads to self actualizing. Maslow (1970) said that self-actualization is the tendency to become all that we are able to become. Self-actualizing person according to Maslow has a sense of inner direction, resists being led by others, has tolerance, caring, acceptance, committed intimate relationships, autonomy and perceives others and the world with spontaneity and naturalness.

Aloneness and Relatedness

Existential approach believes that ultimately we all are alone and have to find meaning to our being/life/existence by realization of being alone. Aloneness leads

to anxiety and results in our being related to others. We have to realize that we are both alone and related to others at the same time. Corey said that for having fulfilling and nourishing relationship with others, we need to first be able to stand alone and find our own strength within ourselves.

8.4.2 Application

Existential approach to psychotherapy can also be used for individual counselling. It is quite suitable for persons who are distressed, destitute, orphans, who have no self awareness, etc. A partnership and sharing among the therapist and client is important. Use of therapist subjectivity, challenging the client, and the need to be somebody or do something are essential parts in this approach.

Check Your Progress Exercise 9

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List the key concepts of existential counselling approach.

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8.5 INDIAN PSYCHOTHERAPY AND COUNSELLING

Psychotherapy in India started in ancient times. Its origin is traced to about 2000 BC (Veerashwar, 2002). Ayurveda and Yoga contribute largely to the Indian Ayurveda, which started with Vedas about 600BC and Patanjali's Yoga started about 150 BC. A deep research in this domain, though now initiated by some, needs to be highly strengthened by good research work, in the second year of this programme of study [M.Sc. (CFT)] you will learn more about the applications of Yoga and meditation in the field of counselling and family therapy.

In this section, we will try to understand the Indian psychotherapy system. In the world over, tensions and stress are engripping the human force leading to major or minor physical or mental health problems. Use, understanding and practice of yoga in daily life helps to live a healthy life. Indian psychotherapy is using the scientific facts with the art of living. It is a philosophy. it is not promoting magic or the mystique. According to Prakash Veereshwar (2002) : Indian philosophy is of Advait (Absolute monism) which has given the concept of 'Shoonyta' or the great void. 'Shoonyta' is not negative, is a void which is more 'filled' than all the plentitudes of the universe. Indian thought understands man as an essentially luminating *Atman* being, belonging directly to *Brahman* or Supreme Being. According to the Indian thought, there are two problems; one being the endless

sufferings of mankind and second is man's powerful yearning for release from suffering and attaining ultimate happiness — *Moksha* or salvation.

Existentialism discussed in the West also to an extent deals with the philosophy of being or existing which is related to the ancient Indian thought.

There are inherent differences in Indian and Western psychology and psychotherapy. It can be distinguished by the fact that most of the Western therapies emphasize on the self, and are ego-based, while Indian thought denounces the self for attainment of *nirvana* and espouses ultimate self detachment. Western thought is therefore narrow while Eastern thought is vast as it also considers the universe. Shri M.V. Govindaswami, founder of NIMHANS, used to say that, "Mahabharata is a great text book of psychopathology and Gita a great treatise on psychotherapy". According to Veereshwar, the Indian psychotherapy has shown the following trends after 1960's:

- Leaning towards the eternal classic Gita;
- Sanction to *guru-shishya parampara* in therapeutic situation.

- Leaning towards the eternal classic Gita:

The Indian classic on Gita, which largely contains the lessons given by Lord Krishna, a Hindi deity, mythologically to Arjuna, enlightens people to the right and wrong paths, living for the righteous ways, *karma* and ultimate happiness. It give strength, encouragement and insight to look within oneself (Satyananda, 1972).

- The Basic Pattern of *Guru-shishya* Relationship:

According to therapists like Dhairyam, Carstus and Neki, the *guru-shishya* relationship is most acceptable to Indian patients in therapeutic relationships. According to Neki (1978), guru is involved in the whole process more actively and takes the whole burden of decision upon himself and gives insight to the shishya (patient). Guru acts as a therapist, friend, philosopher and guide in the real school.

For a therapy to be effective, it has to come from the Indian culture (Dr. E.M. Hock, 1964, a swiss psychotherapist).

Now we will discuss the Indian psychotherapy in brief as given by Veereshwar. It mainly consists of Atharva Veda, Ayurveda and Yoga.

The Vedas

The Vedas are the ancient wisdom of India, contain philosophy, art and science of living. There are four Vedas, which are:-

Rig Veda - It is in prose form and gives methods of performing yagyas.

Sam Veda - It is in singable lyrical form and deals with the ways to fight the elements disturb yajya and also appeases various vedic gods.

Atharva Veda - It contains worldly problems and their solutions. This veda is consulted for psychotherapy in India. It is practical and psychological in nature. it provides solutions to everyday needs and problems.

Ayurveda - Ayurveda is the science of life. It presents a holistic, patient-oriented approach. It studies the patient's, mind and body. It consists of 3 main samhitas—Charak Samhita, Sushruta Samhita and Ashtanj Sangrha.

Charak Samhita contains description of various mental and physical diseases. Sushruta Samhita deals with the medicine and surgery. Ashtanga Sangrha of Vagabhatta is the combination of eight branches of Ayurveda for treatment of mental disorders.

Yoga - Yoga is gaining wide popularity the world over. Yoga is used as a relaxation technique and exercise by the therapists. Yoga means to unite. Tenets advocated by Maharishi Patanjali are mainly applied today. Yoga helps to boost ego strength and improve complete wellness among the humans.

8.6 ELECTRIC APPROACH TO COUNSELLING

Electric approach to counselling or integrated approach to counselling is using more than one specific approach in the psychotherapeutic process. The therapist should have clear reasons for the usage of more than one therapy. Counsellor should be able to define the goals of integrated approach to counselling, give direct reasons for using different approaches and what one wants to achieve by it should be clearly hypothesized.

Always remember that all counselling and psychotherapeutic approaches want to change their client for good. They all differ in the approach and method to help their client. While deciding upon which technique is to be used, cost effectiveness in terms of time, human resources, and number of sessions should be kept in mind. All therapies are effective and all approaches are considered to change the patient or help the client and also the client believes that she or he shall change with this approach. All approaches emphasize on an honest relationship, clear understanding, empathy for client. All the approaches are diverse in their method to help the patient or cure the symptoms. Compatibility of approaches in an electric approach should be thoroughly considered. In the end, remember that an approach in which the counsellor or therapist is well versed should be used and approach which is most suitable to your client needs to be used.

Check Your Progress Exercise 8

Note: a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What do you mean by electric approach to counselling?

.....

.....

.....

.....

.....

.....

8.7 LET US SUM UP

In this Unit, we studied that :

- We are all born and live in some kind of group.
- Group counselling is an effective way of counselling parents of young children, parents of children with disabilities, alcoholic groups, etc.
- Group psychology is concerned with individual member as a member of a race, nation, caste or group who have been organized for a definite purpose. There could be various types of groups like structured groups, religious group, groups belonging to various age groups like elderly young children, adolescents, etc.
- Group leader needs to be courageous, has personal power to influence, emotionally present to be with others, willingness for self confrontation, sincerity, authenticity, sense of identity, belief in group process and enthusiasm, inventiveness and creativity to approach the group.
- Transactional analysis approach is basically a group counselling approach. The personality structure is made of three ego states, namely, the parent ego state, the adult ego state and the child ego state.
- Transactional analysis approach emphasizes the use of strokes, injunctions and counter-injunctions during childhood which lay the foundation of our personality. Understanding of the fact that the decisions taken during childhood could be reversed leads to redecisions and change to being 'OK'. I, others, OK and not Ok are the key words in this approach.
- Existential approach lay emphasis on being or ought to be. The realization of the self-awareness, self-determination and to lay responsibility on self for what we are today would lead to change. Anxiety produced in the fact of death and non-being gives search to the meaning of our existence. One has to re-define our quest of 'why', 'where', and 'how'. What questions to lead an authentic life leading to self actualization.
- Eclectic approach to counselling or integration of various approaches should be carefully planned after understanding the clients need. Clear goals and hypothesis should be formulated.

8.8 GLOSSARY

Adult ego state	:	Ego state which processes information and take decisions in a realistic way in one's brain.
Child ego state	:	Ego state consisting of emotions, feelings and impulsive Desires.
Disclosing oneself	:	Group counsellor reveals personal information about oneself to the group.
Existential anxiety	:	Anxiety as a result of change or desire to become what we are capable of.

Group leader	:	Group counsellor or group therapist.
Parent ego state	:	Ego state consisting of attitudes and behaviour incorporated from external sources primarily one's parents.
Restating	:	Repeating what the speaker said in different words.
Summarizing	:	Putting together important elements.
Terminating	:	Closing or ending the group sessions.

8.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. According to Le Bon, psychological group is a coalition of heterogeneous individuals which are combined for a cause or purpose to work as a whole unified unit for a given reason or cause.
2. McDougall described a group as a 'crowd' that fulfills certain conditions.

Check Your Progress Exercise 2

1.
 - Some of groups usually found are :
 - Mahila mandal group,
 - Panchayati group,
 - IIT – Training group,
 - Residents welfare association,
 - Self help groups, and
 - Anonymous group.

Check Your Progress Exercise 3

1. Multi-cultural context means when group members belong to different races, cultures, ethnicity or religions.

Check Your Progress Exercise 4

1.
 - i) Emotional presence,
 - ii) Personal power,
 - iii) Courage,
 - iv) Willingness to confront oneself,
 - v) Sincerity and authenticity,
 - vi) Sense of identity,
 - vii) Belief in group process and enthusiasm, and
 - viii) Inventiveness and creativity.

Check Your Progress Exercise 5

1. a) Modeling: Modeling is a skill of the group leader. Through modeling or being a role model to the group, the group leader can foster those qualities in the group members which she or he wants the group to imbibe.
- b) Evaluating: The group leader needs to evaluate the group as a whole, the individual members of the group and the group process. It is also a skill of a group leader.
- c) Interpreting: Interpreting is a skill of a good group leader. It means to interpret group members' behaviour, feelings, thoughts, emotions or experiences.

Check Your Progress Exercise 6

1. Following are the four stages of group formation:
 - i) Initial stage – Orientation and exploration
 - ii) Transition stage – Dealing with resistance
 - iii) Working stage – Cohesion and productivity
 - iv) Final stage: Consolidation and termination

Check Your Progress Exercise 7

1. According to Berne, diagrammatic presentation of the personality structure is given below:

Parent Ego state (P)

Adult Ego state (A)

Child Ego state (C)

2. Strokes can be both positive or negative. They are the verbal and non-verbal communication received from primarily the parents and also others in the group. Positive strokes have a positive impact on the individual while negative strokes have a negative impact.

Check Your Progress Exercise 8

1. The Gouldings and Berne differ in decisions and redecisions approach in transactional analysis. The Gouldings believe that the child takes the decisions based on their perception, fantasy and understanding of what parents say and this understanding during adulthood leads to redecisions at an adult level. On the other hand, Berne believed that the child as young was not taking decisions but receiving the same from their parents.

Check Your Progress Exercise 9

1. The key concepts of existential counseling approach are given below:
 - i) Self-awareness,
 - ii) Self-determination and personal responsibility,
 - iii) Existential anxiety,

- iv) Death and non-being,
- v) The search for meaning,
- vi) The search for authenticity, and
- vii) Aloneness and relatedness.

Check Your Progress Exercise 10

1. The eclectic approach to counselling means to use more than one approach while dealing with a client. It is the integration of various counselling approaches as per the need. The goals of therapy have to be clear and hypothesization done before starting the therapy.

8.10 UNIT END QUESTIONS

1. What are the skills and characteristics you should develop as a group counsellor? Support your answer with examples.
2. 'I am OK – You are not OK'. What do you understand by this statement. Discuss your answer from theoretical perspectives.
3. 'Anita has been admitted to a women's home. She has no home to go and most of the time she is crying. She has not been able to cope up with sewing classes in which she was sent. She does not talk to the other group members. She remains alone and within herself'.

In the above situation, what approach to counselling you would use? Give reasons to support your answer. Also describe the procedure you would follow in the psycho-therapeutic process.

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NOTES

MCFT-003

COUNSELLING AND FAMILY THERAPY: BASIC CONCEPTS AND THEORETICAL PERSPECTIVES

BLOCK 1 : INTRODUCTION TO COUNSELLING AND FAMILY THERAPY

- Unit 1 : Counselling: Meaning, Scope and Applications
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- Unit 8 : Group Counselling and other Counselling Approaches

BLOCK 3 : SCHOOLS OF FAMILY THERAPY

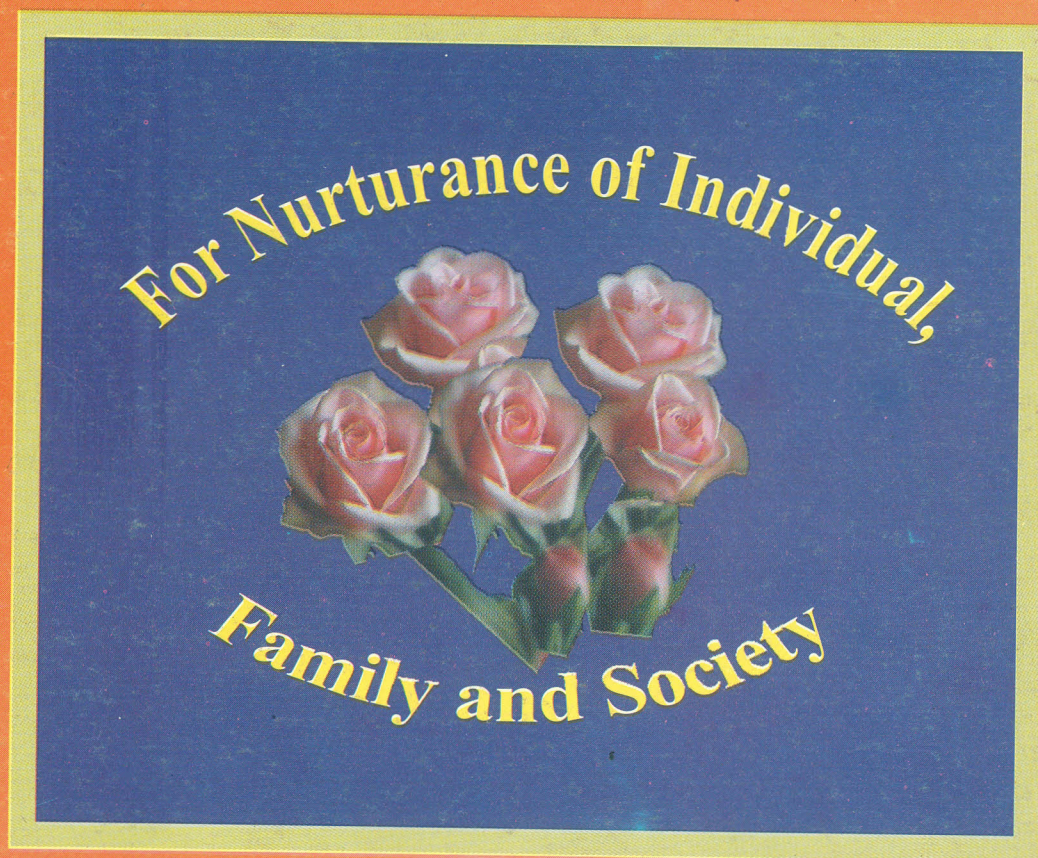
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